www.monctonnaturopathic.com
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Intake Form - Adults

We respectfully ask that you complete this form prior to arriving for your scheduled appointment time.

Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the patient. Your time, thoughtfulness and honesty in completing this overview will go along way in assisting our doctors to determine the causes of your health condition(s) and individualize your health needs.

Name: _____ Date: _____

Address: _____ City: _____

Province: _____ Postal Code: _____NB Medicare #: _____

Telephone (home):_____ (work): _____ (cell): _____

Email address (for info sheets, newsletters, etc…): _____

Which is your preferred contact method for visit reminders (circle one)? email or phone

Which is your preferred spoken language during office visits (circle one)? English or Français

Age: _____ Date of Birth: _____ Gender: female _____ male _____

Married: _____ Separated: _____ Divorced: _____ Widowed: _____ Single:_____ Partnership:_____

Occupation: _____ Hours per week: _____Retired: _____

Employer: _____

How did you hear about our clinic (*circle & be as specific as you can*):

Person - name(s):_____, Yellow Pages (in book/online),

Internet (Google search, clinic website, Facebook, other:_____), Other: _____.

Has any other family member already been a patient at the clinic? _____.

Next of Kin or other to reach in an emergency: _____

Relationship: _____ Phone: _____

Are you currently receiving healthcare? Y N If yes, where & from whom:_____

If no, when & where did you last receive medical or health care? _____

What was the reason? _____

When filling out the form, note that:

Y=a condition you have now	**N=**Never had	**P=**Significant problem in the past

Thank you for your time and effort. Our team looks forward to providing you with the best possible care.

CONTEXT OF CARE REVIEW

1) Why did you choose to come to *this* clinic?

2) What do you know about our *approach*?

3) What 3 expectations do you have from *this visit*?
   1.
   2.
   3.

4) What *long-term* expectations do you have from working with our clinic?

5) What expectations do you have *of me personally* as your doctor?

6) What is your present level of *commitment* to address any underlying causes of your signs and symptoms that *relate to your lifestyle*? (Rate from 0 to 10, with 10 being 100% committed)

   0% 0 1 2 3 4 5 6 7 8 9 10 100%

7) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

8) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

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

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

11) What are your **most important health concerns**? List as many as you can in *order of importance*:

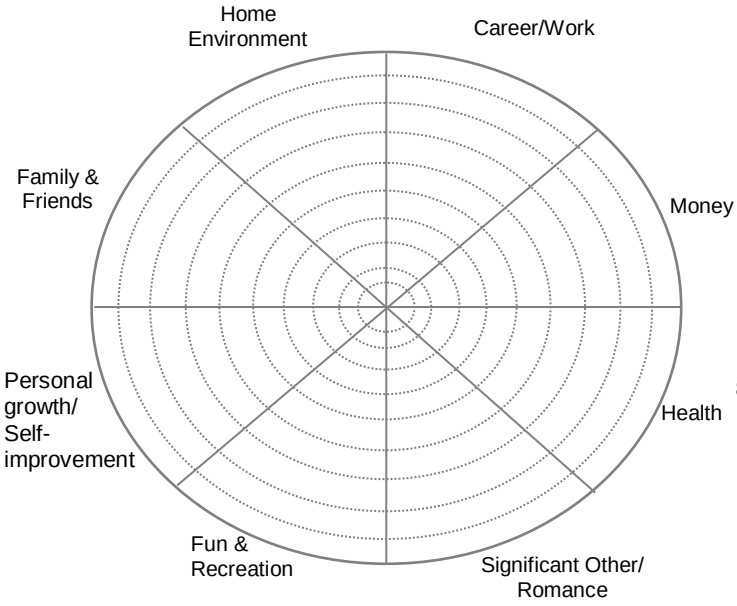
1. _____ onset: _____
2. _____ onset: _____
3. _____ onset: _____
4. _____ onset: _____
5. _____ onset: _____
6. _____ onset: _____
7. _____ onset: _____
8. _____ onset: _____
9. _____ onset: _____
10. _____ onset: _____

Wheel of Balance

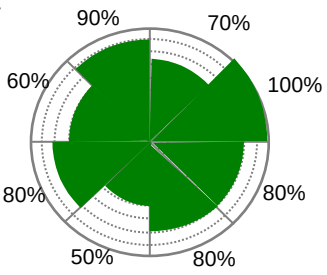
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Example:



General

Height: _____Weight:_____ lbs. Weight 1 year ago: _____lbs.
Maximum weight : _____ when: _____ What is your *ideal* weight? _____

Family History (please circle)

Heart Disease: high blood pressure, stroke, heart attack, other _____.
Autoimmune Disease*:* rheumatoid arthritis, celiac disease, Hashimoto's thyroiditis, other*:*_____.
Mental Illness, ***Asthma***, ***Allergies***, ***Eczema, Psoriasis, Vitiligo***.
Cancer - list all types & write down your connection: mother (M), father (F), sibling (S), child (C), maternal grandparent (MG), paternal grandparent (PG), other (O): _____
_____.
Any other relevant family history? _____

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-rays, CAT scans, EEG, ECG/EKG's, etc…have you had?
_____year: _____ _____ year: _____
_____year: _____ _____ year: _____
_____year: _____ _____ year: _____

Allergies - Are you hypersensitive or allergic to...

Any drugs? _____
Any foods? _____
Any environmental or chemicals? _____
Any anaphylactic reactions? _____

Current Medications & Supplements

Please list **any** prescription medications (including those for pain relief), over-the-counter medications, vitamins or other supplements you are taking (please give dosages & use an extra page if needed)?
1)_____ 6) _____
2)_____ 7) _____
3)_____ 8) _____
4)_____ 9) _____
5)_____ 10) _____
If any, please list natural supplements that you reacted to in a negative way: _____
If any, please list natural supplements that you tried and were not effective: _____

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Desserts/treats/junk foods: _____
Water intake (circle): low, adequate (~8cups), in excess of. **Other drinks**: _____
Water source (circle): tap, filtered, well, spring, mineral, distilled, reverse osmosis, other: _____
Alcohol (# of drinks - per day or week): _____ **Coffee** (# of 6 oz cups - per day or week): _____
Pop or other sodas (cans or mL - per day or week): _____
Do you have a good **appetite** (circle)? No, sometimes, yes, always hunger
What food(s) do you **crave** (circle)?: sugar (chocolate, candy, desserts, other: _____), salty (add salt to food, chips, other: _____), grains (bread, pasta, pastries, other: _____), condiment(s): _____, tobacco, alcohol, coffee, pop, Redbull, other:_____.
Do you **skip meals**? never, sometimes, often. If so, which meals do you skip (circle): breakfast, lunch, dinner
Do you have **3 sit-down meals**? Y N or do you rather **snack** throughout the day? Y N
Eat **on the run**? Y N **Cook your own** meals (circle one)? never, sometimes, frequently, almost always
Are there any **foods that do not agree** with you or aggravate you? Explain: _____
Specific diet (circle): religious, vegetarian, vegan, Weight Watchers, SFL, other: _____
Dietary restriction (circle): salt, dairy (lactose, casein), gluten, wheat, egg, soy, other: _____

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Gastrointestinal/Liver/Gallbladder (*note: fill out both sides*)

Bowel movements: How often? _____		Heartburn?	Y N P
Constipation?	Y N P	Reflux?	Y N P
Hemorrhoids?	Y N P	Abdominal pain?	Y N P
Diarrhea?	Y N P	Abdominal cramps?	Y N P
Nausea	Y N P	Belching?	Y N P
Black stools?	Y N P	Bad breath?	Y N P
Blood in stool?	Y N P	Passing gas?	Y N P
Mucus in stool (jelly-like discharge)?	Y N P	Bloated (distented abdomen)?	Y N P
Fatty Liver?	Y N P	Gallbladder removal?	Y N
Liver inflammation (hepatitis)?	Y N P	Gallstones?	Y N P
Antacids (Tums, etc.) use?	Y N P	Laxatives use?	Y N P

Date of last **antibiotic** prescription: _____, # of antibiotic prescriptions in last 5 yrs: _____
approximate # of antibiotic prescriptions in childhood (age 0-5): _____.
Were you **breastfed**? Y N if so, for how long? : _____.
Travel frequently outside of Canada/USA/Europe? Y N if so, have you been sick (diarrhea, etc…) Y N

Toxicity Risk Assessment

Have you ever been exposed to **toxic substances** such as pesticides, herbicides, solvents, sprays, paints, heavy metals, oils, etc…(from work, home, hobbies, etc.)? If yes, list & give details: _____
_____
# of teeth amalgam fillings (mercury/silver): _____#/week consume big fish (e.g. tuna):_____
Do you use **tobacco**? Y N P Use recreational drugs? Y N P
if so, between what years did you smoke (e.g. 1992-2010 & 2012-2014 or 1970-present): _____
how many cigarettes or packs per day did/do you smoke? _____
Do you consume artificial sweeteners (please circle)?: Nutrasweet, aspartame, other: _____
Any known **tick bites**? Y N Do you eat **organic foods**? Never Sometimes Often
Any **mold** exposures? Y N (circle if applies to you): Had you just moved to a new home or exposed to a new building when you became ill? (work, school, gym, cottage?) Any water intrusion, leaky pipes, or musty smells (in home, office or cottage)? Have you ever had a plumbing leak or leaky window sills, roof leakage or basement flooding? Have you lived in a home or worked in a building that smelled musty or moldy?

Sleep

Sleep well? always, often, rarely, never. Ideal hours of sleep per night?_____
Do you take sleeping pills? Y N Take nap(s)? Y, at times, N Sleep apnea? Y N P
Difficulty falling asleep? Y, at times, N When is the average time that you fall asleep?: _____
Wake during the night? Y N if so, what time(s)?_____& why?_____
When do you wake up in AM?: _____Do you wake refreshed in the morning? Y N
Do you avoid caffeine because it keeps you up at night? Y N P Keep cell phone on at night? Y N

Habits

Main interests, hobbies & what you do for fun:_____
_____
Do you **exercise**? Y N
if yes, what kind?_____ how often (#/day or week)? _____
What time during the day is your **energy** the best? _____ worst? _____
when your energy is the worst, how low is it from 0-10 (with 10 being the best)?: _____
do you have low exercise tolerance (i.e. feel tired during, immediately after or the next day)? Y N
Do you have a religious or spiritual practice? Y N if yes, what?_____
Enjoy your work? Y N Take vacations? Y N
Spend time outside? Y N Watch television? Y N hours/day? _____
Have a history of abuse? Y N Computer screen time outside of work? Y N
Any major traumas? Y N P how many hours/day? _____

Mental / Emotional

Treated for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Easily stressed?	Y N P

What stresses you out the most?: _____
How do you manage stress?: _____

Immune/Respiratory

Recurring infections?	Y N P	Reactions to vaccinations?	Y N P
Many colds & flus?	Y N P	Night sweats?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P
Seasonal allergies?	Y N P	Stuffiness (nose)?	Y N P
Sinus problems?	Y N P	Frequent sore throat?	Y N P
Asthma?	Y N P	Difficulty breathing?	Y N P
Do you have any known contagious diseases? Y N		Production of phlegm? (colour: _____) Y N	
if yes, what? _____		Pneumonia?	Y N P

Endocrine

Hypothyroid?	Y N P	Heat intolerance?	Y N P
Goiter?	Y N P	Cold intolerance?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Hypoglycemia (low blood sugar)?	Y N P	Diabetes?	Y N P
Decreased libido?	Y N P	Hair loss?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Memory problems?	Y N P	Poor concentration?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Musculoskeletal

Joint pain?	Y N P	Low bone density?	Y N P
Joint stiffness?	Y N P	Sciatica?	Y N P
Muscle cramps?	Y N P	Muscle pain?	Y N P

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Skin

Rashes?	Y N P	Eczema?	Y N P
Acne?	Y N P	Itching?	Y N P
Lumps?	Y N P	Dry skin?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency (daytime)?	Y N P
Inability to hold urine?	Y N P	Increased frequency (nighttime)?	Y N P
Frequent urinary infections?	Y N P	Kidney stones?	Y N P

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P
Impaired vision?	Y N P	Dry eyes	Y N P
Impaired hearing?	Y N P	Ringing in the ears?	Y N P
Teeth grinding?	Y N P	Hoarseness (voice)?	Y N P
Gum problems?	Y N P	Dental cavities?	Y N P

Cardiovascular/Circulation

High blood pressure?	Y N P	Palpitations/fluttering?	Y N P
Low blood pressure?	Y N P	Swelling in ankles?	Y N P
Easy bleeding?	Y N P	Anemia (low red blood cells)?	Y N P
Easy bruising?	Y N P	Low iron blood levels	Y N P
Blood clots?	Y N P	Cold hands?	Y N P
Varicose veins?	Y N P	Cold feet?	Y N P

Male Reproduction

Prostate disease?	Y N P	Impotence?	Y N P
Sexually transmitted disease?	Y N P	Premature ejaculation?	Y N P
Are you sexually active?	Y N	Erection problems?	Y N P
Enlarged breast (non-muscular)	Y N P	Sexual orientation: _____	

Birth control? Type? _____

Female Reproduction

Age of first menses? _____
Age of last menses? (if menopausal) _____
Length of menstrual cycle (ave. = 28 days)?_____days
Duration of menses (bleeding)? _____ days
Painful menses? Y N P
Heavy or excessive flow? Y N P
# of days with heavy flow: _____
how many tampons/maxi pads - # used/day:_____
PMS? Y N P
if yes, what are your symptoms?
_____
_____

Endometriosis? Y N P
Ovarian cysts? Y N P
Cervical Dysplasia? Y N P
Sexual difficulties? Y N P
Sexually transmitted disease? Y N P
Do you do breast self-exams? Y N P
Breast pain/tenderness? Y N P

Date of last annual exam/ PAP _____
Are cycles regular? Y N
Bleeding between cycles? Y N P
Pain during intercourse? Y N P
Clots (menstrual related)? Y N P
Discharge? Y N P
Difficulty conceiving? Y N P
Birth control? Y N P
what type? _____
Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____
Menopausal symptoms? Y N P
Abnormal PAP? Y N P
Are you sexually active? Y N
Sexual orientation: _____
Breast lumps? Y N P
Nipple discharge? Y N P

Y=a condition you <u>have now</u> **N=**Never had **P=**<u>Significant</u> problem in the past

Is there anything else you would like to add or comment on (use back of page if needed)?

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Medical Clinic - Clinique Médicale

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Declaration and Informed Consent for Naturopathic Care

We would like to take this opportunity to welcome you. Your naturopathic doctor will conduct a thorough case history, physical examinations (when indicated) and may recommend specific blood, urinary or other laboratory reports as part of the treatment work-up. Your naturopathic doctor integrates supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, physical medicine and lifestyle counseling to assist the body's ability to heal and to improve the quality of life and health.

Statement of Acknowledgement
Printed name of patient: _____

As a patient, I have read this information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided in this intake form is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. Slight health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing symptoms;
- allergic reactions and other adverse effects to supplements, homeopathics, injectables or herbs;
- pain, fainting, bruising or injury from acupuncture, venipuncture, musculoskeletal injections, intramuscular injections, joint injections and/or intravenous injections; and
- muscle strains, sprains and spasms, disc injuries from spinal manipulations.

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient is **not mutually exclusive** from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. It is highly recommended that I update my health care providers of any new treatments.
- I also confirm that I have the ability to accept or reject this care of my own free will and choice. I understand results are not guaranteed. I accept full responsibility for any fees incurred during care and treatment.
- I understand that a record will be kept of my visits. This record will be kept confidential and **will not be released** without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am responsible for **payment at the time services are rendered.** Dispensary items must be paid for in full before leaving the office.
- I am aware that **24 hours notice** must be given for all cancelled appointments or a **cancellation fee** will be applied.
- I understand that your naturopathic doctor reserves the right to determine which cases fall outside of his scope of practice, in which case the **appropriate referral will be recommended.**
- I have read and understand the **Privacy Policy** which is available on the clinics website at www.monctonnaturopathic.com (see Forms).

I consent to receive naturopathic treatment. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: _____ Date: _____