

NATUROPATHIC INTAKE FORM

Name: _____ Date: _____

Date of Birth (M/D/Y): _____ Gender: _____ Female _____ Male _____

Address: _____ City: _____ Province: _____

Home Phone: _____ Work Phone: _____ Messages: _____ Home _____ Work _____

Would you like naturopathic updates by email? Yes No E-mail: _____

How did you find out about our clinic? If referred, who referred you: _____

Name of Family Doctor: _____ Phone: _____

Emergency contact person: _____ Phone: _____

Your occupation: _____

CURRENT HEALTH CONCERNS

What are your health concerns, in order of importance to you:	For how long:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

MEDICAL HISTORY

Please indicate any serious conditions, illnesses, injuries, and any hospitalizations along with approximate dates:

Do you have any allergies or sensitivities? (food, drugs, herbs, environmental, etc.):

List any medications or supplements (vitamins, herbs etc.) you are currently taking:

If you are female, are you currently pregnant? Yes No

DIET

Please list a typical day's diet with quantities (including beverages):

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Dietary restrictions (religious, vegetarian, vegan, etc): _____

FAMILY HISTORY

Indicate if a close relative (grand parent, parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse	
High blood pressure		Alcoholism	
Cancer		Kidney disease	
Diabetes		Other	

I don't know my family medical history

REVIEW OF SYSTEMS

Approximate weight:

Height:

Please indicate and circle the condition if you have it now or have had it in the past.

- Skin** – rashes, eczema, psoriasis, acne, itching, lumps, colour change, dry, moist, easy bruising
- Nails** – colour changes, fungal infections, brittle/shear, vertical/horizontal lines, hangnails
- Head** – migraines, headaches, dizziness
- Eyes** – pain, tearing, dryness, blurring, redness, discharge, itching, cataracts, glaucoma
- Ears** – impaired hearing, earache, dizziness, discharge, infections, ringing
- Nose & Sinus** – frequent colds, nose bleeds, stuffiness, hay fever, sinus problems
- Mouth & Throat** – frequent sore throat, gum problems, hoarseness, dental cavities, loss of taste
- Neck** – lumps, swollen glands, pain or stiffness, enlarged thyroid
- Lungs** – cough, phlegm, spitting up blood, wheezing, difficulty breathing or shortness of breath, pain on breathing
- Cardiovascular** – heart disease, high blood pressure, murmurs, palpitations, chest pain
- Peripheral Vascular** – deep leg pain, cold extremities, varicose veins, extremity swelling/ulcers
- Gastrointestinal** – heartburn, indigestion, nausea, vomiting, belching, passing gas, stomach pain
- Gastrointestinal** – constipation, diarrhea, blood in stool, mucous in stool, hemorrhoids, black stools
- Urinary** – pain, frequent, frequent at night, inability to hold urine, blood in urine, urgency, infections
- Musculoskeletal** – joint pain/stiffness, muscle pain/stiffness, weakness, back pain, broken bones
- Neurologic** – fainting, seizures, paralysis, numbness/tingling
- Neurologic** – loss of balance, muscle weakness, involuntary movement, speech problems, memory loss
- Endocrine** – fatigue, heat/cold intolerance, thyroid problems, excess thirst/hunger/sweating
- Women's Health** – fibrocystic breasts, breast lumps, breast tenderness, nipple discharge
- Women's Health** – painful periods, PMS, excessive menstrual flow, irregular periods
- Women's Health** – vaginal discharge, painful/difficult intercourse, vaginal itching
- Men's Health** – hernias, testicular masses/pain, discharge from penis, difficult intercourse
- Exposure** to pets, tobacco smoke, toxins/chemicals at work or home
- Sleep** – difficulty falling asleep, frequent waking. Hours asleep: _____ Do you feel well-rested **Yes/ No**
- Adverse reaction to immunizations** – childhood vaccinations, flu vaccination, travel vaccinations, other
- Date of last physical exam** _____
- Exercises/interests/hobbies** (please elaborate) _____

INFORMED CONSENT FOR NATUROPATHIC TREATMENT

Integrated Healthcare Centre, Canadian College of Naturopathic Medicine
1255 Sheppard Ave. East
Toronto, ON, M2K 1E2
T: (416) 498-8265, F: (416) 498-8265

Naturopathic Doctors (ND) are required to obtain informed consent and to make sure you are aware of possible side effects/risks due to treatment.

Teresa Tsui, ND uses the following modalities in her practice: diet and nutritional counseling, Asian medicine and acupuncture, botanical medicine, hydrotherapy, massage, homeopathy, physical modalities, and lifestyle counseling.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases including but not limited to diabetes, heart, liver, or kidney disease. It is very important that you inform your ND immediately if any of the above applies to you. Because each individual may respond differently to treatment, your ND may not be able to anticipate and explain ALL risks and complications and cannot guarantee results.

There are some 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/injury from acupuncture and massage, fainting or puncturing of an organ with acupuncture needles.

I understand that my case may be discussed for educational purposes and information from my medical record may be analyzed for research purposes in which my identity will be kept confidential.

I acknowledge that I have discussed, or have had the opportunity to discuss, with my ND the nature and purpose of naturopathic treatment in general and my treatment in particular as well as the contents of this Consent.

I consent to the naturopathic treatments offered or recommended to me by my ND. I intend this consent to apply to all my present and future naturopathic care.

PLEASE READ BEFORE SIGNING

Patient Name

Signature of Patient/Guardian

Witness Signature

Date

Witness Name