



Naturopathic Intake - Adult

Patient Information

Name _____ Date _____

Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-Mail _____

Date of Birth *day* _____ *month* _____ *year* _____ Age _____

Occupation _____

Referred By _____

Emergency Contact Information

Name _____ Relation _____

Phone _____ E-Mail _____

Other Health Care Providers

1. _____ 2. _____ 3. _____

Medical Concerns

List your primary health concerns, in order of importance.

Please describe their onset, how long you have been experiencing them, and any other useful information in the space provided below.

1.
2.
3.
4.
5.

If you are female, are you currently pregnant? _____

How would you rate your current health? (*circle one*) Excellent Good Fair Poor

Medical History

Please list any serious conditions, illnesses, or injuries, and any hospitalizations below, along with their approximate dates.

Do you have any allergies? If so, what to? _____

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List all medications you are currently taking. _____

List all supplements you are currently taking. _____

List all past prescription medications you have taken. _____

Do you frequently take any of the following products? *(please circle all that apply)*

Aspirin

Tylenol

Ibuprofen

laxatives

cough remedies

antacids

diet pills

birth control pills

How much *alcohol* do you consume per week? _____

How much *tobacco* do you consume per week? _____

How much *caffeine* do you consume per week? _____

Do you use *recreational drugs*? What type and how often? _____

Please list the five most significant, stressful events in your life, from the most recent to the most distant. Do any of these events still affect your life now? If so, please explain.

1. _____

2. _____

3. _____

4. _____

5. _____

Do you get regular screening done by another doctor? _____

Do you have any dietary restrictions or sensitivities? _____

Describe a typical day's food and beverage intake

breakfast _____

lunch _____

dinner _____

snacks & drinks _____

Family History

Indicate which of your close relatives suffers from any of the following conditions.

allergies _____ *asthma* _____

heart disease _____ *high blood pressure* _____

cancer _____ *diabetes* _____

depression _____ *mental illness* _____

drug/alcohol abuse _____ *kidney disease* _____

Environmental Factors

Where do you work? _____

What are your hobbies and activities? _____

Describe your home environment. _____

Are you regularly exposed to smoke? _____

Are you regularly exposed to animals? _____

How is your home heated? _____

Is there anything that has not been covered that you feel is important? Describe below.

Patient Signature _____ Date _____

Review of Systems

Circle the relevant conditions listed below. Circle **Y** (*yes*) when a condition that you currently is listed. Circle **P** (*past*) when a condition is listed that you have suffered from at anytime in your past. Please comment on any condition when you feel it is pertinent.

Weight			
Weight 1 year ago			
Maximum weight			
Height			
Fatigue/Weakness	Y	P	
Fever/Chills	Y	P	
Skin		Comments	
Rashes	Y	P	
Eczema	Y	P	
Hives	Y	P	
Acne	Y	P	
Boils	Y	P	
Itching	Y	P	
Color change	Y	P	
Lumps	Y	P	
Night sweats	Y	P	
Dry	Y	P	
Moist	Y	P	
Cold to the touch	Y	P	
Hot to the touch	Y	P	
Nail changes	Y	P	
Change in Mole	Y	P	
Skin Cancer	Y	P	
Head		Comments	
Headache	Y	P	
Head injury	Y	P	
Dizziness	Y	P	
Eyes		Comments	
Impaired vision	Y	P	
Glasses/Contacts	Y	P	
Eye pain	Y	P	
Tearing	Y	P	

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Dry	Y	P	
Double vision	Y	P	
Glaucoma	Y	P	
Cataracts	Y	P	
Blurring	Y	P	
Sensitive to the sun	Y	P	
Itching	Y	P	
Redness	Y	P	
Discharge	Y	P	
Blind spot	Y	P	
Ears			Comments
Impaired hearing	Y	P	
Earache	Y	P	
Dizziness	Y	P	
Vertigo	Y	P	
Discharge	Y	P	
Infections	Y	P	
Nose & Sinuses			Comments
Frequent colds	Y	P	
Nose bleeds	Y	P	
Stuffiness	Y	P	
Hay fever	Y	P	
Sinus problems	Y	P	
Mouth & Throat			Comments
Frequent sore throat	Y	P	
Sore tongue/mouth	Y	P	
Gum problems	Y	P	
Hoarseness	Y	P	
Cavities	Y	P	
Loss of taste	Y	P	
Neck			Comments
Lumps	Y	P	
Swollen glands	Y	P	
Goiter	Y	P	
Pain	Y	P	
Stiffness	Y	P	
Respiratory			Comments
Cough	Y	P	

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Cough up sputum	Y	P	
Spit up blood	Y	P	
Wheezing	Y	P	
Asthma	Y	P	
Bronchitis	Y	P	
Pneumonia	Y	P	
Pleurisy	Y	P	
Emphysema	Y	P	
Difficulty breathing	Y	P	
Pain on breathing	Y	P	
Shortness of breath	Y	P	
Shortness of breath at night	Y	P	
Shortness of breath lying down	Y	P	
Tuberculosis	Y	P	
Tuberculin Test	Y	P	
Last Chest -ray			
Cardiovascular	Comments		
Heart disease	Y	P	
Angina	Y	P	
High blood pressure	Y	P	
Murmurs	Y	P	
Rheumatic fever	Y	P	
Chest pain	Y	P	
Palpitations/fluttering	Y	P	
Cyanosis	Y	P	
Swelling in ankles	Y	P	
Heart attack	Y	P	
Stroke	Y	P	
Past ECG/EKG	Y	P	
Other heart tests			
Breasts (Men & Women)	Comments		
Do you do monthly self exams?	Y	P	N
Lumps	Y	P	
Pain/tenderness	Y	P	
Fibrocystic breasts	Y	P	
Nipple discharge	Y	P	
Breast cancer	Y	P	

Abdomen & Gastrointestinal				Comments
Trouble swallowing	Y	P		
Heartburn	Y	P		
Change in thirst	Y	P		
Change in appetite	Y	P		
Nausea	Y	P		
Vomiting	Y	P		
Vomiting blood	Y	P		
How often do you have a bowel movement?				
Is this a change?	Y		N	
Blood in stool	Y	P		
Belching or passing gas	Y	P		
Jaundice (yellow skin and eyes)	Y	P		
Liver disease	Y	P		
Gall Bladder disease	Y	P		
Ulcer	Y	P		
Indigestion	Y	P		
Diarrhea	Y	P		
Rectal bleeding	Y	P		
Hemorrhoids	Y	P		
Black, tarry stool	Y	P		
Abdominal pain	Y	P		
Hernias	Y	P		
Urinary				Comments
Pain on urination	Y	P		
Increased frequency	Y	P		
Frequency at night	Y	P		
Inability to hold urine	Y	P		
Frequent infections	Y	P		
Kidney stones	Y	P		
Blood in urine	Y	P		
Urgency	Y	P		
Hesitancy	Y	P		
Male Reproductive				Comments
Hernia	Y	P		
Testicular mass	Y	P		
Testicular pain	Y	P		
Enlarged prostate	Y	P		

Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P		
Venereal disease	Y	P		
Discharge	Y	P		
Genital sores	Y	P		
Genital rash	Y	P		
Sexual preference: Heterosexual	Y			
Bisexual	Y			
Homosexual	Y			
Female Reproductive				Comments
Age menses began				
Average length of menses (including spotting)				
Length of cycle (day 1 to day 1)				
Last menstrual period (day 1)				
Are cycles regular	Y	P	N	
Bleeding between periods	Y	P		
Painful menses	Y	P		
Excessive flow	Y	P		
PMS	Y	P		
Pain during intercourse	Y	P		
Vaginal discharge	Y	P		
Vaginal itching	Y	P		
Fibroids	Y	P		
Date of last PAP				
Number of pregnancies				
Number of live births				
Number of miscarriages				
Number of abortions				
Difficulty conceiving	Y	P		
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P		
Venereal disease	Y	P		
Genital sores	Y	P		
Genital rash	Y	P		
Sexual preference: Heterosexual	Y			
Bisexual	Y			
Homosexual	Y			

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Musculoskeletal			Comments
Joint pain	Y	P	
Joint stiffness	Y	P	
Joint swelling	Y	P	
Arthritis	Y	P	
Broken bones	Y	P	
Muscle spasms or cramps	Y	P	
Weakness	Y	P	
Backache	Y	P	
Peripheral Vascular			Comments
Deep leg pain	Y	P	
Cold hands/feet	Y	P	
Varicose veins	Y	P	
Thrombophlebitis	Y	P	
Leg cramps	Y	P	
Extremity numbness	Y	P	
Extremity swelling	Y	P	
Extremity ulcers	Y	P	
Neurologic			Comments
Fainting	Y	P	
Involuntary movement	Y	P	
Seizures/Convulsions	Y	P	
Paralysis	Y	P	
Muscle weakness	Y	P	
Numbness or tingling	Y	P	
Loss of memory	Y	P	
Loss of balance	Y	P	
Speech problems	Y	P	
Endocrine			Comments
Heat intolerance	Y	P	
Cold intolerance	Y	P	
Thyroid trouble	Y	P	
Excessive thirst	Y	P	
Excessive hunger	Y	P	
Excessive urination	Y	P	
Excessive sweating	Y	P	
Diabetes	Y	P	
Hypoglycemia	Y	P	

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Hormone therapy	Y	P	
Blood & Lymphatic			Comments
Anemia	Y	P	
Easy bleeding or bruising	Y	P	
Past transfusions	Y		
Swollen lymph nodes	Y	P	
Emotional			Comments
Depression	Y	P	
Mood swings	Y	P	
Anxiety or nervousness	Y	P	
Tension	Y	P	
Phobias	Y	P	
Insomnia	Y	P	
Hobbies & Habits			Comments
What are your main interests and hobbies?			
Do you have time for your interests and hobbies?	Y	P	N
When do you feel the happiest and/or most alive?			
Do you eat three meals daily?	Y	P	N
Do you awake rested?	Y	P	N
Do you sleep well?	Y	P	N
How many hours do you sleep each night?			
Do you enjoy your work?	Y	P	N
Do you watch television?	Y	P	N
How many hours/day?			
Do you take vacations?	Y	P	N
Have you been treated for alcoholism?	Y	P	N
How often?			
Have you been treated for drug dependence?	Y	P	N
How often?			

Patient Agreement Form

Each patient is required to read the following before treatment.

Your signature below acknowledges the following:

1. I understand that Naturopathic medicine is not covered by the provincial government, yet Naturopathic expenses may be covered by private insurance plans and may be tax deductible.
2. The fees and services have been clarified in advance. Payment is due at the end of each visit as the clinic does not bill insurance companies directly. Cash, cheque, Interac, Visa, and Master Card (no other credit card) are acceptable methods of payment
3. Twenty-four hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 50% of the missed appointment.
4. Items purchased are non-refundable, whether or not they have been opened.
5. I understand that natural health care is a joint responsibility between me (the patient) and my practitioner. Improving my lifestyle can be as important as the remedies and treatments.
6. I understand that I may contact my ND by phone or e-mail and that all e-mails will be screened by reception and forwarded to the appropriate Naturopathic doctor.
7. I realize that Naturopathic medicine is not an isolated system and that Naturopaths welcome teamwork with MDs, DCs, RMTs, and other health practitioners.

Patient Signature _____ Date _____

Informed Consent

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths 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. A number of different approaches are used. Diet and nutritional supplements, botanical medicine, homeopathy, Asian medicine and acupuncture, hydrotherapy, physical medicine, and lifestyle counselling are mainstays of Naturopathic medicine.

Individual *diets and nutrition supplements* are recommended to address deficiencies, treat disease processes, and promote health. The benefits include increased energy, increased digestive health, improved immune function and general well being.

Botanical medicine is a plant-based medicine that uses teas, tinctures, capsules, and other compounds to assist the body in recovery from injury and disease. These compounds are also used to boost the body's immune system and prevent disease.

Asian medicine is a system of care, which includes acupuncture, dietary recommendations, and botanical medicines. These various treatments are used to eliminate disease and restore balance in the body's functions. Sometimes moxa (a compressed herb) is burned over an acupuncture point to relieve symptoms.

Homeopathy is a form of medicine based on the Law of Similars - simply described as the use of tiny doses of naturally occurring substances to stimulate the body's ability to heal itself. Homeopathy is a powerful tool and effects healing on an emotional as well a physical level.

Physical medicine refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems. Hydrotherapy refers to the use of hot and cold water applications to improve circulation and to stimulate the immune system.

As Naturopathic medicine is a holistic approach to health, *lifestyle* is considered relevant to a Naturopath's approach to most health problems. Thus, the identification of lifestyle risk factors will allow for recommendations to be made that will help to optimize physical, mental, and emotional environment.

At your first appointment you can expect a thorough physical examination and history taking. This will include urine testing, and may include the ordering of blood work or a breast or pelvic examination. Because some therapies must be used with caution when dealing with particular conditions (such as pregnancy and lactation, kidney disease, and heart disease), it is very important that you inform your Naturopathic doctor immediately of any disease that you are suffering from, as well as any forms of medication, drugs, or supplements you are taking.

There exist slight health risks when receiving treatment by Naturopathic medicine. These risks include, but are not limited to, aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, bruising, fainting, or injury from venipuncture or acupuncture; puncturing of an organ with acupuncture needles; accidental burning of the skin from the use of moxa; muscle strains or disc injuries as a result of spinal manipulations.

I understand that a record will be kept of the health services provided to me, and that it will be kept confidential and will not be released to others unless so directed by me, unless the law requires it.
I understand that I may look at my medical records at any time, and can request a copy of this record 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 the practitioner will answer any questions that I may have to the best of her ability.
I understand that results cannot be 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 her judgement during the course of the procedure which she feels at the time is in my best interest, based on the facts then known.
With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above.
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 my participation in these procedures at any time.
I understand if I am seeing more than one doctor at the Ottawa Integrative Health Centre I imply consent for them to share and discuss my file and deemed necessary by the practitioners.

Patient Name _____

Patient Signature _____ Date _____

Ottawa Integrative Health Centre care provider: _____