



ADULT INTAKE FORM

Every detail you provide will help you achieve your health goals and will remain confidential. Please bring this completed form to your first appointment, along with any relevant blood work or health reports.

Name: _____ Date: _____

Date of birth (dd/mm/yy): _____ Age: _____ Gender: _____

Address: _____

Home Tel: _____ Work Tel: _____ Email address: _____

What is the best way for us to contact you? _____

May we leave telephone messages at home or work? _____

Would you like to receive our clinic email newsletter? _____

Emergency contact information:

Name: _____ Relationship: _____ Tel: _____

Please circle the name of the Naturopathic Doctor you are seeking healthcare services from:

Dr. Sonya Nobbe

Dr. Christina Vlahopoulos

Dr. Jennifer Wheeler

How did you hear about this naturopathic medical practice? _____

Please list all other healthcare practitioners you are seeing:

1. _____ 2. _____ 3. _____

() _____ () _____ () _____

Please list your primary health concerns, in order of importance:

1. _____ Date of onset: _____

2. _____ Date of onset: _____

3. _____ Date of onset: _____

4. _____ Date of onset: _____



MEDICAL HISTORY

Please list any hospitalizations, surgeries, traumas (including emotional traumas) or major illnesses:

- 1. _____ Date started: _____ Date Resolved: _____
- 2. _____ Date started: _____ Date Resolved: _____
- 3. _____ Date started: _____ Date Resolved: _____
- 4. _____ Date started: _____ Date Resolved: _____
- 5. _____ Date started: _____ Date Resolved: _____

Please list any **medications** you are taking, including antacids, pain medications, and laxatives:

- 1. _____ Date started: _____ Dose: _____
- 2. _____ Date started: _____ Dose: _____
- 3. _____ Date started: _____ Dose: _____
- 4. _____ Date started: _____ Dose: _____

Please list any **supplements** or vitamins you are taking:

- 1. _____ Date started: _____ Dose: _____
- 2. _____ Date started: _____ Dose: _____
- 3. _____ Date started: _____ Dose: _____
- 4. _____ Date started: _____ Dose: _____

Please list any medications or supplements you have taken **in the past**:

- 1. _____ Date started: _____ Finished: _____
- 2. _____ Date started: _____ Finished: _____
- 3. _____ Date started: _____ Finished: _____
- 4. _____ Date started: _____ Finished: _____
- 5. _____ Date started: _____ Finished: _____
- 6. _____ Date started: _____ Finished: _____

Approximately how many times have you been treated with antibiotics? _____

Please list any allergies, sensitivities, or adverse reactions (e.g. to medications, immunizations, food, chemicals, pets):



LIFESTYLE

Please describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

How much and how often do you consume the following:

Alcohol: _____ Recreational Drugs: _____

Caffeine: _____ Water: _____ Tobacco: _____

Please describe what forms of exercise you participate in, and how often:

What is your occupation? _____

Please list some of your hobbies: _____

Please briefly describe your travel history: _____

Do you have any children living in your home? _____

EMOTIONAL HEALTH

On a scale of 1 (low) to 10 (high), please rate your overall level of stress: _____

On a scale of 1 (low) to 10 (high), please rate your overall energy level: _____

On a scale of 1 (low) to 10 (high), please rate how happy you are generally: _____

How would you describe the emotional climate of your home? _____

Do you feel that your home is a safe place? _____

Have you ever felt sad or depressed for two weeks or more at a time in the past year? Yes No

Do you have any concerns regarding your emotional or mental health (please describe)? _____



ENVIRONMENT

Are you regularly exposed to any of the following at home or work (please circle)?

Tobacco smoke Chemicals/toxins Pets Radiation Well water

Please describe: _____

Have you ever been exposed to a constant source of heavy metals (e.g. welding, stained glass making, water in lead pipes)? _____

FAMILY HISTORY

Please indicate whether the following health conditions **pertain to any of your family members:**

Condition	Relative	Age of Onset	Details
Heart problems (e.g. high blood pressure)			
Lung problems (e.g. asthma)			
Nervous system problems (e.g. seizures)			
Digestion problems (e.g. Crohn's disease)			
Allergies (moderate/severe)			
Skin problems			
Cancer			
Diabetes			
Autoimmune disease			
Mental illness (e.g. depression)			
Difficulties with drugs and/or alcohol			
Other			

Is there anything else you would like to include on this form? _____



REVIEW OF SYSTEMS

Please indicate with a check mark (✓) whether you are currently experiencing the following healthcare concerns (C), or if you have experienced them in the past (P):

CONDITION	C	P		C	P
Skin					
Rash, eczema, hives			Excessive sweating/ Night sweats		
Acne			Nail or hair changes		
Colour change or change in a mole			Boils		
Warts, lipomas, or other masses			Excessive dry skin		
Head, Nose & Sinus					
Headache or migraine			Hair loss		
Head injury			Dandruff		
Nose bleeds			Sinus infections		
Nose stuffiness			Loss of smell		
Ears					
Impaired hearing or ringing			Ear pain or infections		
Eyes					
Eye pain			Glaucoma or Cataracts		
Tearing, dryness, itching, redness			Spots or "floaters"		
Discharge			Double or blurred vision		
Mouth, Throat & Neck					
Frequent sore throat or throat dryness			Hoarseness		
Sore tongue or mouth sores			Dental cavities or teeth problems		
Cold sores			TMJ or jaw pain		
Gums bleeding or receding			Loss of taste		
Swollen lymph nodes in neck			Thyroid problems		
Musculoskeletal					
Joint pain or stiffness; Arthritis			Muscle soreness		
Neck, back, or foot pain			Muscle spasms or cramps		
Broken bones			Muscle weakness		
Respiratory					
Prolonged Cough or Phlegm			Difficulty or pain breathing		
Asthma, emphysema			Shortness of breath at night		
Frequent colds, bronchitis, or pneumonia			Tuberculosis		
Cardiovascular					
Heart disease			High cholesterol		
High or low blood pressure			Sensation of blood rushing in ears		
Murmurs			Palpitations (can feel heart beating)		
Chest pain			Rapid, slow, or irregular heart rate		
Peripheral Vascular, Hematological & Lymphatic					
Deep leg pain			Anemia		
Cold or numb hands/feet			Easy bleeding or bruising		
Varicose veins or spider veins			Lymph node swelling		
Swelling ankles			Swelling wrists		



CONDITION	C	P	C	P
Gastrointestinal				
Heartburn or Reflux			Diarrhea or loose stool	
Ulcer			Constipation	
Indigestion, bloating after eating			Blood in stool or rectal bleeding	
Sensation of heaviness after eating			Black or clay (grey) coloured stool	
Belching or passing gas			Floating stool	
Recurrent nausea or vomiting			Undigested food in stool	
Change in thirst or appetite			Rectal or anal itching	
Excessive thirst or appetite			Change in bowel habits	
Abdominal pain			Liver disease, such as hepatitis	
Hemorrhoids or Hernia			Gall Bladder stones and/or disease	
Urinary System				
Pain during urination			Frequent infections	
Increased frequency or excessive urination			Kidney or bladder stones	
Hesitancy or urgent urination			Dark coloured urine	
Neurologic				
Fainting/ Loss of consciousness			Loss of memory or confusion	
Dizziness/ Loss of balance			Speech or swallowing difficulty	
Seizures/Convulsions			Numbness or tingling	
Paralysis			Involuntary movement	
Mental & Emotional Health				
Depression, anxiety, or nervousness			Difficulty concentrating	
Episodes of extreme energy or mood swings			Phobias	
Female System				
Breast pain, tenderness, or lumps			Menstrual cycle pain or other difficulty	
Breast discharge			Menopausal symptoms	
Vaginal infection or discharge			Syphilis, chlamydia, or gonorrhea	
Male System				
Prostate problems			Testicular lumps, sores, or pain	
Syphilis, chlamydia, or gonorrhea			Penile sores or discharge	
General				
Unexplained or excessive fatigue			Allergies (environmental, food)	
Unintentional weight loss or gain			Insomnia or sleep difficulties	
Blood sugar problems (high or low)			Dizziness or vertigo	

EXAM HISTORY

Please indicate when you most recently (if ever) had the following tests/procedures performed:

- Tuberculin (TB) test: _____
- Chest x-ray: _____
- CT, MRI, or ultrasound: _____
- ECG: _____
- Eye exam: _____
- Hearing test: _____
- PAP smear or gynaecological exam: _____
- Prostate exam: _____
- Blood or urine tests: _____
- Full physical exam: _____



INFORMED CONSENT FOR TREATMENT

Naturopathic Medicine is a distinct system of primary care that addresses the whole body and root cause of illness and disease. It promotes health by assisting the body's own healing mechanisms according to current medical research and ancient healing knowledge. Naturopathic doctors are primary care providers who integrate standard medical diagnostics with a broad range of natural therapies, including botanicals (herbs), acupuncture, clinical nutrition, counseling, and homeopathy. They work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

Your first naturopathic appointment will generally last 60 to 120 minutes and may include a physical exam and referral for laboratory tests. Follow-up appointments may range from 15 to 60 minutes each, according to your individual health requirements. The first consultation fee is generally \$150 to \$165 and does *not* include the cost of laboratory testing or prescription items. Follow-up consultation fees are prorated at \$140 per hour. OHIP does *not* cover the fees of a naturopathic doctor, however many extended healthcare insurance providers do.

STATEMENT OF ACKNOWLEDGEMENT

I, _____, as a patient of _____, understand that the form of medical care is based on naturopathic principles and practices. I will inform my naturopathic doctor of all health concerns, medications and medical interventions, including over-the-counter drugs and supplements, because safe care requires that I truthfully and completely disclose this information. I will also inform my naturopathic doctor if I am pregnant or breastfeeding.

I 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 courses of action. I am encouraged to request more information as needed, and to take an active role in my care. 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 are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, and bruising or injury from acupuncture.

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 any time. I accept full responsibility for any fees incurred during care and treatment. I am aware that I am always at liberty to seek or continue care from another healthcare provider.

SIGNATURE

DATE

WITNESS



**CONSENT FOR COLLECTION, USE, AND DISCLOSURE
OF PERSONAL HEALTH INFORMATION**

Your health privacy is a primary concern and the personal health information you disclose to your Naturopathic Doctor during your appointments will be handled in accordance with current privacy legislation and standards determined by the naturopathic regulatory body, the Board of Directors of Drugless Therapy - Naturopathy. Personal health information includes identifiable information such as age, gender, family status, and health history.

Your Naturopathic Doctor, employees, and health practitioners of 541 Palace Road will collect, use, and disclose information about you for the following purposes:

- To assess your health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Employees and health practitioners of 541 Palace Road will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. Staff members and practitioners will collect, use, and disclose your personal health information accordingly to protect your privacy and the confidentiality of your information.

I have reviewed the above information and authorize _____, Doctor of Naturopathic Medicine, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information as outlined above.

NAME

DATE

SIGNATURE

WITNESS