Adult Intake Form

Personal Information

Name: First: _____Middle:_____ Last:_____ Age: _____

Birth Date: m/__d/__y/____ Gender:_____

Address: _____City: _____ Postal Code: _____

Telephone (Home): _____ (Work): _____ May we leave a message? _____

Email: _____*(Please indicate with an * the best way to contact you)*

Occupation: _____ Employer: _____

Relationship Status: *Single* *Married* *Divorced* *Separated* *Common-law* *Widowed* *Other* _____

Number of Children: ____ Who do you currently live with? *Partner* *Parents* *Friends* *Children* *Alone* *Other* _____

Emergency Contact: _____ Relation: _____ Telephone: _____

How did you hear about my practice? _____

What is your primary health concern?

_____

_____

_____

What are your other health concerns, and what treatment(s) have you received for them?

1) _____

_____ Onset: _____

2) _____

_____ Onset: _____

3) _____

_____ Onset: _____

4) _____

_____ Onset: _____

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Olivia Rose
Naturopathic Doctor

Health History

How would you rate your general state of health? *Excellent* *Good* *Average* *Fair* *Poor*

Have you suffered any major injuries or trauma? If yes, please describe.

_____

_____

Have you ever been hospitalized or had surgery? (Please describe)

_____

_____

Do you have any allergies to drugs, plants, foods, animals, or the environment? (Please describe)

_____

_____

Do you use any of the following? If yes, please describe the amount, frequency, duration, and type.

Alcohol: _____ Tobacco: _____

Hormones: _____ Coffee: _____

Cortisone: _____ Laxatives: _____

Sleeping Aids: _____ Antacids: _____

Recreational drugs: _____ Diet pills: _____

Vitamins, Homeopathics, or Herbs: _____

Prescription medications (past and present): _____

Other: _____

List the other health care providers you are seeing or have seen in the past (please indicate name, specialty & phone #):

1. _____(____)_____
2. _____(____)_____
3. _____(____)_____

Are you screened regularly by other doctors (ie. pap, prostate exam, blood tests, etc.)? Y / N

When was your last physical exam? _____ blood test? _____

What is your blood type? _____

If you are female, are you currently pregnant? Y / N

Please indicate what immunizations you have had:

- r DPT (diphtheria, pertussis, tetanus)
- r Haemophilus influenza B
- r Hepatitis A
- r Hepatitis B
- r MMR (measles, mumps, rubella)
- r "Flu"

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r Smallpox
r Tetanus booster
r Polio
Other: _____

Please describe any adverse reactions: _____

How many times have you been treated with antibiotics? _____

Review of Systems

Height:	Current weight:
Maximum weight (non-pregnant):	Ideal weight:

Have you had any of the following conditions? If yes, indicate "yes" (Y), "no" (N) or "past" (P).

Allergies		Weight Fluctuations		Stroke		STD	
Asthma		Gallstones		Cancer		Syphilis	
Canker Sores		Hepatitis		Headaches		Constipation	
Chicken Pox		Fainting		Diabetes		'Mono'	
Diphtheria		Speech Concerns		Parasites		Physical Abuse	
Ear Infections		Tonsillitis		'PMS'		Broken Bones	
Eczema		Gout		Epilepsy		Gonorrhea	
Hayfever		Anemia		Smallpox		Cold Hands/Feet	
Heart Disease		Alcoholism		HIV		Kidney Disease	
Measles		High Blood Pressure		Tuberculosis		Visual Problems	
Mumps		Rheumatic Fever		Malaria		Warts	
Pneumonia		Acne		Gas/Bloating		Varicose Veins	
Psoriasis		Arthritis		Migraine		Miscarriage	
Scarlet Fever		Ringing In Ears		Rectal Bleeding		Liver Disease	
Shingles		Balance Problems		Diarrhea		Child Abuse	
Sinusitis		Jaundice		Herpes		Emotional Abuse	
Strep Throat		Thyroid Concerns		Polio		Numbness/Tingling	

Other:

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Energy and Temperature

On a scale of 1-10, (10 being the best), how would you rate your energy level? _____

At what time of day is your energy the best _____? worst_____?

How often do you get colds, flues or sore throats in a year? _____

In general, your body temperature is warm/cool (circle one)

Sleep

On a scale of 1-10 (10 being the best), how would you rate the quality of your sleep? _____

Do you have problems falling asleep?_____ Staying asleep?_____

How many hours do you sleep? _____ How many hours do you think you need?_____

Do you wake up refreshed?_____ Do you nap or rest throughout the day?_____

If yes, what is your average nap time?_____

Digestion and Elimination

Do you have any problems with gas, bloating, or fullness after eating? If yes, please describe.

_____

_____

How often do you have bowel movements? _____

Do you ever have any blood, mucous or undigested food in your stool? _____

Do you ever have black, tarry or gray stool? _____ Do you ever have yellow or light-coloured stool? _____

Are your stools formed or loose? _____

Do you ever have alternating constipation and diarrhea? _____ If yes, how often? _____

Do you ever have to strain to pass stool? _____ If yes, how often? _____

Do your stools or gas have a strong disagreeable odour? _____ Do you pass gas often? _____

Do you ever have rectal itching? _____ Do you burp frequently? _____

Have you traveled outside of Canada in the last 5 years? _____

Have you been camping in the last 5 years? _____

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Kidney and Bladder

Have you had a bladder infection? _____ How often? _____ How was it treated? _____

Do you have any burning sensation during or after urination? _____ Have you in the past? _____

What colour is your urine (dark yellow, bright yellow, cloudy, pale, clear, etc.)? _____

Does your urine have an odor (strong, sweet, etc.)? _____

Do you have any difficulty starting or stopping when urinating? _____

How often do you get up in the night to urinate? _____

Perspiration

Do you have any difficulty perspiring? _____ Does your sweat have a strong odor? _____

Do you perspire when exercising? ___Do you perspire at times other than when you exercise? _____

Reproductive System

Read each question below carefully. Please write n/a if not applicable. Thank you.

What is your sexual orientation identity? _____ Are you sexually active? _____

Is this more or less than a year ago? _____ Do you practice safer sex? _____

Do you use birth control? _____ What type of birth control? _____

What was your age when you had your first period? ____ Has your period ever stopped? _____

if yes, at what age ?_____ and for how long? _____

Are your cycles regular? _____ If yes, your period begins every _____ days, and lasts _____ days.

How heavy/light is the flow? _____ What colour is the blood? _____

Are there any clots? _____ Any cramps? _____

Do you have any spotting or bleeding between your periods? _____

Do you have any premenstrual symptoms? _____

How many pregnancies? _____ Live births? _____ Abortions? _____ Miscarriages? _____

Any difficulties conceiving? _____

Do you get regular PAP smears? _____ Any abnormal PAP smears? _____

Do you do regular breast self-exams? _____ Have you noticed any breast lumps? _____

Has this increased over the years?_____ Any problems with getting or maintaining an erection? _____

Do you have any sores on your penis? _____ Any prostate problems? _____

When was your prostate last examined? _____

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Olivia Rose
Naturopathic Doctor

Lifestyle

What do you enjoy most in your life? _____

What are your main interests or hobbies? _____

Do you have a religious or spiritual practice? _____

Do you enjoy your work? _____ Do you take vacations? _____

Do you exercise? _____ If yes, what do you do and how often?

By your standards, are you currently in a happy and supportive relationship? Y / N

What do you worry about most in your life? _____

What are the 3 most significant and/or stressful events in your life (past and/or present)?

1) _____ Date: _____

2) _____ Date: _____

3) _____ Date: _____

Please circle the number that indicates your level of stress (0= no stress, 10=extremely stressful)

Job related	0	1	2	3	4	5	6	7	8	9	10
Financial	0	1	2	3	4	5	6	7	8	9	10
Marriage	0	1	2	3	4	5	6	7	8	9	10
Family members	0	1	2	3	4	5	6	7	8	9	10
School	0	1	2	3	4	5	6	7	8	9	10
Health	0	1	2	3	4	5	6	7	8	9	10
Spiritual	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

Did you experience any significant childhood trauma/grief/stress?

_____

_____

_____

_____

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Olivia Rose
Naturopathic Doctor

Occupation and Household Environment

Do you have a basement? ________ If yes, does it have any cracks in the foundation? ___________________

Do you find your home to be damp or moldy? _____ Do you use an air filtration system? _______________

Do you work in an office building? ______________ Do the windows open? _________________________

Do you work in the presence of toxic fumes or chemicals? ____

Do any of your hobbies involve toxic materials? ____

Are you currently exposed to second hand smoke? ____

How many 8oz. glasses of water do you drink per day (on average)? __________________________________

Do you prefer a/c or open windows in car/at home? ____

Family History

	Father	Mother	Brothers	Sisters	Grandmother		Grandfather	
					Maternal	Paternal	Maternal	Paternal
Age								
Health (G=good, P=poor)								
Alcoholism								
Anemia								
Asthma								
Cancer								
Diabetes								
Epilepsy								
Hay fever								
Heart Disease								
High Blood Pressure								
Hives								
Kidney Disease								
Mental Illness								
Osteoarthritis								
Rheumatoid Arthritis								
Stroke								
Tuberculosis								
Other								
Age (at death)								
Cause of death								

Is there anything else you'd like to mention? ____

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Olivia Rose ND, RAc

Naturopathic Doctor, Registered Acupuncturist
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INFORMED CONSENT

I would like to take this opportunity to welcome you to the care of naturopathic doctor and registered acupuncturist, Olivia Rose, ND, RAc. This clinic utilizes the principles and practices of Naturopathic Medicine and Traditional Chinese Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

The natural treatments used in this clinic include: nutrition, supplementation, homeopathy, botanical medicine, acupuncture, and lifestyle counseling. Naturopathic Doctors assess the whole person, including physical, mental, emotional and spiritual aspects of the individual. Your naturopathic consultation will consist of a thorough case history and a screening physical examination, and may include specific blood and/or urinary laboratory reports. More specific examinations such as breast, rectal or genital examinations may be included if necessary.

It is important that we are informed of any diseases that you are suffering from and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or are breast-feeding, please let us know immediately.

Statement of Acknowledgement

As a patient of this clinic I understand that Olivia Rose ND, RAc, utilizes non-invasive methods for the assessment of bodily dysfunction and supportive natural therapies. I consent to the diagnostic and therapeutic procedures outlined to me by the naturopathic doctor and registered acupuncturist, Olivia Rose, ND, RAc. I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or 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; and pain, fainting, bruising or injury from acupuncture. I further acknowledge and confirm that I will become informed of the diagnostic and therapeutic procedures and plans with respect to the financial costs, expected benefits, potential risks and side effects, the likely consequence of not having or following the procedure/plan, and what alternative course(s) of action is/are available to me. As a patient I also confirm that I have the ability to accept or reject this care of my own free will.

I accept and agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies and any other fees. I am aware that these fees are not covered by OHIP.

I, _____, consent to treatment as prescribed by my naturopathic doctor/registered acupuncturist, and have read, understood, and acknowledge the above statements.

_____ Date: _____

(Patient/Guardian's signature – Please sign in the office)

_____ Date: _____

(Witness's signature – Please sign in the office)

Olivia Rose ND, RAc

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PRIVACY POLICY CONSENT FORM

Privacy of your personal information is an important part of the business practices of Olivia Rose, ND, RAc, while at the same time providing you with quality health care. We understand the importance of protecting your personal information and we are committed to collecting, using and disclosing your personal information responsibly and only when necessary.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information. The reception staff will require your name, telephone number, and address when booking your first appointment. The health file that you create with Olivia Rose, ND, RAc is completely confidential and not shared with anyone else, unless you request otherwise by signing a consent form for the release of records.

HOW OUR CLINIC COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

Olivia Rose, ND, RAc stands by the importance of protecting your personal information. Our privacy protocols comply with privacy legislation and standards of the Board of Directors of Drugless Therapy – Naturopathy and the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario. Olivia Rose, ND, RAc will collect, use and disclose information about you for the following purposes.

- To assess your health concerns
- To provide health care
- To establish and maintain contact with you
- To email/mail newsletters, clinic updates and other information
- To remind you of upcoming appointments
- To allow us to efficiently follow-up for treatment and billing
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

PATIENT CONSENT

I have reviewed the above information that explains how Olivia Rose, ND, RAc will use my personal information, and the steps taken to protect my information. I agree that Olivia Rose, ND, RAc can use and disclose personal information about _(Print Name)_____ as set out above.

_____ _____ _____

Signature Date