CONFIDENTIAL PATIENT INFORMATION

Naturopathic Intake Form

Name: ____

Address: ____

City: ____________________ Province: ____________ Postal Code: ____________

Home Phone: ____________________ Cell Phone: ____________________

E-Mail Address: ____

Date of Birth: ______________ Sex: ____________
(DD/MM/YY)

Employer: ____________________ Occupation: ____________________

Alberta Health Care #: ____________________ Marital Status: ____________________

Family Physician: ____

Emergency Contact: ____________________ Phone: ____________________

How would you like to receive your appointment reminders: __Email __Text*_
**CELL PHONE PROVIDER (required for TEXT reminder- circle ONE)* Bell _Telus _Fido _Koodo _Virgin Rogers PC Mobile

How did you hear about our office?____________________ If referred, who can we thank?____________________

Have you ever seen a Naturopathic Doctor before? ___Yes ___No
If yes, for what reason(s)?____

Current Health History
Height: __________ Weight: __________ Weight one year ago: __________
Are you concerned about your weight? ___Yes ___No
Please rank your main concerns in order of importance to you and when they started:
1)____
2)____
3)____
4)____
5)____

Please list any current diagnosis you have been given (if any) and when:
____
____

What activities aggravate your condition? ____

Does your health interfere with any of the following?
___ Work ___ Sleep ___ Daily Routine ___ Other

Please list any allergies you have:
____
____

Have you ever had any mental or emotional disorders? ________________________________
If yes, please list: ____
If yes, when? ______________

When was your last physical exam? ______________
When did you last have blood work done? _______________

Please indicate how often you go for dental visits:
___ Every 6 Months ___ Yearly ___ Toothache or Emergency ___Wear Dentures

What other therapies are you currently using? (Chiropractic, Physiotherapy, Acupuncture etc)
____
____
What other treatments have you tried in the past for these concerns?
____
____

Are you currently under the care of any other physicians or practitioners?
Yes No

If yes, please give names and contact info:
____
____

Medication (Please list all of your prescription and non-prescription medication, including birth control, aspirin, and over the counter medications)

Medication	Dosage	Since	Reason

Are you currently experiencing any side effects from your medication? Yes No

History of **antibiotic** use: (last two years) When: ____________________
How long: _________________
For what condition(s):
____
____
Did you experience any side effects? Yes No

Supplements (Please list any vitamin, mineral, or natural supplements you are taking with doses and brands)

Medication	Dosage	Since	Reason

Health History
Please indicate which of the following conditions you have had: Please indicate if you have or have experiencing and P for experienced in the past):

___Abscesses
___Alcoholism/Substance abuse
___Allergies/Hay fever
___Amnesia
___Anemia
___Anxiety/Depression
___Asthma
___Autoimmune disease
___Bells' Palsy
___Cancer
___Chicken Pox
___Cold Sores
___Concussion
___Diabetes
___Eating Disorder
___Emphysema
___Epilepsy
___Eye disease
___Gall Stones
____Pneumonia
___Prostatitis
___Rheum. Fever
____Rubella
___Scarlet Fever
___Sexually Transmitted Infection
___Sinusitis
___Skin Disease
___Sleep apnea
___Strep Throat
___Stroke Thyroid disease
___Tonsillitis
___Tuberculosis
___Typhoid
___Warts
___Yellow Fever

___Goiter
___Gout
___Heart Disease
___Hepatitis
___High Blood Pressure
___Influenza
___Kidney Disease
___Leukemia
___Lyme disease
___Malaria
___Measles
___Miscarriage
___Mononucleosis
___Mumps
___Neurological disease
___Obesity
___Osteoporosis
___Parasites
___Peritonitis

GENERAL

__ Allergies
__ Chills
__ Convulsions
__ Dizziness
__ Fainting
__ Fatigue
__ Headache
__ Migraines
__ Loss of sleep
__ Weight loss
__ Weight gain
__ Nervousness
__ Depression
__ Neuralgia
__ Sweats
__ Tremors
__ Weakness

GASTROINTESTINAL

__ Abdominal pain
__ Acid reflux
__ Belching
__ Bloating
__ Blood in mucous or stool
__ Change in taste or thirst
__ Colitis/IBD
__ Constipation
__ Diarrhea/loose stools
__ Difficult digestion
__ Excessive hunger
__ Gallbladder trouble
__ Heartburn
__ Hemorrhoids
__ Jaundice
__ Liver trouble
__ Nausea
__ Poor appetite
__ Rectal itching
__ Trouble swallowing
__ Ulcers
__ Vomiting
__ Vomiting of blood

How often do you have a bowel movement?
____
Have you had a colonoscopy? Yes/No
If yes, when? ___________

CARDIOVASCULAR

__ Arteriosclerosis or Atherosclerosis
__ Chest pain
__ Clots
__ Deep leg pain
__ High blood pressure
__ High cholesterol
__ Low blood pressure
__ Murmur
__ Pitting edema
__ Poor circulation
__ Rapid heart beat/palpitations
__ Swelling of ankles
__ Varicose veins

RESPIRATORY

__ Chronic cough
__ Difficult breathing
__ Pain with breathing
__ Shortness of breath while laying down
__ Shortness of breath with activity
__ Slow breathing
__ Spitting up blood
__ Spitting up phlegm
__ Wheezing

MUSCOSKELETAL

__ Burstitis
__Difficulty chewing/jaw clicking
__ Hernia
__ Joint pain
__ Joint stiffness
__ Joint swelling/redness
__ Low back pain
__ Muscle spasms/cramps
__ Neck pain/stiffness
__ Numbness/tingling
__ Osteoarthritis
__ Rheumatoid arthritis
__ Shoulder pain
__ Tendonitis

NEUROLOGICAL

__ Bells' palsy
__ Carpal tunnel syndrome
__ Paralysis
__ Peripheral neuropathy
__ Sciatica
__ Tremors

EYES, EARS, NOSE, THROAT

__ Bad breath
__ Blurry vision
__ Deafness
__ Dental decay
__ Detached retina
__ Double vision
__ Ear discharge
__ Earache
__ Enlarged glands/Swollen lymph
__ Enlarged thyroid
__ Eye pain
__ Eye strain
__ Far-sightedness
__ Floaters
__ Gingivitis
__ Glaucoma
__ Gum trouble
__ Hay fever
__ Hoarseness
__ Increased ocular pressure
__ Loss of central vision
__ Loss of peripheral vision
__ Loss of taste or smell
__ Macular edema
__ Mercury fillings
__ Mouth sores
__ Nasal obstruction
__ Near-sightedness
__ Nosebleeds
__ Root canals
__ Sensitivity to light
__ Sensitivity to noise
__ Sinus infection
__ Sore throat
__ Tearing or dryness
__ Tinnitus
__ Tonsilitis
__ Tooth pain

SKIN

__ Acne
__ Bruise easily
__ Cellulite
__ Dryness/Eczema
__ Hair loss
__ Hives/Allergies
__ Itching
__ Moles removed
__ Psoriasis
__ Rash
__ Rosacea
__ Vitiligo

GENITO-URINARY

__ Bed-wetting
__ Blood in urine
__ Frequent urination
__ Painful urination

Is your urine clear? ___________

MEN

__ Erectile dysfunction
__ Low libido
__ Penile discharge
__ Prostatitis

Have you had a rectal exam? Yes/No
If yes, when? _________

WOMEN

__ Excessive menstrual flow
__ Fertility issues
__ Low libido
__ Lumps in breast
__ Menopausal symptoms
__ Painful menstruation
__ Tender/swollen breasts
__ Vaginal discharge

Are you pregnant? ___
Number of pregnancies: ___
Have you had a recent pap? ___
Have you had a recent mammogram?

Please indicate if you've had any hospitalizations, surgeries, or serious injuries:

Hospitalizations/Surgeries:

Operation	Date	Complications	Long- term side effects

Injuries:

Injury	Date	Long-term side effects

Diet and Lifestyle

How much of the following substances do you use on a daily basis?
(Heavy, moderate light, or none)

Alcohol: __________ Caffeine: __________ Recreational Drugs: __________ Laxatives: _________
Carbonated beverages: ____________

Are you seeking guidance in nutrition and daily lifestyle? Yes No

Do you use any tobacco products? _____ Type and quantity per day: ______________

Have you had a recent chest x-ray? _____ If yes, when? ___________________

Have you had any exposure to toxic chemicals? _______ If yes, which ones:
____

Are there any foods or food groups that you avoid? Yes No

If yes, which ones and why?
____
____
____

How often do you engage in physical activity?

Daily ___ 2-3 times/week ___ Once/week ___ Less than once/week ___

What type of activities? ____

On average, how many hours of sleep do you get per night? _____________
How many glasses of water do you drink per day? ________

Have you traveled to a foreign country in the last five years? ____
If yes, where? _____________
Please list any illnesses you had while abroad: ____ Have you had any recent vaccinations? ____
If yes, which ones: ___________________________

Family Health History
Please indicate any relevant health conditions of your blood relatives only.

Relation	Past and Present Health	Age at time of death (if applicable)

INFORMED CONSENT

I would like to take this opportunity to welcome you to Southcentre Health & Wellness! This Clinic utilizes the principles and practices of Naturopathic Medicine and supplemental therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means. Your practitioner will conduct a thorough case history, which may include a physical exam and specific laboratory testing as part of the treatment. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

I, (printed name) ____ as a patient of this clinic, have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As the clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest of therapies potentially have their complications in certain physiological conditions, in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre- existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture; and muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so declaring.

I understand that, as a patient, I am responsible for all costs incurred as a result of the decision including, but not limited to; the cost of all procedures involved in the treatment plan, the care provider's time, supplements, supplies and appointments missed or cancelled without sufficient notice (24 hours). I am aware that treatments are not covered through Alberta Health Care and may not be covered under private health insurance.

Patient Name (please print): ____

Patient Signature: ____

Witness Signature: ____

Date: ____

Office Financial Policy

Cancellation Policy
The time you have booked for your appointment is valuable. If you will not be able to attend a scheduled appointment, it is your responsibility to call the office with at least 24 hours notice to reschedule it. Failure to do so will result in 100% of the appointment cost being charged to you.

Appointment Reminders
Please understand that it is your responsibility to keep booked appointments. As a courtesy we offer email/text message reminders. If for whatever reason you do not get a confirmation by text or email, it is still your responsibility to be on time for this appointment.

Direct Billing

Insurance Company__________________________ Name of Plan Holder ______________________

ID #_____________________________________ Policy#__________________________________

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

Date: ________________________________

______________________________________ ____________________________________
Patient Signature (Legal Guardian) Witness Signature

______________________________________ ____________________________________
Patient Name (please print) Witness Name (please print)

CREDIT CARD INFORMATION __Visa __Mastercard

Card Number____ CardExpiry______________________

Signature____

ALL HARD COPIES OF CREDIT CARD INFORMATION WILL BE DESTROYED ONCE ENTERED INTO OUR COMPUTER TO ENSURE YOUR INFORMATION IS KEPT SECURE.