NATUROPATHIC INTAKE FORM

Confidential Patient Case History

Last name:________________________________ **First name**:______________________ Middle:_______________

Date of birth:_________________________ Age:_______ Height:____________ Weight:______________

Occupation:___________________________________ Date of last physical ____________year________

Please list your chief complaints in order of importance to you, and your age when they began:

1.____Age__________________

2.____Age__________________

3.____Age__________________

4.____Age__________________

5.____Age__________________

I was treated by a □Medical Dr □Chiropractor □Naturopath □Homeopath □Hospital

I was treated for____
____-
____

Members of your family who have similar conditions:____
____
____

I am: □Single □Married □Divorced □Separated □Common Law □Widow. Number of Children____

Address:____ City___________________ Postal Code______________

Home phone:( )________________________ Work phone:( )______________________ Ext:__________

Cellular/Pager:( )_______________________ Email: ____

Emergency Contact:

Last name:_______________________ First name:_______________________ Relationship:__________________
Home phone: ( )_______________________ Work phone: ( )______________________ Ext:____________

How did you hear about Dr. Carl/the clinic?____

Please bring, or have faxed all medical test results (blood, urine, x-ray, ultrasound, MRI, surgery results) from you doctor’s office or hospital.

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

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

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

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

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

Please list all medications currently taking:
1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____

Please list all natural supplements currently taking:
1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____

Indicate with a check mark those symptoms that apply to you now with some frequency. If they are not now present, but applied to you in the past, please mark them with a **P.**

	GENERAL SYMPTOMS
	Headaches
	Migraine
	Anemia/low iron
	Excessive Sweating
	Fainting
	Dizziness
	Exhaustion
	Chronic fatigue
	Sudden weight loss
	Cannot lose weight
	Hyperactive
	Have you taken Antibiotics for 1 month or longer
	# of times you have taken short courses of Antibiotics
	Have you taken prednisone or other cortisone-type drugs
	Do perfumes, insecticides, other chemicals provoke symptoms
	Sugar or bread cravings

Comments____________________

	SKIN AND HAIR
	Acne
	Warts
	Cold sores
	Eczema
	Psoriasis
	Dryness
	Itchy
	Scalp itchy
	Dandruff
	Oily
	Hair loss
	Bald patches
	Bruise easily
	Fungal (Tinea)
	Athlete's foot/ringworm
	Change in moles
	Brittle nails

Comments____________________

	MOUTH
	Cold sores
	Canker sores
	Tooth Cavities
	Bleeding gums
	Teeth sensitive to hot/cold
	Taste change/loss
	Sore tongue

Comments____________________

	NOSE
	Nosebleeds
	Nasal/Sinus congestion
	Runny nose
	Sneezing spells
	Sinus infection
	Polyps
	EARS
	Ringing
	Earache
	Ear canal itch
	Discharge
	Excessive Ear wax
	Infection

Comments____________________

	EYES
	Itchy/Watery
	Redness
	Pink eye/infection
	Macular degeneration
	Near/far sighted
	Glaucoma
	Cataracts
	Dark circle under eyes

Comments____________________

	THROAT
	Voice loss
	Tonsillitis
	Swollen glands/nodes
	Itchy
	Hoarse voice
	Voice change lately

Comments____________________

	GASTRO-INTESTINAL
	Bloating
	Indigestion
	Flatulence
	Burping
	Nausea
	Diarrhea
	Constipation
	Blood in stool
	Mucous in stool
	Heartburn/Reflux
	Ulcers
	Poor appetite
	Excessive hunger
	Pain in abdomen
	Gall bladder problems
	Hepatitis
	Colitis/Crohn's
	Diverticulitis
	Polyps in colon
	Worms/parasites
	Bad breath
	Bulimia/anorexia
	Rectal itch
	Rectal bleeding/
	Hemorrhoids

Comments____________________

	MUSCLE, BONE, JOINTS
	Gout
	Arthritis
	Rheumatoid arthritis
	Bursitis
	Stiff neck
	Back pain
	Slipped disc
	Joint stiffness
	Swollen joints
	Pain or numbness in
	Shoulders
	Between shoulders
	Arms
	Elbows
	Hands
	Legs
	Knees
	Ankles
	Feet
	Poor posture
	Sciatica
	Osteoporosis
	Muscle twitches
	Restless legs

Comments____________________

	CARDIOVASCULAR
	Septal defect
	Heart murmur
	Chest pain
	Fluttering/rapid heartbeat
	Poor circulation
	High cholesterol
	Low blood pressure
	High blood pressure
	Lightheaded
	Leg cramps at night
	Shortness of breath

Comments____________________

	RESPIRATORY
	Chest pain
	Chronic cough
	Difficulty breathing
	Spitting of phlegm
	Asthma
	Wheezing
	Chest tightness
	Bronchitis
	Daily inhaler use
	Emphysema
	Pneumonia
	Frequent Colds/Flus
	Colds/Flus last too long

Comments____________________

	ENDOCRINE
	Goiter
	Hypothyroid
	Hyperthyroid
	Puffy face
	Adrenal disease
	Protruded eyes
	Adult onset Diabetes
	Juvenile diabetes
	Intolerant to heat/cold
	Crave salt
	Hypoglycemia
	Symptoms present since stressful event
	Faintness/dizzy
	Low blood pressure
	Unexplained Weight gain

Comments____________________

	NERVOUS SYSTEM
	Poor memory
	Epilepsy
	Difficulty concentrating
	Annoyed easily
	Hopeless outlook
	Dislike criticism
	Cannot relax
	Cannot fall asleep
	Cannot stay asleep
	Worrier
	Lose temper
	Irritable
	Peer problems
	Low self-esteem
	Shy/nervous with people
	Nervous
	Frightening dreams
	Frightening thoughts
	Lonely
	Unhappy
	Depression
	Very sensitive
	Anxiety
	Panic attacks

Comments____________________

	GENITO-URINARY
	Bed wetting
	Blood in urine
	Brown urine
	Kidney stones
	Kidney infections
	Bladder infections
	Cloudy urine
	Burning urination
	Slow urination
	Incontinence
	Difficult starting urine
	Cannot hold urine
	Frequent urination

Comments____________________

	FOR MALES ONLY
	Enlarged prostate
	Discharge from penis
	Prostatitis
	Painful testicles
	Lumps in testicles

Date last prostate exam__________

Comments____________________

	FOR FEMALES ONLY
	Constant PMS
	Sore breasts
	Congested breasts
	Cracked nipples
	Nipple discharge
	Lumps in breast
	Fibrocystic breasts
	Irregular cycle
	Heavy menstrual flow
	Menopausal
	Hot flashes
	Painful menstruation
	Vaginal discharge
	Vaginitis
	Yeast infections
	Vaginal itch
	Bleeding between cycles
	Bleed after intercourse
	Vaginal dryness
	Pads
	Tampons

Date of last Pap________________

Total miscarriages______________

Total live births________________

Date last breast exam___________

Comments____________________

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	BIRTH CONTROL
	Oral contraceptive
	IUD
	Withdrawal/rhythm
	Tubal ligation
	Diaphragm
	Sponge
	Condom
	Spermicide

Comments____________________

	HABITS
	Tea per day
	Coffee per day
	Milk per day
	Soft drinks per day
	Beer per day
	Alcohol per day
	Chocolate per day
	Candy per day
	Cigarettes per day
	No. of meals eaten per day
	Cannabis
	Hard drugs

Comments____________________

Please list any allergies to foods, plants, insects/animals, hayfever, drugs or other substances:

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____

Statements of Acknowledgement & Consent to Treatment

Naturopathic medicine uses non-invasive method of assessing bodily functions, and natural therapeutics for their corrections. In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your co-operation in signing these statements of acknowledgement. In so doing, you understand that:

1. Your medical information discussed during your appointment is strictly confidential and will not be disclosed to a third party unless you give consent.

2. You authorize the release of medical records from your health care providers to this clinic for the purpose of diagnoses and monitoring of treatment progress.

3. While changes in dietary habits are not an absolute pre-requisite for treatment, the failure to follow sound nutritional, exercise and lifestyle programs could undermine the expected results.

4. You are accepting or rejecting this care at your own free will.

5. You accept the potential risks, although infrequent, fro9m the treatments we agree on.

6. The ultimate responsibility for your health care is your own, and I am here to support you in this. I reserve the right to discontinue my services when it is apparent that your expectations and what I can provide are not in agreement.

7. Naturopathic care is not covered under O.H.I.P. at the present time, and therefore you are responsible for any fees incurred while under treatment at the clinic. Naturopathic care is covered under many private insurance plans, and upon request, we will do the utmost to provide the appropriate documentation to your insurer.

8. All fees for services and supplements are payable at the time of the appointment by the patient or the guardian. There is a fee for telephone consultations of greater than 10 minutes.

9. Your appointment time is reserved for you. If you are unable to keep your appointment, please give us a 24 hours notice in advance to avoid a $35 cancellation charge.

Please sign below if you have read, understood and acknowledge the above statements.

This is to acknowledge that I have read the above information and understood its contents. I hereby consent to naturopathic treatment and will pay for all examinations and treatments when rendered.

____________________________________ _________________________

Patient's/Guardian's Signature Date

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Please print name