ADULT INTAKE FORM

Dr Karley Denoon ND

Thank you for taking the time to complete the following new patient forms to the best of your ability. They are an important step towards defining your health care needs and achieving your health goals.

Please bring this completed form to your first appointment or drop it off in advance for review. Please also bring any relevant blood work or health reports. All the answers on this form will be held **absolutely confidential.**

Name: _____ Birthdate: _____
Address: _____ City: _____Prov_____ PC:_____
Phone (Home): _____Cell: _____Work:_____
Email: _____ Occupation:_____
Family Doctor: _____Phone #:_____
Referring Professional: _____Phone #: _____
Care Card #: _____ Preferred method of communication: _____
Spouses name _____
Children's names and ages _____
Emergency Contact (name, relationship): _____Phone: _____
Why did you choose to come to this clinic?:_____
Have you seen a Naturopathic Doctor before? Y/N When: _____ Dr_____

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		

ALLERGIES: (please list your allergy, your reaction and severity on a scale of 1-10)
Medications: _____
Food: _____
Environmental: _____

PAST MEDICAL HISTORY:

Have you ever been hospitalized Y/N, Why and dates?

_____

_____

Have you ever had any major accidents, traumas or surgeries? Y/N explain, dates:

_____

_____

Your Birth History (prolonged labour, forceps, breastfed etc) :

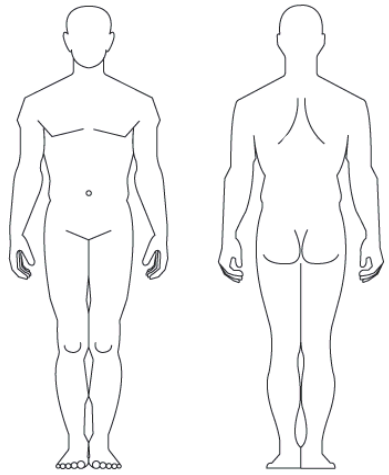
_____

_____

Occupational Stress:
Chemical: _____
Physical: _____
Psychological: _____

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:

_____

_____

571b 2nd Ave, Box 1295, Fernie, BC V0B 1M0 **Ph:** 250-531-0154 **Fax:** 1-800-858-8623 **Email:** info@drdenoon.ca

Please describe your current physical condition (Truth please) **:**
Exercise: Daily 5x Week 3x Week Weekly Monthly or Never

Type (length, aerobic, strength, intensity): _____

FAMILY HEALTH HISTORY:			
RELATION	MEDICAL CONDITION	AGE AT DEATH	CAUSE OF DEATH
Father			
Mother			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			
Paternal GF			
Paternal GM			
Maternal GF			
Maternal GM			

Please mark conditions you previously or currently experience with P or C

P = past **C** = current

GENERAL SYMPTOMS

- ☐ Loss of consciousness
- ☐ Numbness/tingling
- ☐ Fever
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Loss of sleep/insomnia
- ☐ Frequent colds/flu
- ☐ Loss of weight

HEAD AND NECK

- ☐ Headaches
- ☐ Type
- ☐ Vision problems
- ☐ TMJ concerns
- ☐ Ear aches
- ☐ Decreased hearing

CARDIO VASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Bleeding disorders
- ☐ Chest pain
- ☐ Stroke
- ☐ Artery hardening
- ☐ Varicose veins
- ☐ Swelling of the ankles
- ☐ Poor circulation
- ☐ Angina
- ☐ Heart disease

GENITOURINARY

- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Bed wetting

INFECTIONS/ILLNESSES

- ☐ Herpes
- ☐ Hepatitis
- ☐ Plantar warts
- ☐ TB
- ☐ HIV/AIDs
- ☐ Cancer
- ☐ Allergies

MUSCLES & JOINTS

- ☐ Stiff neck
- ☐ Backache
- ☐ Swollen joints
- ☐ Painful tailbone
- ☐ Foot trouble L - R
- ☐ Shoulder pain L - R
- ☐ Elbow pain L - R
- ☐ Wrist pain L - R

- [ ] Sinus problems

SKIN
- [ ] Rashes/eczema
- [ ] Itching
- [ ] Bruise easily
- [ ] Dryness
- [ ] Boils/hives
- [ ] Contagious skin disease

RESPIRATORY
- [ ] Chronic cough
- [ ] Shortness of breath
- [ ] Smoking
- [ ] Breathing problems
- [ ] Asthma/bronchitis

- [ ] Prostate trouble

GASTROINTESTINAL
- [ ] Poor digestion
- [ ] Indigestion
- [ ] Excessive hunger
- [ ] Belching or gas
- [ ] Nausea/vomiting
- [ ] Abdominal pain
- [ ] Constipation
- [ ] Diarrhea
- [ ] Hemorrhoids
- [ ] Liver concerns
- [ ] Gall bladder trouble
- [ ] Bladder concerns
- [ ] Ulcer
- [ ] Diabetes

- [ ] Hip pain L - R
- [ ] Knee pain L - R
- [ ] Arthritis
- [ ] Weakness/lost strength

WOMEN'S HEALTH
- [ ] Painful menstruation
- [ ] Excessive flow
- [ ] Irregular cycle
- [ ] Hot flushes
- [ ] Cramps or backache
- [ ] Vaginal discharge
- [ ] Swollen breasts
- [ ] Lumps in breast
- [ ] Are your pregnant
- [ ] Birth control
- [ ] Number of pregnancies
- [ ] Number of children

SEXUAL HEALTH HISTORY: (Please indicate with a Y or N below)
Have you ever had or are you currently experiencing:

Chlamydia: _____ Gonorrhea: _____ Syphilis: _____ Herpes:_____
Yeast infections: _____ Bacterial Vaginosis:_____ Hep B_____ Hep C_____
Human Papillomavirus (HPV-warts): _____Pubic Lice: _____ scabies:_____
Lymphogranuloma Venereum (LGV):_____ Trichomoniasis: _____

What kind of birthcontrol 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 Xray:_____ 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 next page including vitamins/supplements.**

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:

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LIFESTYLE:
DIET:
Please describe a typical days diet:
Breakfast: _____
Lunch: _____
Dinner:_____
Snacks: _____Beverages: _____

How MUCH and HOW OFTEN do you consume:
Alcohol: _____Recreational Drugs (which ones):_____
Caffeine:_____Water:_____Tobacco:_____
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 you are generally: _____
Stress in the home: _____ Satisfaction in relationship: _____
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)? :
_____
_____

SETTING THE STAGE:

-What is your main expectation from this visit: _____
-What long term expectations do you have: _____
-What expectations do you have of me professionally: _____
-What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle: (1(low)- 10 (high):_____
-What behaviors or lifestyle habits do you currently engage in regularly that you think support your health: _____
-Are self destructive or negative lifestyle habits:
_____
-What potential obstacles do you foresee in addressing lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which I will be sharing with you: _____
-Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?: _____
-What do you LOVE to do? _____

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 no 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: _____