

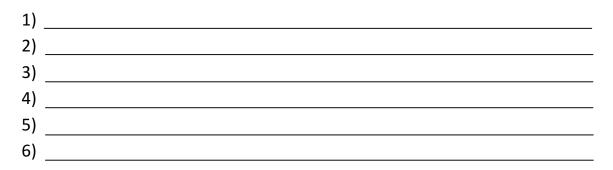
Market Mall Executive Professional Centre Suite 228, 4935 - 40 Ave NW | Calgary, AB, T3A 2N1 Phone: 403-247-4646 | Fax: 587-387-2262

ADULT INTAKE FORM

Name:	Date:				
Address:					
City: Pro	vince: Postal Code:				
Telephone: (Home)	(Bus) (Cell)				
Email:	Would you like to receive our newsletter by email? Yes				
Male 🗌 Female 🗌 Age: Date of Birth:					
larital Status: Number of Children:					
Occupation:	Employed by:				
Emergency Contact:	Phone:Relation:				
How did you hear about c	ur practice?				

HEALTH CONCERNS

Please, list your health concerns in order of importance.



Vitamins and Supplements

List all vitamins/minerals/herbal supplements you are currently taking:

Medications

List all prescription and non-prescription medications you are currently taking:

Medical History

List any major illness, injuries and/or surgeries that you have had and when:

Allergies
Do you have any hypersensitivity or allergy to any drugs?
Do you have any food intolerances or allergies?
Do you have any environmental sensitivity?
General
Height: Weight: lbs Weight 1 year ago:

Family History

Please put an "L" for living and "D" for deceased and present age or age at time of death. Indicate if the family member suffered from any disease or conditions such as cancer, high blood pressure, heart attack, stroke or diabetes.

Relationship	L/D	Age	Health Conditions/Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sister (s)			
Brother (s)			

Dental

Do you have any root canals?	Yes 🗌 No 🗌 If yes, how many?
Do you have any amalgam fillings?	Yes 🗌 No 🗌 If yes, how many?

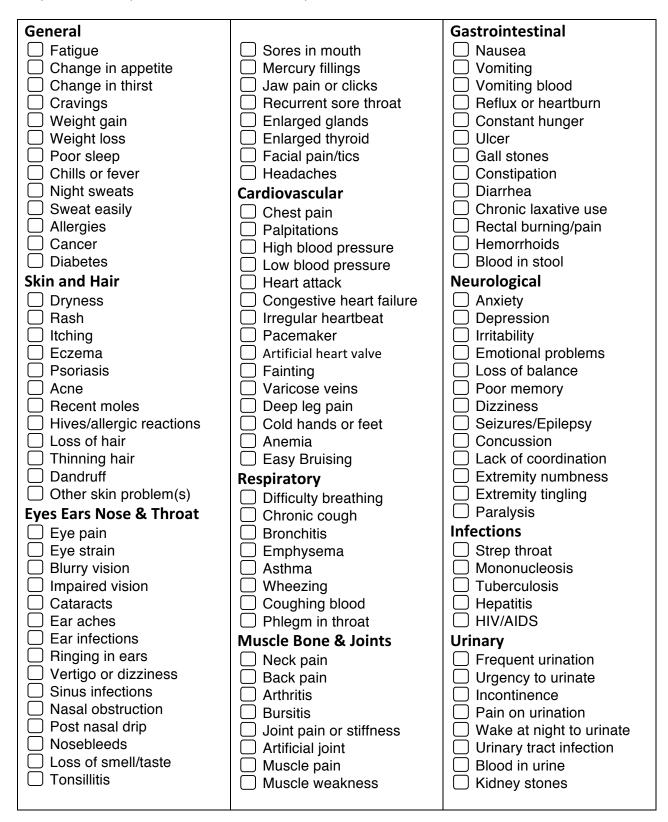
Typical Food Intake

Breakfast:														
Lunch:														
Dinner:														
Snacks:														
To Drink:														
Habits:														
Main interest and hobbies:														
Do you exercise? Yes 🗌 No	D 🗌 If yes,	, ho	w ofte	en?_										
Do you smoke? Yes 🗌 No 🛛] If yes, ho	ow l	ong?			Нс	w	ma	ny	ре	r da	ay?_		
Do you use recreational drugs? Yes No If yes, which ones?														
Rate your energy between 2	1 and 10.	(Lo	w) 1	2	3	4	5	6	7	8	9	10	(High)
Rate your Stress between 1	and 10.	(Lc	w) 1	2	3	4	5	6	7	8	9	10	(Higł	ı)
Sleep														
How many hours of sleep d	o you get d	on a	verag	e?_										
Do you have difficulty falling asleep? Yes No														
Do you wake up during the night? Yes No If yes, how often?							_							
Do you feel refreshed in the morning? Yes 🗌 No 🗌														
Digestive Health														
How frequently do you mov	ve your bo [,]	wels	s?											_
Do you experience any of the	ne followin	ıg?												
Loose Stools?	Yes 🗌 No		Muco	ous ii	n st	ool	s?				Ye	s 🗌	No	\Box
Diarrhea?	Yes 🗌 No		Gas?								Ye	s 🗌	No	
Hard Stools?	Yes 🗌 No	>	Bloat	ing?							Yes	s 🗌	No (
Difficulty Passing?	Yes 🗌 No)	Hear	burı	n/R	eflu	ıx?				Yes	s []	No	
Blood in Stools?	Yes 🗌 No		Abdo	mina	al P	ain	?				Ye	s 🗌	No	
Undigested Foods in Stools?	Yes 🗌 No													
Do you have your gallbladd	ler? Yes	No(Do	you	ı ha	ve	you	ır a	ppe	end	ix?	Yes		10

Female Reproductive	
Age of your first menses?	How many days of menses?
How long is your cycle?	When was your last pap test?
Do you get yeast infections? Yes	Νο
History of abnormal pap? Yes	No
Are you menopausal? Yes	No 🗌 If yes, age of last menses
Have you had a hysterectomy? Yes	Νο
Do you experience any of the following	ng?
Heavy flow Yes	No
Light flow Yes	Νο
Clotting Yes	No
Bleeding between periods Yes	No
If you experience PMS, which sympto	ms?
Pain or cramping	Headaches
Mood Swings	Breast Tenderness
Bloating	Cravings
Do you experience any of the following	
Hot flashes	Low libido
Disrupted sleep	Pain during intercourse
Poor memory	Vaginal itching
Changes in mood	Vaginal dryness
Are you sexually active? Yes No	Form of contraception
Male reproductive	
Please, indicate if any of the following	g applies to you:

	Testicular Pain						
Sexually Transmitted Disease	Infertility/Low Sperm Count						
Sores on Genitals	Hernia						
Discharge	Prostate Condition						
Testicular mass							
Are you sexually active? Yes No	Form of contraception						

Please check any of the following that apply to you or write "P" beside the box if you have experienced these in the past.



Signature

I attest that the information provided is true and accurate to the best of my knowledge.

Signature

Date

DECLARATION AND CONSENT TO TREATMENT

Naturopathic Doctors minimize the risk of harmful side effects, by supporting the body's own capacity to heal and by using the least invasive procedures for diagnosis and treatment whenever possible. However, even the gentlest therapies have potential for complications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease, or in specific patient populations such as pregnant or lactating women, very young children, or patients taking multiple medications. It is very important that you inform your Naturopathic doctor immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture or blood draws
- Fainting or puncturing of an organ with acupuncture needles

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my Naturopathic Doctor will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I will rely on the Naturopathic Doctor to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known.

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

If I am unable to make my appointment I must provide advance notification within 48 hours in which case no charge will be applied.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

I. Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving from another licensed health care provider, or may receive in the future;

II. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Alberta;

III. No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;

IV. The treatment and therapies rendered or recommended by this Clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, as well as other applicable fees. I understand that_there is a fee for completing insurance forms, letter writing, and telephone consultations greater than 10 minutes and emails that take greater than 10 minutes to answer. Notice of 48 hours is required for appointment cancellation, otherwise you will be charged an administrative fee of \$35.00.

Patient's Full Name:

Date of Consent: _____

Signature of Patient: _____