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# Naturopathic Adult Intake Form

**Full Name**:
_____
_____

**Date of Birth**: _____ **Age**: _____
**Gender**: F M

**Mailing Address**:
_____
_____

**Home#** _____ **Mobile#** _____**Work#**
_____

**Email**:
_____
_____

**Emergency Contact**:

**Name:** _____**Relation**:
_____

**Home#** _____ **Mobile#** _____**Work#**
_____

**Medical Doctor**:

**Name:** _____ **Phone**:
_____

**Address:** _____ **Fax**:
_____

**Specialists and Other Current Health Practitioners:**

_____
_____

_____
_____

**Personal Health Number** (Care Card)
_____

**How did you hear about *Active Back to Health Centre*?**

_____
_____

**Would you like us to email you newsletters and special promotions?** Yes No

## Medical Information

**What is the main reason for your visit today?**

**Current Health Concerns and/or Goals**
*Please list your concerns in order of importance, when the symptoms began and any treatments that you have tried.*

1. _____Onset:
_____

Treatments:
_____
_____

2. _____Onset:
_____

Treatments:
_____
_____

3. _____Onset:
_____

Treatments:

_____
_____

4. _____Onset:
_____

Treatments:

_____
_____

5. _____Onset:
_____

Treatments:

_____
_____

**General Info**

**Height: _____ Weight: _____ Weight 1 year ago:**
_____

**Energy Level on a scale from 0-10:**
_____

**When during the day is your energy the best? _____ worst?**
_____

**What is your occupation?**
_____

**Do you smoke?** YES NO If yes, how many packs per day _____ For how long? _____

**How many alcoholic drinks do you consume per week?** None 1-4 5-7 7-10 10+

**Please list any recreational drug use**:
_____

**How many cups of caffeine do you drink per week?** None 0-6 7-9 10-14 14+

**Do you adhere to a specific diet (e.g. vegetarian, vegan, high-protein, gluten-free, paleolithic)?**

_____
_____

**What foods do you avoid?**

_____

_____

_____

## Psychosocial

*Please rate on a scale from 0-10 (10=best) how satisfied you are with the following areas of your life*

Work/School _____
Financial Situation _____
Social Life/Friends _____
Spirituality _____
Relationship _____
Sexual Life _____
Family _____

## Allergies & Sensitivities

*Please list any known drug, environmental or food reactions that you have experienced and the reaction that occurred.*

**Drug Allergy:** _____ Reaction:
_____

**Drug Allergy**: _____ Reaction:
_____

**Environmental Allergy**: _____ Reaction:
_____

**Environmental Allergy**: _____ Reaction:
_____

**Food Allergy**: _____ Reaction:
_____

**Food Allergy**: _____ Reaction:
_____

**Food Sensitivity**: _____ Reaction:
_____

**Food Sensitivity**: _____ Reaction:
_____

## MEDICATIONS (Prescription drugs and over-the-counter preparations)

*Please list all medications that you are currently taking, and any other information you can provide.*

| Drug | Dose | Reason for Taking | Year Started |
|---|---|---|---|
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**<u>SUPPLEMENTS</u> (vitamins, herbal medicines, homeopathic preparations)**

*Please list all supplements that you are currently taking, and any other information you can provide.*

| **Supplement** *(Including brand if known)* | **Dose** | **Reason for taking** *(Including who prescribed this to you)* | **Year Started** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## <u>Past Medical History</u>

**<u>Conditions</u>**

*Please list any previous medical conditions, and when you suffered from them*

1.

_____

_____

2.

_____

_____

3.

_____

_____

4.

_____

_____

5.

_____

_____

**Other Medical Events: Hospitalizations, Injuries, Trauma & Surgery**

*Please list any hospitalizations, major injuries, emotional/physical trauma, or surgeries experienced and the year they occurred*

1. Year: _____Condition:

_____

2. Year: _____Condition:

_____

3. Year: _____Condition:

_____

4. Year: _____Condition:

_____

**Did you receive all general childhood vaccinations?** YES NO

**What other vaccines have you received?**

- ○ Hepatitis A
- ○ Hepatitis B
- ○ Typhoid
- ○ Flu Shot
- ○ Chicken Pox
- ○ HPV (Gardasil)

## Family Medical History

*Below is a list of common health conditions. To the best of your knowledge please include which family member was or currently is affected.*

| | Mother | Father | Sibling | Children | Maternal Grandparents | Paternal Grandparents | Aunts | Uncles |
|---|---|---|---|---|---|---|---|---|
| **Cancer** (include type) | | | | | | | | |
| **Genetic Disorders** (e.g. MS, ALS, etc.) | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Cardiovascular Disease** (Heart Attack, Stroke, High Blood Pressure, etc) | | | | | | | | |
| **Diabetes** | | | | | | | | |
| **Dementia** | | | | | | | | |
| **Psychiatric or Mood Disorders** | | | | | | | | |
| **Depression/Anxiety** | | | | | | | | |
| **Autism/ADHD** | | | | | | | | |
| **Food/ Environmental Allergies** | | | | | | | | |
| **Digestive Conditions** (Crohns, IBS, Ulcerative Colitis, etc) | | | | | | | | |
| **Autoimmune Disease** (Rheumatoid arthritis, Lupus, etc) | | | | | | | | |
| **Thyroid Disease** | | | | | | | | |
| **Osteoporosis/Arthritis** | | | | | | | | |
| **Other Health Concerns** | | | | | | | | |

# Review of Symptoms

*Please check all symptoms that you have experienced during the last 6 months*

**GENERAL**

- ○ Weight gain
- ○ Weight loss
- ○ Heat/Cold Intolerance
- ○ Insomnia
- ○ Fatigue
- ○ Night sweats

**HEAD, EYES, EARS, NOSE & THROAT**

- ○ Headache
- ○ Migraine
- ○ Ear pain
- ○ Ringing in ears
- ○ Changes in hearing
- ○ Itching or watery eyes
- ○ Dry or red eyes
- ○ Eye pain
- ○ Changes in vision
- ○ Throat pain
- ○ Difficulty swallowing
- ○ Sinus infection/pain
- ○ Nasal congestion

**CARDIOVASCULAR**

- ○ Chest pain
- ○ Heart palpitations
- ○ High blood pressure
- ○ Easy bruising
- ○ Varicose veins
- ○ Swollen feet/ankles
- ○ Cold hands/feet

**RESPIRATORY**

- ○ Difficulty breathing
- ○ Exercise intolerance
- ○ Cough
- ○ Hoarseness of voice
- ○ Sleep apnea
- ○ Snoring
- ○ Asthma or wheezing

**GASTROINTESTINAL**

- ○ Bloating & Flatulence
- ○ Indigestion
- ○ Constipation
- ○ Diarrhea
- ○ Blood and/or mucous in stool
- ○ Pain during bowel movements
- ○ Belching
- ○ Acid reflux
- ○ Hemorrhoids
- ○ Anal fissures
- ○ Nausea

**EATING & APPETITE**

- ○ Difficulty gaining weight
- ○ Difficulty losing weight
- ○ Frequent dieting
- ○ Poor appetite
- ○ Always hungry
- ○ Emotional eating
- ○ Cravings
- ○ Binge eating
- ○ Anorexia or bulimia

**PSYCHOLOGY & NERVOUS SYSTEM**

- ○ Anxiety or panic attacks
- ○ Depression
- ○ Difficulty concentrating
- ○ Poor memory
- ○ Numbness or tingling
- ○ Difficulty with speech
- ○ Seizures
- ○ Trembling or tremor
- ○ Dizziness or vertigo
- ○ Fainting or feeling lightheaded
- ○ Loss of balance
- ○ Difficulty walking

**MUSCULOSKELETAL**

- ○ Joint pain, redness, or stiffness

*Specify* _____

- ○ Neck or back pain
- ○ Foot cramps or pain
- ○ Wrist or hand pain
- ○ Joint deformity
- ○ Muscle pain or cramps
- ○ Muscle weakness
- ○ Restless legs
- ○ Tendonitis
- ○ TMJ /Jaw pain

**URINARY**

- ○ Acute or Chronic UTI's
- ○ Incontinence or Dribbling
- ○ Pain or burning on urination
- ○ Frequent urination
- ○ Blood in urine

**IMMUNE**

- ○ Enlarged lymph nodes
- ○ Painful or tender lymph nodes
- ○ Frequent infections
- ○ Frequent colds or flu
- ○ Slow wound healing

**SKIN & NAILS**

- ○ Acne
- ○ Athlete's foot
- ○ Jock Itch
- ○ Dandruff
- ○ Dark circles under eyes
- ○ Profuse sweating
- ○ Rashes or hives
- ○ Dry or itchy skin
- ○ Bumps on the back of arms
- ○ Suspicious moles
- ○ Changes in pigment
- ○ Hair loss
- ○ Brittle or breaking nails
- ○ White spots or ridges on nail

## MEN'S HEALTH

*Please check all boxes that apply*

- ○ Prostate enlargement
- ○ Change in libido
- ○ Hernia
- ○ Erectile dysfunction
- ○ Testicular mass or pain
- ○ Prostate or urinary infection
- ○ Urinary urgency, hesitancy or dribbling
- ○ Sexually transmitted infections
  Specify: _____

Date of most recent PSA test: _____ Normal/Abnormal?

Date of most recent Prostate Exam: _____ Normal/Abnormal?

## WOMEN'S HEALTH

*Please provide the numbers as they apply*

- ○ Pregnancy _____
- ○ Miscarriage _____
- ○ Caesarean _____
- ○ Abortion _____
- ○ Vaginal Delivery _____
- ○ Living Children _____
- ○ Gestational Diabetes _____
- ○ Postpartum Depression _____
- ○ Breast Feeding _____

Date of last PAP test _____ Normal/Abnormal?

Date of last Mammogram _____ Normal/Abnormal?

## MENSTRUAL HISTORY

Age at first period _____
Length of period _____
Length of cycle _____ Irregular Y N
Date of last period _____

- ○ Blood Clots
- ○ Menstrual Cramping
- ○ Breast Tenderness
- ○ Mood Swings/Irritability
- ○ Water retention
- ○ Depression

## GYNECOLOGICAL CONDITIONS

- ○ Endometriosis
- ○ PCOS (Ovarian cysts)
- ○ Uterine Fibroids
- ○ Pain with Intercourse
- ○ Bleeding between periods
- ○ Infertility
- ○ Low libido
- ○ Fibrocystic breasts
- ○ Sexually transmitted infections
  *Specify* _____
- ○ Cervical dysplasia
- ○ Menopause, since age _____
  - o Hot flashes
  - o Vaginal dryness
  - o Night sweats
  - o Mood swings
  - o Difficulty concentrating
  - o Depression
- ○ Perimenopause, since age _____
- ○ Use of Hormone replacement therapy

# Informed Consent for Naturopathic Care

- I understand that the practice of naturopathic medicine requires taking a thorough case history, and may require a physical exam. In some cases, diagnostic testing including the collection of blood, urine and/or saliva may be required.

- I confirm that the information I have provided to *Active Back to Health Centre* is complete and inclusive of all health concerns including the possibility of pregnancy and use of all current medications, including over-the-counter drugs.

- I understand that naturopathic medicine carries a risk of complications and that a resolution of symptoms is not guaranteed. Health risks of some naturopathic treatments include, but are not limited to:
    - Temporary aggravation of pre-existing symptoms
    - Allergic reactions and other adverse effects to botanical medicines or supplements
    - Pain, fainting, bruising or injury from venipuncture, acupuncture or cupping treatments
    - Muscle sprain, ligament strain, swelling and/or pain from spinal manipulation

- I confirm that I have the ability to accept or reject the recommended treatment at my own free will.

- I understand that I have the ability to seek and/or continue medical care from another qualified health care practitioner. I recognize that I am encouraged to speak freely regarding the treatments received and recommendations made at *Active Back to Health Centre*.

- I understand that a record of my visits and medical history will be kept, that this record will be strictly confidential and will not be released to any persons without my written consent.

- I have read and understood the fee schedule and I acknowledge that these services are not covered by MSP and I am responsible for payment of goods and services in full at each visit.

- I understand that there is a cancellation fee for appointments **missed without notice or cancelled with less than 24 hours notice**. I acknowledge that if I arrive late for my scheduled appointment, the visit will be shortened to ensure that other patient visits are kept on time.

- I understand that the doctors at *Active Back to Health Centre* reserve the right to determine which cases fall outside their scope of practice, in which case an appropriate referral will be recommended.

*Fee Schedule:*
*Naturopathic*
*Initial Visit up to 1 Hour - $185*
*Follow-up (45 minutes) - $135*
*Follow-up (30 minutes) - $93*
*Follow-up (15 minutes) - $47*

*Acupuncture*
*Initial Visit - $85*
*Regular visit - $75*

***Please note: fees are subject to change based on time spent with patient***

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

***THANK-YOU for your time and thoughtful consideration when filling out these forms, they will help us in understanding your whole health picture and create a plan that is unique to you.***