Adult Intake Form

Personal Information

Date:_____

Name:_____ Sex: M☐ F☐ Age:_____ Birth Date:_____

Address:_____

City:_____ Province _____ Postal code:_____

Telephone (Home):_____ (Work):_____ (Cell):_____

Email:_____

Preferred contact for appointment reminders: ☐ email ☐ phone

Occupation:_____ Employer:_____

Marital status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated ☐Common-law

Number of children:_____

Other health care providers you are seeing:

	1	2	3
Name			
Occupation or Specialty			
Address			
Phone			
Fax			

In case of emergency, contact:_____ Relationship:_____ Phone:_____

How did you hear about the clinic?_____ Who can we thank?_____

Have you seen a Naturopathic Doctor before: ☐Yes ☐No If yes, for what ailment(s)?_____

Current History:

What health concerns brought you in to the clinic today?

1. _____
2. _____
3. _____
4. _____

Has anything changed recently or become worse?

_____

_____

Medication and Supplement History

Please list all supplements, herbs, and medications you are currently taking:

Medication/Supplement	Dosage	Since	Reason

When was the last time you used antibiotics? _____ Reason: _____

How many times (approx) have you used antibiotics in your life? _____

Do you frequently use any of the following? (check all that apply)

☐ Aspirin ☐ Laxatives ☐ Antacids ☐ Diet pills ☐ Birth control: ☐ pills ☐ implants ☐ injections

☐ Alcohol. Which type(s): _____ How many drinks/day or week: _____

☐ Caffeine. Form: _____ Amount/day: _____

☐ Tobacco. Form: _____ Amount/day: _____

☐ Recreational drugs. What type? _____ How often: _____

Do you have a past history using any of the above? _____

Do you have any allergies (medicines, environmental, etc.)?

_____

_____

Please list any past medications/supplements:

Medication/Supplement	Time taken	Reason

Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis A

☐ Tetanus booster. When: _____ ☐ "Flu" ☐ Hepatitis B

☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Smallpox

Other: _____ Any adverse reactions? _____

Health History

How would you describe you general state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any serious conditions, illnesses, injuries, fractures, hospitalizations (any health history!):

Condition/illness/injury or hospitalization	Date	Complications or long term consequences?

Family History

Please indicate whether you or any of your family members have, or have had the following:

Illness	Relative	Illness	Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Mental illness		Suicide	
Liver disease		Other familial disease	

Gastrointestinal Health

How often do you have a bowel movement? _____

Do you tend towards: ☐ Constipation ☐ Diarrhea ☐ Both ☐ Neither

Have you had blood in your stool? ☐ Yes ☐ No Mucus? ☐ Yes ☐ No Black, tarry stool? ☐ Yes ☐ No

Do you have gas? ☐ Yes ☐ No Bloating? ☐ Yes ☐ No Heartburn? ☐ Yes ☐ No

Diet

Do you have any food allergies or intolerances? _____

Do you have dietary restrictions (religious), vegetarian/vegan, etc)? _____

How much water do you drink per day? _____

Please jot down a typical day's diet:

Breakfast	Lunch	Dinner	Drinks/Snacks

Lifestyle / Environment

Do you sleep well? ☐ Yes ☐ No On average, how many hours of sleep do you get a night? _____

Do you exercise regularly? ☐ Yes ☐ No What do you do for exercise? How often? _____

_____

Are you exposed to significant tobacco smoke (work, home, etc)? ☐ Yes ☐ No

Are you frequently exposed to animals (work, pets, etc)? ☐ Yes ☐ No

Are you regularly exposed to toxins or other hazards? ☐ Yes ☐ No Which ones? _____

Please rate your stress level: ☐ Low ☐ Average ☐ High ☐ unbearable

How would you describe the emotional climate of your home?

_____

_____

How do you deal with your stress? _____

Women's Health

Are you currently pregnant? ☐ Yes ☐ No

Do you get Pap smears? ☐ Yes ☐ No Last Pap date: _____ Have you had an abnormal Pap: ☐ Yes ☐ No

Age of first period: _____ Is your period regular? ☐ Yes ☐ No Length of cycle (Days):_____ Flow (Days)_____

Are you menopausal? ☐ Yes ☐ No If yes, age of last period:_____

Are you currently sexually active? ☐ Yes ☐ No Have you been sexually active in the past? ☐ Yes ☐ No

Current form of contraception:_____

Have you ever had a sexually transmitted infection? ☐ Yes ☐ No

Number of pregnancies? _____ Live births? _____ Miscarriages? _____ Abortions? _____

Do you have any sexual problems of concern? ☐ Yes ☐ no. If yes, please explain: _____

Men's Health

Do you get regular screening tests done (blood work, prostate examinations)? ☐ Yes ☐ No

Date of last prostate exam? _____

Are you currently sexually active? ☐ Yes ☐ No Have you been sexually active in the past? ☐ Yes ☐ No

Current form of contraception:_____

Have you had any of the following: ☐ Testicular pain ☐ Hernia ☐ STI's ☐ Discharge ☐ Sores

Do you have any sexual problems of concern? ☐ Yes ☐ no. If yes, please explain: _____

Review of Systems

Please check off all that apply. C = currently experiencing. P = experienced in the past.

C	P	General	C	P	Cardiovascular	C	P	Muscle. Bone & Joints
☐	☐	Headaches	☐	☐	High/low blood pressure	☐	☐	Back pain
☐	☐	Poor/change in appetite	☐	☐	Irregular heartbeat	☐	☐	Muscle spasms/cramps
☐	☐	Weight change (____lbs)	☐	☐	Dizziness / Fainting	☐	☐	Muscle weakness
☐	☐	Chills and fevers	☐	☐	Chest pain/Angina	☐	☐	Arthritis/joint pain
☐	☐	Night sweats	☐	☐	Anemia			**Female**
☐	☐	Excessive sweating	☐	☐	Easy bruising/bleeding	☐	☐	Irregular or painful periods
☐	☐	Cravings	☐	☐	Varicose veins	☐	☐	Heavy/light flow
☐	☐	Intense hunger	☐	☐	Cold hands or feet	☐	☐	Blood clots
☐	☐	Intense thirst	☐	☐	Swelling of limbs	☐	☐	Pain during intercourse
		Skin & Hair	☐	☐	Date of last CBC: __/__/_____	☐	☐	Vaginal discharge/itching
☐	☐	Rashes/Itching/Hives			**Respiratory**	☐	☐	Yeast infections
☐	☐	Eczema	☐	☐	Difficulty breathing	☐	☐	Sore breasts
☐	☐	Acne, Boils	☐	☐	Chronic cough	☐	☐	Do self breast exams?
☐	☐	Loss of hair/dandruff	☐	☐	Sputum			**Male**
☐	☐	Nail Changes	☐	☐	Pneumonia/Bronchitis	☐	☐	Testicular masses
☐	☐	Mole colour change	☐	☐	Asthma	☐	☐	Testicular pain
		Eyes, Ears, Nose & Throat	☐	☐	Coughing blood	☐	☐	Prostate problems
☐	☐	Impaired hearing	☐	☐	Shortness of breath	☐	☐	Impotence
☐	☐	Earaches / infections	☐	☐	Wheezing	☐	☐	Do testicular self exams?
☐	☐	Ringing in ears			**Gastrointestinal**			**Neurological**
☐	☐	Sinus infections	☐	☐	Ulcers	☐	☐	Depression
☐	☐	Enlarged thyroid	☐	☐	Hiatal Hernia	☐	☐	Irritability
☐	☐	Recurrent sore throats	☐	☐	Bad breath	☐	☐	Poor memory
☐	☐	Nosebleeds	☐	☐	Nausea	☐	☐	Dizziness
☐	☐	Eye strain / blurry vision	☐	☐	Abdominal pain/cramps	☐	☐	Seizures
☐	☐	Night / colour blindness	☐	☐	Hepatitis/Jaundice	☐	☐	Concussion
☐	☐	Glasses/contacts			**Genito-Urinary**	☐	☐	Numbness in fingers/toes
☐	☐	Change in Prescription	☐	☐	Frequent/urgent urination	☐	☐	Mood swings
☐	☐	Cataracts	☐	☐	Pain on urination			
☐	☐	Itchy/red eyes	☐	☐	Urinary tract infections			
☐	☐	Facial pain/tics	☐	☐	Wake at night to urinate			
☐	☐	Jaw pain or clicks	☐	☐	Incontinence			
☐	☐	Mercury fillings	☐	☐	Kidney stones			
☐	☐	Sores in mouth	☐	☐	Blood in urine			
☐	☐	Loss of taste	☐	☐				

Was there anything missed on this form that you would like to address?

_____

_____

I thank you ~ and your health thanks you ~ for taking the time filling out this form! It will bring insight to your intake and treatment plan.

SOW
h·e·a·l·t·h
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Informed Consent

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. Naturopathic Doctors 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. Your naturopathic doctor will take a thorough case history, perform an appropriate physical examination, and perform laboratory tests as needed. If your case requires, the physical may include more specific examinations such as gynaecological, rectal, prostate or genital exams. It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor 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.

There are some slight health risks associated with treatment by naturopathic medicine.

These include but are not limited to:

- Naturopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parenteral (intravenous) therapy.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa.
- Muscle strains and sprains or disc injuries from spinal manipulation.
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened by the Naturopathic Doctor prior to manipulating the neck.

The staff are trained to handle emergencies should the need arise.

I understand that:

- The clinic does not guarantee treatment results.
- My Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- I am free to withdraw my consent and to discontinue treatment at any time.

Patient Name (Please print): _____

Signature of Patient or Guardian: _____ Date: _____

Naturopathic Doctor: Sarah Oulahen, ND. Lic. #1754.

Patient Consent Form for Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an important part of our clinic, and while providing you with quality naturopathic care, we understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.
Your Naturopathic Doctor is aware of the sensitive nature of the information that you have disclosed to us. Your Naturopathic Doctor is trained in the appropriate use and protection of your information.

In this clinic, Sarah Oulahen, ND acts as the Privacy Information Officer regarding Naturopathic care.

Our privacy policy outlines what we are doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

How our Clinic Collects, Uses and Discloses Patients' Personal Information

We understand the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how we are using and disclosing your information.
The clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow up for treatment, care and billing
- To complete claims for insurance purposes
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse and reporting diseases and individuals who may be an imminent threat to harm themselves or others

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient Consent
I have reviewed the above information that explains how the clinic will use my personal information and the steps that the clinic is taking to protect my information. I agree that Sarah Oulahen, ND can collect, use and disclose personal information about _____ as set out above in the information about the clinic's privacy policies.
(Patient Name)

_____ _____ _____
Signature Print name Date