ADULT HISTORY & INFORMATION

This intake form is a *confidential* health assessment tool designed to gain insight into your personal health status. When embarking on an individualized health plan it is important to begin with a thorough understanding of where you are currently, your personal and family history, as well as your habits, concerns, and thoughts with respect to your health. Please take the time to answer the questions on this form as genuinely and as accurately as possible.

PATIENT CONTACT INFORMATION

Name:____ Birthday: _____/_____/_____ Age: _______ MALE / FEMALE

First + Last name — Day / Month / Year

Height: ______ Weight:______ Frame **S /M/ L**

Address: ____

Street Name — Apt/Suite # — City — Postal Code

Home Tel #: (____) _______________ Mobile #: (_____) _________________ Work Tel #: (_____) __________________

Email address: __________________________@_________________ Best way to reach you: _______________________

Status: **SINGLE / MARRIED/ PARTNERED** # of Children: ________ Occupation: __________________________________

Referred by: ____

IN CASE OF EMERGENCY

Name: ___________________________ Relationship: _________________________ Tel #: __________________________

<u>CURRENT HEALTH CONCERNS</u>. Please list in order of importance to you.

1) ___________________________________ 4) ___________________________________

2) ___________________________________ 5) ___________________________________

3) ___________________________________ 6) ___________________________________

<u>MEDICAL HISTORY</u>

Current /past illnesses and hospitalizations (include dates).

____

____

____

____

Allergies/Sensitivities (foods, drugs, pets, seasonal, etc.):

____

____

(♀) Are you currently pregnant: **YES / NO**

Have you received all vaccinations? **YES / NO**
If yes, any complications: ___________________________________

Date of last – Annual Physical exam /Blood test: ___________________

Date of last - Antibiotic use: ___________________________________

LIST OF MEDICATIONS & NUTRITIONAL SUPPLEMENTS

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

Family Physician: ________________________ Specialty: __________________ Phone number: (_____) _____________

Address: ____ Fax number: (_____) _______________

Thank you for taking the time to fill out your form before your visit. Please remember to bring any lab work, medications, or supplements with you.

ADULT HISTORY & INFORMATION

FAMILY MEDICAL HISTORY

Please indicate current/past medical conditions and or hospitalizations both Paternal and Maternal.

- What is your birth order, how many siblings do you have? (First and only, 2nd child, 3rd child, etc.) ______________________________

FATHER	
P. GRANDFATHER	
P. GRANDMOTHER	
MOTHER	
M. GRANDFATHER	
M. GRANDMOTHER	

DIET & LIFESTYLE

Do you eat or use any of the following? ✓ Please check all that apply.

	Aluminum pans		Microwave		Margarine
	Candy		Fried foods		Refined/processed foods
	Luncheon meats		Plastic Tupperware		Artificial sweetener
	Fast foods		Air Freshners		Scented body products

How would you describe your eating habits, any dietary restrictions: ✓ Please check one.

☐ A meat eater ☐ Vegan – Eat no animal foods of any type
☐ Vegetarian ☐ Other - __________________________

How do you eat your meals: With family around the table _____ In front of the T.V. ____ On the run ____ Alone ____

Restaurant ______ how often (weekly) Fast food _____ how often(weekly)

Please describe what you typically eat in one day:

Breakfast ____ Time:____________

Lunch ____ Time:____________

Dinner ____ Time: ___________

Snacks ____ Times:___________

Water _______ cups/day

Milk ________ cups/day

Coffee _______ cups/day

Tea ______ cups/day

Alcohol ______ drinks/wk

Other ________________

Do you have a bowel movement every day? **YES / NO** Do you Strain? **YES / NO**

Food Likes/Cravings: ____

Smoking ________ cigarettes/d How long have you been smoking? ______________________________

Exercise _________ times/wk What type? ____

Describe your current stress level: **LOW / MODERATE / HIGH**

How many hours do you sleep daily? (include naps) ____

Do you wake feeling rested? (Please circle one) **YES NO SOMETIMES**

FEMALE / MALE REPRODUCTIVE SYSTEM

Circle what describes you best: REGULAR / IRREGULAR / NO PERIODS / PERI-MENOPAUSAL / MENOPAUSAL

Date of last normal period: _________________ PMS Symptoms: ____

Please use this space to describe any information that has not been discussed above ____

____

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ADULT HISTORY & INFORMATION

DOCTORS NATURAE™ PRIVACY & CANCELLATION POLICIES

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

The office will collect, use and disclose only necessary information about you for the following purposes:

- To collect information for naturopathic assessments.
- To collect information for nutritional and dietary assessments.
- To collect consultation or cancellation fees, and fees for supplements, food, and seminars.

As our valued patient we trust that you will appreciate a friendly reminder call or monthly newsletter via email in order to continue our relationship together during your personal health journey. ☐ If you wish to opt out of this program please check this box.

Your information will be disclosed as follows:

- To all health professionals and staff employed by Doctors Naturae.
- To an emergency service personnel if one's life could be endangered.
- To an appropriate association, organization or other if one of our health professionals feels it's necessary.

We will only share your information with your consent, with the exception of the above. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols set out by the Board of Drugless Therapies Naturopathy (BDDTN), the International Organization of Nutritional Consultants (IONC) and Ontario's Personal Health Information Protection Act (PHIPA).

At Doctors Naturae, we value the time we get to spend with you and strive to offer the best customer service possible, even if that is to schedule you a last minute appointment. Thus, in order to serve you better we enforce a strict 24 hour cancellation policy. If something comes up and you cannot make your appointment, please call us right away. If we do not receive a phone call or voice message, a cancellation fee of $50 will apply. We hope you will appreciate this service as your time here at Doctors Naturae is valuable.

I have reviewed the above information that explains how Doctors Naturae will use my personal information, and the steps that will be taken to protect my personal information. I agree that Doctors Naturae can collect, use, and disclose my personal information as set out above in the information about the clinic's privacy policies and charge a cancellation fee if I do not provide 24 hours notice for a missed appointment.

______________________________	______________________________	__________________________
Signature	Print Name	Date

CONSENT TO DIAGNOSTIC/THERAPEUTIC PROCEDURES

RECOMMENDED DIAGNOSTIC/THERAPEUTIC PROCEDURES(S) (Including those by referral to another practitioner)

____

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic/therapeutic procedure(s) described by the attending practitioner, as indicated below, and have discussed to my satisfaction this and any requests for related information with the practitioner named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the procedure(s) with respect to the nature of the procedure, expected benefits, potential risks, side effects and financial cost; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. I understand that I can withdraw my consent at any time.

Attending Practitioner(s): ____

Signature of Patient: _______________________________________ Date: ______________________________

CONSENT TO NUTRITIONAL CONSULTING

I understand and acknowledge that the services hereby provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnoses, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Signature: _______________________________________ Date: ______________________________

For Office Purposes Only

☐ Verbal consent acquired and witnessed. Patient understands and acknowledges risks and benefits to treatment explained.

Thank you for taking the time to fill out your form before your visit. Please remember to bring any lab work, medications, or supplements with you.