Family Focused Naturopathic Care
Dr. Karley Denoon, ND
Dr. Claire Wilson, ND

571b (upstairs) 2nd Ave. Fernie, BC
Phone: (250) 531-0154
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drdenoon.ca

Adult Renewal Intake Form

Dr. Karley Denoon ND

Have you been out of the clinic for over 1.5 years? Catch us up on basics and what has prompted your return.
Please also include any relevant blood work or health reports.

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

Please note any *changes* to the following information:

Name:	**Birthdate:**	
Address with PO 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 return to this clinic?	
Last time you saw your ND? When:	**Dr:**
Reason	

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		

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

Medications:

Food:

Environmental :

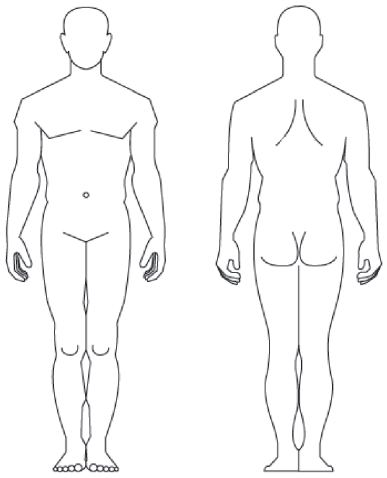
CHANGES TO SOURCES OF STRESS:

Chemical:

Physical:

Psychological/emotional:

CHANGES TO PHYSICAL CONDITION:
(Please indicate on the diagram the nature of your symptoms using the provided symbols.)



Aching	**O**
Stabbing	**X**
Shooting	**=**
Burning	**~**
Numbness or Tingling	**^**

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):

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:**

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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)? :

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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: _____

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