
ADULT INTAKE FORM

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-mail: _____ Would you like to receive our newsletter by email? yes

Male Female Age: _____ Date of Birth: _____

Marital Status: _____ Number of children: _____

Occupation: _____ Employed By: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Name of Medical Doctor: _____ Phone: _____

How did you hear about our practice? _____

Has another family member already been a patient of our practice? _____

CONTEXT OF CARE REVIEW

Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your health and the most appropriate approach toward improvement. Your time, thoughtfulness and honesty in completing this overview will greatly aid my assisting your health needs.

What do you know about the naturopathic approach to medicine?

What expectations do you have from this visit?

What long term expectations do you have from working with the clinic?

CONTEXT OF CARE REVIEW

What is your present level of commitment to address the underlying causes of your symptoms?

(0% committed) 0 1 2 3 4 5 6 7 8 9 10 (100% committed)

What behaviours or lifestyle habits do you currently engage in regularly that support your health?

What behaviours or lifestyle habits do you currently engage in regularly that are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

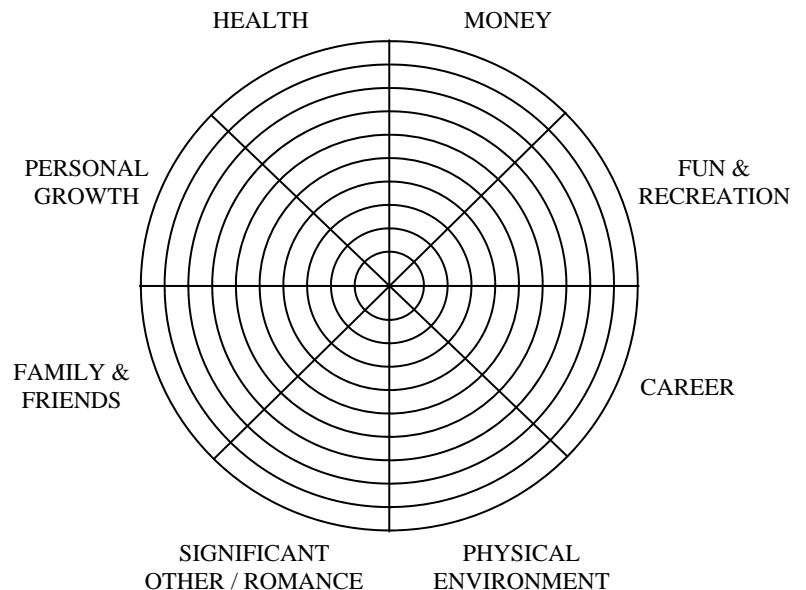
What do you love to do?

The Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied with your career, shade in the first six levels of the career slice, starting from the center of the wheel.

Do the same for each area.



Health Concerns

What are your primary health concerns in order of importance to you?

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Medical History

List any major illnesses, injuries and/or surgeries that you have had and when:

Family History

Please put an “L” for living and “D” for deceased, and present age or age at the time of death. Indicate if the family member suffered from any diseases or conditions such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies or arthritis.

Relationship	L/D	Age	Health Conditions/Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sister(s)			
Brother(s)			

Vitamins and Supplements

List all vitamin/mineral/herbal supplements you are currently taking:

Supplement (Including Brand)	Dosage	When did you begin this supplement?

Medications

List all prescription and non-prescription medications you are currently taking:

Medication	Dosage	When did you begin this medication?

Allergies

Do you have any Food Intolerances or Allergies? _____

Do you have any Allergies (ie. hayfever, grass, dust, dogs/cats)? _____

Do you have any Environmental Sensitivities (ie. paints, perfumes, scents)? _____

Digestive Health

How many meals do you eat each day? _____

How frequently do you move your bowels? _____ (# of movements) per day or week?

Do you experience any of the following?

Loose stool/Diarrhea? yes no

Hard stool? yes no

Difficulty passing? yes no

Blood in stool? yes no

Undigested food in stool? yes no

Mucous in stool? yes no

Fatty residue in stool? yes no

Gas? yes no

Bloating? yes no

Bad Breath? yes no

Heart burn/Reflux? yes no

Abdominal pain? yes no

Do you have your gallbladder? yes no

When did you last use antibiotics? _____

Do you have your appendix? yes no

How long did you take them for? _____

Sleep

How many hours of sleep do you get on average? _____

What time do you go to bed? _____ What time do you wake in the morning? _____

Do you have trouble falling asleep? yes no If yes, how long do you take to fall asleep? _____

Do you wake up during the night? yes no If yes, how often? _____

If you wake during the night, what time(s) do you wake? _____

If you wake during the night, do you have trouble falling back to sleep? yes no

Do you feel refreshed in the morning? yes no

Lifestyle

How many hours do you work each day? _____

Do you enjoy your work? _____

Do you often feel overworked? yes no

Do you exercise? yes no If yes, how often? _____

What types of exercise do you do? (indicate how often and how long)

Do you smoke? yes no If yes, for how long? _____ How many per day? _____

Do you use recreational drugs? yes no If yes, which ones? _____

Rate your energy between 1 and 10. (low) 1 2 3 4 5 6 7 8 9 10 (high)

When during the day is your energy the highest? _____ lowest? _____

Rate your stress between 1 and 10. (low) 1 2 3 4 5 6 7 8 9 10 (high)

What are your biggest sources of stress? _____

Please check “✓” any of the following that apply to you or write “P” beside the box if you have experienced these in the past.

General

- Fatigue
- Change in appetite
- Change in thirst
- Cravings
- Weight gain
- Weight loss
- Poor sleep
- Chills or fever
- Night sweats
- Sweat easily
- Allergies
- Cancer
- Diabetes

Skin and Hair

- Dryness
- Rash
- Itching
- Eczema
- Psoriasis
- Acne
- Recent moles
- Hives or allergic reactions
- Loss of hair
- Thinning hair
- Dandruff
- Other skin problem(s)

Eyes Ears Nose & Throat

- Eye pain
- Eye strain
- Blurry vision
- Impaired vision
- Cataracts
- Ear aches
- Ear infections
- Ringing in ears
- Vertigo or dizziness
- Sinus infections
- Nasal obstruction
- Post nasal drip
- Nosebleeds
- Loss of smell/taste
- Sores in mouth
- Mercury fillings
- Jaw pain or clicks
- Recurrent sore throat
- Tonsillitis

- Enlarged glands
- Enlarged thyroid
- Facial pain/tics
- Headaches

Cardiovascular

- Chest pain
- Palpitations
- High blood pressure
- Low blood pressure
- Heart attack
- Congestive heart failure
- Irregular heartbeat
- Pacemaker
- Artificial heart valve
- Stroke
- Fainting
- Varicose veins
- Deep leg pain
- Cold hands or feet
- Swelling of limbs
- Anemia
- Easy Bruising

Respiratory

- Difficulty breathing
- Shortness of breath
- Chronic cough
- Bronchitis
- Emphysema
- Asthma
- Wheezing
- Coughing blood
- Phlegm in throat

Muscle Bone & Joints

- Neck pain
- Back pain
- Arthritis
- Bursitis
- Joint pain or stiffness
- Artificial joint
- Muscle pain
- Muscle weakness

Gastrointestinal

- Nausea
- Vomiting
- Vomiting blood
- Reflux or heartburn
- Constant hunger
- Ulcer

- Indigestion
- Gall stones
- Liver disease
- Jaundice
- Intestinal parasites
- Constipation
- Diarrhea
- Chronic laxative use
- Rectal burning/pain
- Hemorrhoids
- Blood in stool

Neurological

- Anxiety
- Depression
- Irritability
- Emotional problems
- Loss of balance
- Poor memory
- Dizziness
- Seizures/Epilepsy
- Concussion
- Lack of coordination
- Extremity numbness
- Extremity tingling
- Paralysis

Infections

- Strep throat
- Mononucleosis
- Tuberculosis
- Hepatitis
- HIV/AIDS

Urinary

- Frequent urination
- Urgency to urinate
- Incontinence
- Pain on urination
- Waking at night to urinate
- Urinary tract infection
- Blood in urine
- Kidney stones

DECLARATION AND CONSENT TO TREATMENT

Naturopathic Doctors minimize the risk of harmful side effects, by supporting the body's own capacity to heal and by using the least invasive procedures for diagnosis and treatment whenever possible. However, even the gentlest therapies have potential for complications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease, or in specific patient populations such as pregnant or lactating women, very young children, or patients taking multiple medications. It is very important that you inform your Naturopathic doctor immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture or blood draws
- Fainting or puncturing of an organ with acupuncture needles

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my Naturopathic Doctor will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I will rely on the Naturopathic Doctor to exercise judgement during the course of the procedure which they feel at that time is in my best interests, based on the facts then known.

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

If I am unable to make my appointment I must provide advance notification within 24 hours in which case no charge will be applied.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

- I. Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving from another licensed health care provider, or may receive in the future;
- II. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Alberta;
- III. No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;
- IV. The treatment and therapies rendered or recommended by this Clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

