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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

SUPPLEMENTS (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

Past Medical History

Conditions

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.