



Naturopathic Adult Intake Form

Name: _____ Date: _____

Address: _____ City: _____

Postal Code: _____ E-mail: _____

Date of birth: _____ Sex: _____ Age: _____ Weight: _____ Height: _____

Pregnant: Y/N, How many weeks: _____ Breast feeding: _____

Phone (primary): _____ (secondary): _____

May we leave phone messages relating to your visits? Y/N

Emergency Contact Name: _____

Phone: _____ Relation: _____

Occupation: _____

Marital Status: _____ Number of Children: _____

Medical Doctor: _____ Phone: _____

Have you received naturopathic care previously? Y/N

How did you hear about us: _____

What are your main health concerns (in order of importance)?

1. _____ 2. _____

3. _____ 4. _____

Do you have any known allergies or sensitivities? Y/N If yes, please list:

Please list all vitamins, minerals, herbal supplements you are currently taking and for how long? (Include the brands)

Please list all the medications that you are taking and for how long?

Please list any injuries, major surgeries, major diseases or illnesses that you have had and when they occurred?

How many times have you been treated with antibiotics? _____

Do you have any dietary restrictions e.g. vegetarian, vegan, religious?

Do you drink alcohol? Y/N If yes, how many drinks per week? _____

Do you smoke? Y/N If yes, how many cigarettes per day? _____

Do you use recreational drugs? Y/N If yes, please list. _____

<p>Please check any condition(s) you have or have had in the past:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Cardiovascular disease <input type="checkbox"/> Cancer <input type="checkbox"/> Mental Health Conditions <input type="checkbox"/> Other: _____ 	<p>Please check any condition(s) that may have occurred in a close relative (parent, child, sibling):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis <input type="checkbox"/> Mental Health Conditions <input type="checkbox"/> Other: _____
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Is there anything you feel is important that has not been covered?



Review of systems

Please check any symptoms you have or had:

<p>General:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue <input type="checkbox"/> Change in appetite <input type="checkbox"/> Change in thirst <input type="checkbox"/> Night sweats <input type="checkbox"/> Heat or cold intolerance <p>Skin:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Poor wound healing <input type="checkbox"/> Easy bruising <input type="checkbox"/> Rashes/ Itching/hives <input type="checkbox"/> Eczema/Psoriasis <input type="checkbox"/> Excess dryness or moistness <input type="checkbox"/> Frequent skin infections <input type="checkbox"/> Skin ulcer/Skin cancer <input type="checkbox"/> Nail changes <input type="checkbox"/> Hair changes <p>Eyes, Ears, Nose, Throat, Respiratory:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Floaters/blind spot <input type="checkbox"/> Eye pain <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Frequent colds <input type="checkbox"/> Sinus issues <input type="checkbox"/> Swollen glands <input type="checkbox"/> Sore throat <p>Cardiovascular:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitation/fluttering <input type="checkbox"/> Cold hands and feet <p>Lungs:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chronic cough <input type="checkbox"/> Emphysema <p>Gastrointestinal:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heartburn <input type="checkbox"/> Gas or bloating <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Nausea /Vomiting <input type="checkbox"/> Blood or mucus in the stool <input type="checkbox"/> Diarrhea or constipation 	<p>Musculoskeletal:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Joint pain /stiffness <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Muscle weakness <p>Neurological:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fainting or loss of consciousness <input type="checkbox"/> Loss of sensation <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> Memory problems <input type="checkbox"/> Seizures <p>Urinary:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Pain during urination <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Urgency <input type="checkbox"/> Inability to hold urine <p>Men's Health:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Erectile difficulties <input type="checkbox"/> Prostate difficulties <input type="checkbox"/> Discharge from the penis <p>Women's Health:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Clots in menstrual blood <input type="checkbox"/> Heavy or excessive menstrual flow <input type="checkbox"/> Scanty or light menstrual flow <input type="checkbox"/> Irregular cycles <input type="checkbox"/> Difficulties becoming pregnant <input type="checkbox"/> Difficulty maintaining a pregnancy or history of miscarriages <input type="checkbox"/> Menopausal symptoms
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Thank you for filling the forms out



Please note that this form must be signed prior to your first appointment.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. I will conduct a thorough case history and perform any necessary physical examinations, including more specific examinations such as breast, gynecological, rectal, prostate or genital exams with your consent. Specific blood and/or urine laboratory samples may be used as part of your treatment work-up.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture.
- Fainting or puncturing of an organ with acupuncture needles.

Supplements, remedies, botanicals, laboratory tests and other services are charged separately and are not included in the visit fee. There will be no refunds or exchanges on visit fees, supplements, remedies, botanicals, laboratory tests, and other services.

My health records will be kept confidential and will only be released to comply with legal and regulatory requirements. It may also be used to complete claims for insurance purposes. If needed, my Naturopathic Doctor may communicate with other health-care providers. I may look at my medical record at anytime and can request a copy of it by paying \$0.10 per page.

I understand:

- The clinic does not guarantee treatment results.
- I am free to withdraw my consent and to discontinue treatment at any time.
- I give my informed consent to provide naturopathic medical consultation, assessment and/or treatment to me.
- I intend this informed consent to apply to all my present and future naturopathic care.
- I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications

Patient's Name (please print): _____

Signature of patient or guardian: _____ Date: _____

ND: _____