



ADULT INTAKE FORM

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (Home) _____ (Bus) _____ (Cell) _____

Email: _____ 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: _____

How did you hear about our practice? _____

HEALTH CONCERNS

Please, list your health concerns in order of importance.

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

Vitamins and Supplements

List all vitamins/minerals/herbal supplements you are currently taking:

Medications

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

Medical History

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

Allergies

Do you have any hypersensitivity or allergy to any drugs? _____

Do you have any food intolerances or allergies? _____

Do you have any environmental sensitivity? _____

General

Height: _____ Weight: _____ lbs Weight 1 year ago: _____

Family History

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

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

Dental

Do you have any root canals? Yes No If yes, how many? _____

Do you have any amalgam fillings? Yes No If yes, how many? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Habits:

Main interests and hobbies: _____

Do you exercise? Yes No If yes, how often? _____

Do you smoke? Yes No If yes, 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)

Rate your Stress between 1 and 10. (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Sleep

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

Do you have difficulty falling asleep? Yes No

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

Do you feel refreshed in the morning? Yes No

Digestive Health

How frequently do you move your bowels? _____

Do you experience any of the following?

Loose Stools?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mucous in stools?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diarrhea?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gas?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hard Stools?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bloating?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty Passing?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heartburn/Reflux?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood in Stools?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Abdominal Pain?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Undigested Foods in Stools?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Do you have your gallbladder? Yes No Do you have your appendix? Yes No

Female Reproductive

Age of your first menses? _____

How many days of menses? _____

How long is your cycle? _____

When was your last pap test? _____

Do you get yeast infections? Yes No

History of abnormal pap? Yes No

Are you menopausal? Yes No If yes, age of last menses _____

Have you had a hysterectomy? Yes No

Do you experience any of the following?

Heavy flow Yes No

Light flow Yes No

Clotting Yes No

Bleeding between periods Yes No

If you experience PMS, which symptoms?

Pain or cramping

Headaches

Mood Swings

Breast Tenderness

Bloating

Cravings

Do you experience any of the following?

Hot flashes

Low libido

Disrupted sleep

Pain during intercourse

Poor memory

Vaginal itching

Changes in mood

Vaginal dryness

Are you sexually active? Yes No Form of contraception _____

Male reproductive

Please, indicate if any of the following applies to you:

<input type="checkbox"/> Impotence	<input type="checkbox"/> Testicular Pain
<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Infertility/Low Sperm Count
<input type="checkbox"/> Sores on Genitals	<input type="checkbox"/> Hernia
<input type="checkbox"/> Discharge	<input type="checkbox"/> Prostate Condition
<input type="checkbox"/> Testicular mass	

Are you sexually active? Yes No Form of contraception _____

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

<p>General</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Change in appetite</p> <p><input type="checkbox"/> Change in thirst</p> <p><input type="checkbox"/> Cravings</p> <p><input type="checkbox"/> Weight gain</p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Poor sleep</p> <p><input type="checkbox"/> Chills or fever</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Sweat easily</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Diabetes</p> <p>Skin and Hair</p> <p><input type="checkbox"/> Dryness</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Acne</p> <p><input type="checkbox"/> Recent moles</p> <p><input type="checkbox"/> Hives/allergic reactions</p> <p><input type="checkbox"/> Loss of hair</p> <p><input type="checkbox"/> Thinning hair Dandruff</p> <p><input type="checkbox"/> Other skin problem(s)</p> <p><input type="checkbox"/></p> <p>Eyes Ears Nose & Throat</p> <p><input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> Eye strain</p> <p><input type="checkbox"/> Blurry vision</p> <p><input type="checkbox"/> Impaired vision</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Ear aches</p> <p><input type="checkbox"/> Ear infections</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Vertigo or dizziness</p> <p><input type="checkbox"/> Sinus infections</p> <p><input type="checkbox"/> Nasal obstruction</p> <p><input type="checkbox"/> Post nasal drip</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Loss of smell/taste</p> <p><input type="checkbox"/> Tonsillitis</p>	<p><input type="checkbox"/> Sores in mouth</p> <p><input type="checkbox"/> Mercury fillings</p> <p><input type="checkbox"/> Jaw pain or clicks</p> <p><input type="checkbox"/> Recurrent sore throat</p> <p><input type="checkbox"/> Enlarged glands</p> <p><input type="checkbox"/> Enlarged thyroid</p> <p><input type="checkbox"/> Facial pain/tics</p> <p><input type="checkbox"/> Headaches</p> <p>Cardiovascular</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Heart attack</p> <p><input type="checkbox"/> Congestive heart failure</p> <p><input type="checkbox"/> Irregular heartbeat</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Artificial heart valve</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> Deep leg pain</p> <p><input type="checkbox"/> Cold hands or feet</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Easy Bruising</p> <p>Respiratory</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Coughing blood</p> <p><input type="checkbox"/> Phlegm in throat</p> <p>Muscle Bone & Joints</p> <p><input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> Joint pain or stiffness</p> <p><input type="checkbox"/> Artificial joint</p> <p><input type="checkbox"/> Muscle pain</p> <p><input type="checkbox"/> Muscle weakness</p>	<p>Gastrointestinal</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting blood</p> <p><input type="checkbox"/> Reflux or heartburn</p> <p><input type="checkbox"/> Constant hunger</p> <p><input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> Gall stones</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Chronic laxative use</p> <p><input type="checkbox"/> Rectal burning/pain</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Blood in stool</p> <p>Neurological</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Irritability</p> <p><input type="checkbox"/> Emotional problems</p> <p><input type="checkbox"/> Loss of balance</p> <p><input type="checkbox"/> Poor memory</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Seizures/Epilepsy</p> <p><input type="checkbox"/> Concussion</p> <p><input type="checkbox"/> Lack of coordination</p> <p><input type="checkbox"/> Extremity numbness</p> <p><input type="checkbox"/> Extremity tingling</p> <p><input type="checkbox"/> Paralysis</p> <p>Infections</p> <p><input type="checkbox"/> Strep throat</p> <p><input type="checkbox"/> Mononucleosis</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> HIV/AIDS</p> <p>Urinary</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Urgency to urinate</p> <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Pain on urination Wake</p> <p><input type="checkbox"/> at night to urinate</p> <p><input type="checkbox"/> Urinary tract infection</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Kidney stones</p>
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Signature

I attest that the information provided is true and accurate to the best of my knowledge.

Signature _____ Date _____

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 judgment 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 48 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.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive and hereby authorize and consent to treatment.

Patient's Full Name: _____

Date of Consent: _____

Signature of Patient: _____