ADULT INTAKE FORM

Our health is influenced by many different factors. Your health history provides valuable information to help me understand your current health. Please fill out this form to the best of your ability and bring it with you to your first visit.

GENERAL CONTACT INFORMATION

Name ____________ Today's Date: ___________________ Age: ______Gender: ___________

Phone (H): _________ E-mail: __________________

How did you hear about the Service? _____________ Last Physical Exam: ____________

PERSONAL MEDICAL HISTORY

What would you like to address health wise in order of importance to you?

1. ____

2. ____

3. ____

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations along with approximate dates:

1. ____

2. ____

3. ____

Do you have any allergies or hypersensitivities to any of the following? Foods:
____

Medicines: ____
Environment: ____
Other: ____

Do you have any dietary restrictions? (Religious, Vegetarian, Vegan, etc.)?
____

Please list all prescription, over the counter medications, vitamins or supplements you are currently taking including brands:

Please list any other Healthcare Providers you are currently seeing:

FAMILY MEDICAL HISTORY

Indicate if any of your following relatives (F: Father; M: Mother; B: Brother; S: Sister; C: Children; Sp: Spouse; MGM: maternal grandmother; PGM: paternal grandmother; MGF: maternal grandfather; PGF: paternal grandfather) have any of the following:

Condition	Family Member	Condition	Family Member	Condition	Family Member
Allergies/ Hay Fever		Epilepsy		Multiple Sclerosis	
Alcoholism/ Drug Addictions		Fibromyalgia		Myasthenia gravis	

Alzheimer's / Parkinson's	Glaucoma	Osteoporosis
Anemia	Headaches	Obesity
Arthritis	Heart Disease	Skin Conditions
Asthma	High Blood Pressure	Stroke
Autoimmune Disease	High Cholesterol	Syphilis
Cancer	Kidney Disease	Thyroid Conditions
Celiac Disease	Liver Disease	Tuberculosis
Diabetes	Lupus	Other
Digestive (Crohn's, Colitis, etc)	Mental Illness	

LIFESTYLE HABITS

Typical Daily Food Intake:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages (Quantity and Amount): ______________________________

Cravings: ______________________________

Aversions: ______________________________

Drinks	How many/day or week?	How long?	Have you quit? When?
Liquor			
Beer			
Wine			
Caffeine			
Soft Drinks			
Cigarettes			
Cigars			
Pipe			
Marijuana			
Recreational drugs			
Other			

Are you exposed to significant tobacco smoke? (Work, Home, Etc.) Yes No

Are you frequently exposed to animals? (Pets, Work, etc.) Yes No

Do you exercise regularly? What do you do for exercise? How often? How long?

What are your hobbies? What do you do in your spare time?

How stressful is your work? Life? How do you handle your stresses?

REVIEW OF SYSTEMS

GENERAL

Height: ______________ Weight: ______________ Max weight: ______________ Weight one year ago: ________________

For the following check "YES" if you are experiencing the symptom now or have in the last year. Check "PAST" if you've had the symptom more than a year ago. If you've never had the condition, leave it blank.

GASTROINTESTINAL

YES PAST Trouble swallowing Flatulence Hemorrhoids Heartburn Jaundice (yellow skin) Black, tarry stool Change in thirst Liver disease Abdominal pain Change in appetite Gall bladder disease Food allergy Nausea Ulcer Hernias Vomiting Indigestion Bowel movements -how often? Vomiting blood Constipation Blood in stool Diarrhea

Is this a change? Y N Belching Rectal bleeding

SKIN/ HAIR/ NAILS

YES PAST Frequent rashes Dry Skin Hair loss Hives Eczema Changes in hair growth Itching Mole changes Change in skin texture Boils Lumps Nail changes Psoriasis Night sweats Other: ____________________

Acne Skin cancer

RESPIRATORY

YES PAST Emphysema Sputum Pain on breathing Tuberculosis SARS Difficulty breathing Tuberculin Test Asthma Shortness of breath (SOB) Chronic cough Bronchitis SOB at night Spitting up blood Pneumonia SOB lying down Wheezing Pleurisy Last Chest-ray: ____________________

HEAD/ EYES/ EARS/ NOSE/ MOUTH/ THROAT/ NECK

YES PAST

Impaired vision Blind spot Sinus problems Glasses/contacts Headaches Frequent sore throat Eye pain Migraines Sore tongue/mouth Tearing Head injury Bleeding gums Dryness Dizziness Hoarseness Double vision Impaired hearing Dental cavities Glaucoma Earache Mouth ulcers Cataracts Ear discharge Loss of taste Blurring Ear infections Neck Lumps Light Sensitive Frequent colds Swollen glands Itchy eyes Nose bleeds Goiter Redness Nose stuffiness Neck Pain or stiffness Eye discharge Hay fever

CARDIOVASCULAR

YES PAST Thrombophlebitis Varicose veins Swelling in ankles Leg cramps Heart disease Palpitations Extremity numbness Angina Fainting Extremity coldness High blood pressure Cyanosis Extremity swelling Low blood pressure Past ECG Extremity ulcers Murmurs Other heart tests Deep leg pain Rheumatic fever Other: ____________________ Cold hands/feet Chest pain

PSYCHOLOGICAL/ NEUROLOGICAL

YES PAST Fainting Depression Sexual difficulties Seizures Mood swings Suicidal thoughts Convulsions Anxiety or nervousness Recurrent thoughts Paralysis Tension Binge eating Tremor Phobias Eating Disorder Muscle weakness Hallucinations Low Self Esteem Numbness or tingling Alcohol/drug abuse PTSD Loss of memory Insomnia Self-Injury Loss of balance Sadness Poor Concentration Loss of coordination Grief Memory difficulties Speech problems Anger Hyperactivity

URINARY

YES PAST Pain on urination Inability to hold urine Blood in urine Increased frequency Frequent infections Urgency Frequency at night Kidney stones Hesitancy

MUSCULOSKELETAL

YES PAST Joint pain Muscle spasms/ cramps Muscle pain Joint stiffness Weakness Reduced movement Arthritis Joint swelling Decreased flexibility Broken bones Backache Other: ___________________________

MALE REPRODUCTIVE			
YES	PAST	YES PAST	YES PAST
Hernias	Sexual difficulties	Penile sores	
Testicular masses	Venereal disease	STIs	
Testicular pain	Penile discharge	Sexually active	
FEMALE REPRODUCTIVE			
YES	PAST	YES PAST	YES PAST
Bleeding between periods Regular periods Pain during intercourse Painful menses Excessive flow	Difficulty conceiving Sexually active Sexual difficulties Venereal disease STIs	Vaginal itching Breast lumps Breast pain or tenderness Nipple discharge Breast Cancer	
PMS	Vaginal discharge	Ovarian Cancer	

Age menses began: _______________ Last menstrual period: _____________ Number of live births: _____________ Average number of days: ___________ Last PAP -(date): _________________ Number of miscarriages: ___________ Length of cycle: __________________ Number of pregnancies: ____________ Number of abortions: ______________

Is there anything related to your health that has not been covered?

Thank you for completing this form. The info provided will be discussed in further detail during your initial visit.

Informed Consent Form

Please note that this form must be signed prior to your first appointment.

Naturopathic medicine is the treatment and prevention of diseases by natural means. It 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. We will take a thorough case history and perform a physical examination. Each patient seeking care should understand that the practitioner is a Naturopathic Therapist, not a medical doctor.

It is very important that you inform me immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise me immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. Treatments used in this place include nutrition, botanical medicine, lifestyle counseling, alternative medicine (including acupuncture), physical and rehabilitation medicine, energy testing and supplement recommendations.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

x Remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.

x Some patients experience allergic reactions to certain supplements and herbs. Please advise me of any allergies you may have.

x Pain or bruising from acupuncture or vacuum therapy.

Therapist is trained to handle emergencies should the need arise.

I have been informed and I understand that:

x I am free to withdraw my consent and to discontinue treatment at any time.

x I will explain the exact nature of any treatment provided and will answer any questions I may have.

x I agree to pay my account in full at each visit. I am aware that British Columbia Health Care does not cover these fees.

x I understand cancellations must be made with 4 hours notice or a missed appointment fee applies.

Patient Name (please print): ____________________________

Signature of Patient _____________Date: __________________