Family Focused Naturopathic Care

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drdenoon.ca

Adult Intake Form

Thank you for taking the time to complete the following new patient forms to the best of your ability. They are an important step towards defining your health care needs and achieving your health goals.
Please email this form in advance for review, drop in off in advance, or bring this form to your first appointment. Please also include any relevant blood work or health reports.

All the answers on this form will be held ***absolutely confidential.***

Name: **Birthdate:**

Address with P.O. Box #:

City: **Prov:** **Postal Code:**

Phone (Home): **Phone (Cell):** **Phone (Work):**

Email: **Occupation:**

Family Doctor: **Phone #:**

Referring Professional: **Phone #:**

Care Card #:

Emergency Contact (Name, Relationship):

Phone #:

Spouse's Name:

Children's Names & Ages:

Preferred Method of Communication:

Why did you choose to come to this clinic?:

Have you seen a Naturopathic Doctor before? (Y/N) **Dr:**

PRESENT HEALTH CONCERNS:

	Please list most important health concerns in their order of significance.	Please list any prior diagnosis including when and by whom.
1		
2		
3		
4		
5		

ALLERGIES:
(Please list your allergy, your reaction and severity on a scale of 1-10)

Medications:

Food:

Environmental
:

PAST MEDICAL HISTORY:

Have you ever been hospitalized? Y/N Why and which dates?

Have you ever had any major accidents, traumas or surgeries? Y/N Explain and which dates?

Your birth history (prolonged labour, forceps, breastfed, etc.):

OCCUPATIONAL STRESS:

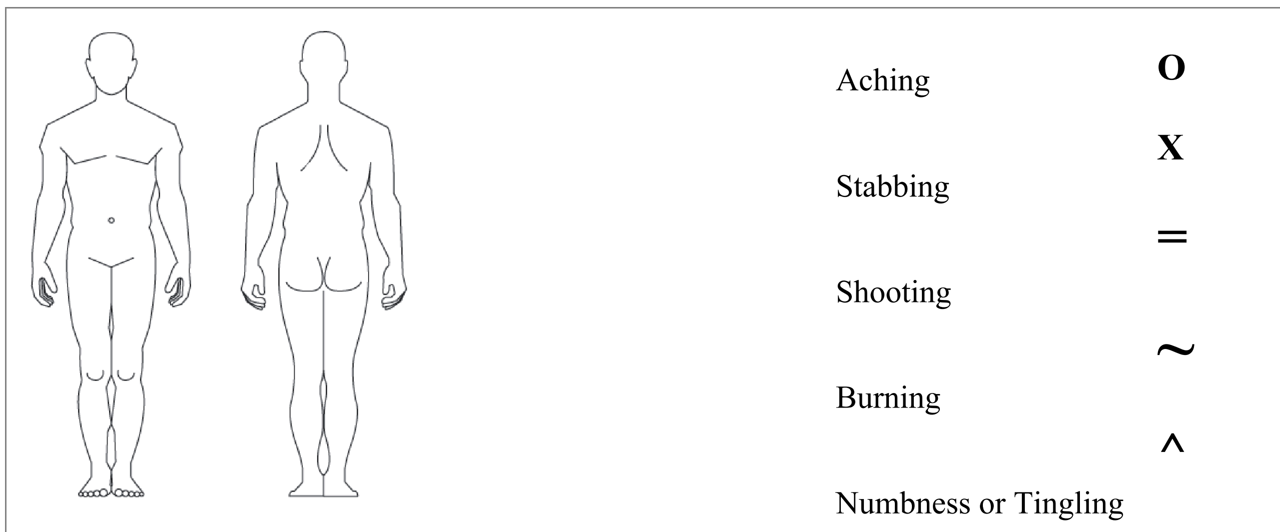
Chemical:

Physical:

Physchological/emotional:

PHYSICAL CONDITION:

(Please indicate on the diagram the nature of your symptoms using the provided symbols.)



If you have indicated pain above, please use the next 2 lines to explain the onset, duration and frequency with which you experience this pain:

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Please describe your current physical condition (Truth please)**:**
Exercise: Daily 5x Week 3x Week Weekly Monthly or Never

Type (length, aerobic, strength, intensity): ______________________________

____

FAMILY HEALTH HISTORY:			
RELATION	MEDICAL CONDITION	AGE AT DEATH	CAUSE OF DEATH
Father			
Mother			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			
Paternal GF			
Paternal GM			
Maternal GF			
Maternal GM			

Please mark conditions you previously or currently experience with P or C	**P** = past **C** = current

GENERAL SYMPTOMS	
	Loss of consciousness
	Numbness/tingling
	Fever
	Sweats
	Fainting
	Dizziness
	Loss of sleep/insomnia
	Frequent colds/flu
	Loss of weight

HEAD AND NECK	
	Headaches
	Type
	Vision problems
	TMJ concerns
	Ear aches
	Decreased hearing
	Sinus problems

SKIN	
	Rashes/eczema
	Itching
	Bruise easily
	Dryness
	Boils/hives
	Contagious skin disease

RESPIRATORY	
	Chronic cough
	Shortness of breath
	Smoking
	Breathing problems
	Asthma/bronchitis

CARDIO VASCULAR	
	High blood pressure
	Low blood pressure
	Bleeding disorders
	Chest pain
	Stroke
	Artery hardening
	Varicose veins
	Swelling of the ankles
	Poor circulation
	Angina
	Heart disease

GENITOURINARY	
	Trouble urinating
	Blood in urine
	Kidney infection
	Bed wetting
	Prostate trouble

GASTROINTESTINAL	
	Poor digestion
	Indigestion
	Excessive hunger
	Belching or gas
	Nausea/vomiting
	Abdominal pain
	Constipation
	Diarrhea
	Hemorrhoids
	Liver concerns
	Gall bladder trouble
	Bladder concerns
	Ulcer
	Diabetes

INFECTIONS/ILLNESSES	
	Herpes
	Hepatitis
	Plantar warts
	TB
	HIV/AIDs
	Cancer
	Allergies

MUSCLES & JOINTS		
	Stiff neck	
	Backache	
	Swollen joints	
	Painful tailbone	
	Foot trouble	L - R
	Shoulder pain	L - R
	Elbow pain	L - R
	Wrist pain	L - R
	Hip pain	L - R
	Knee pain	L - R
	Arthritis	
	Weakness/lost strength	

WOMEN'S HEALTH	
	Painful menstruation
	Excessive flow
	Irregular cycle
	Hot flushes
	Cramps or backache
	Vaginal discharge
	Swollen breasts
	Lumps in breast
	Are you pregnant
	Birth control
	Number of pregnancies
	Number of children

SEXUAL HEALTH HISTORY:
Have you ever had or are you currently experiencing:

Had	Current		Had	Current		Had	Current	
☐	☐	**Chlamydia**	☐	☐	**Gonorrhea**	☐	☐	**Syphilis**
☐	☐	**Herpes**	☐	☐	**Yeast Infections**	☐	☐	**Bacterial Vaginosis**
☐	☐	**Hep B**	☐	☐	**Hep C**	☐	☐	**Scabies**
☐	☐	**Pubic Lice**	☐	☐	**Human Papillomavirus (HPV-warts)**			
☐	☐	**Trichomoniasis**	☐	☐	**Lymphogranuloma Venereum (LGV)**			

What kind of birth control do you use, if any?: __________

EXAM HISTORY:
(Please indicate when you most recently (if ever) had the following tests performed.)

Tuberculin (TB) test:	**Hearing Test:**
Chest X-ray:	**PAP or Gyne Exam:**
CT, MRI, Ultrasound:	**Prostate Exam:**
ECG (heart):	**Blood or Urine Tests:**
Eye Exam:	**Full Physical Exam:**

**Please report all medications on the medication history page, including vitamins/supplements.*

LIFESTYLE:
(Please describe a typical day's diet:)

Breakfast:

Lunch:

Dinner:

Snacks: **Beverages:**

How MUCH and HOW OFTEN do you consume:

Alcohol:	**Caffeine:**
Water:	**Tobacco:**

Recreational Drugs (which ones):

Please list your travel history in the past 3 years:

EMOTIONAL HEALTH:

(Please rate the following on a scale of 1 (low) to 10 (high))

Overall Stress: **Overall Energy:** **How happy are you generally:**

Stress in the Home: **Satisfaction in Relationship:**

Time to Bed: **Average Time of Waking:**

# of Hours of Uninterrupted Sleep: **Use of Sleep Aids (which ones?)**

Waking Feeling Rested (Y/N): **Digital Electronics in Bedroom (Y/N)**

Pets in the Bedroom (Y/N): **Co-Sleeping with Children:**

Have you ever felt sad or depressed for 2 weeks or more at a time in the past year: Y or N

Do you have concerns regarding your emotional or mental health (ie: anxiety, memory loss, voices, hallucinations, depression, binge eating etc)? :

SETTING THE STAGE:

What is your main expectation from this visit:

What long term expectations do you have:

What expectations do you have of me professionally:

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle: [1 (low) – 10 (high)]:

Are self destructive or negative lifestyle habits:

What potential obstacles do you foresee in addressing lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which I will be sharing with you:

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making:

What do you LOVE to do:

Best Possible Medication History

(Include all current and relevant past prescription medications, OTCs, and complementary medicines)

MEDICATIONS **Name:** ______________________________________

Start Date	Name of Medication	Strength	How to take this medication				Purpose	Comment	Prescribed By
dd/mm/yyyy	Brand and Generic name (If available)		Quantity?	Route?	Frequency?	Food?			

Pharmacy:

Informed Consent For Treatment

Welcome to Naturopathic Medicine! As a doctor of Naturopathic medicine it is my honor to take your care and health seriously. The following document is an agreement between you and I that states that you are entitled to understand any detail you wish about your health condition, treatment and diagnosis. It states that you are aware of the costs of naturopathic medicine (including late cancellation policies), the benefits and potential risks and side effects. Your health is ultimately up to you, therefore you also have the right to refuse any suggested treatment. We are in this together, so be sure to ask any questions you have, no matter what they are, at anytime and I will do my best to fulfill the meaning of doctor (docere) “To Teach”.

STATEMENT OF ACKNOWLEDGEMENT

I, ______________________________ as a patient of ______________________________ understand that I am being treated under the practice philosophy and scope of naturopathic principles and practices. I will disclose all health concerns, conditions, medications and medical interventions, including supplements and over the counter drugs to my naturopathic doctor because I understand that safe care requires that I truthfully and completely disclose this information. I also will inform my naturopathic doctor if I am pregnant or breastfeeding so that she can take proper precautions for treatment.

I am aware and understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side effects. I am entitled to know the consequences of not accepting treatment and of alternative treatments that may be applicable. I am encouraged to take an active role in my care and ask any questions needed. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that she has answered all of my questions to the best of her ability.

I understand that though naturopathic treatments re generally safe and gentle, there may be health risks associated with some treatments. This may include, but not limited to: aggravation of pre existing symptoms, allergic reactions to supplements, herbs or pharmaceuticals and bruising or injury from acupuncture or intravenous therapies.

I understand that my naturopathic doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at anytime. I accept full responsibility for any fees incurred during care and treatment, including a 50% late cancellation fee if providing less than 24 hours notice for cancellation of any appointments. I am aware that I am always at liberty to seek or continue care form another healthcare provider.

Signature (of patient, or legal guardian):

____

Date: ____

Witness: _______________________________________

Printed: _______________________________________