Adult Naturopathic Intake Form

572 Weber Street North Unit 3A
Waterloo, Ontario N2L5C6
1-888-454-4667
www.touchstonehealth.ca

Naturopathic and preventative health care is only possible when the Doctor has a complete picture of the client physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire and bring to your first appointment.
Please note that all information disclosed is confidential and will not be released without your permission.

Name: _____ Date: _____

Age: _____ Sex: _____ Birth date: _____

Address: _____

Tel, Home: _____ Other: _____

Email: _____

May we leave messages relating to your visits? Yes No (please circle)

EMERGENCY CONTACT:
Name: _____ Relation: _____

Address: _____

Tel: _____ Email: _____

Other Health Care Providers you are seeing:
1. _____ 2. _____
_____ _____
_____ _____
Tel: _____ Tel: _____

How did you hear about this clinic? _____

Have you seen a Naturopathic Doctor before? Yes No (please circle)

List your **health concerns** in order of importance (include date of onset):

1. _____ Onset Date: _____

2. _____ Onset Date: _____

3. _____ Onset Date: _____

4. _____ Onset Date: _____

5. _____ Onset Date: _____

Are you currently receiving any treatment for these concerns? Have they been effective?
_____

Current Conditions that have been diagnosed:

1. _____ Onset Date: _____

2. _____ Onset Date: _____

3. _____ Onset Date: _____

4. _____ Onset Date: _____

Are you currently receiving any treatment for these concerns? Have they been effective?

_____

List any medications, vitamin, mineral, or herbal supplements you are taking or have taken in the past:

Name of Medication/Supplement	***Dose***	***Frequency***	***Duration***

Any Known Allergies: _____

*If you use the following please check and add **how many per day**:*

	Often	**Sometimes**	**Never**
Laxatives			
Antacids			
Pain Killers			
Caffeine			
Tobacco			
Alcohol			
Recreational Drugs			

List any medical procedures, hospitalizations, surgeries and major injuries.
Approximate date/year Hospitalizations/surgeries/major injuries/procedures

_____ _____

_____ _____

_____ _____

List any screening tests done recently (blood work, X-rays, etc.; include year and results):

_____

When was your last physical exam? _____

FAMILY HISTORY

Have any family members (including immediate family, grandparents, aunts and uncles) had any of the following conditions:

☐Allergies	☐Anemia	☐Headaches	☐ Depression	☐Thyroid
☐Asthma	☐Diabetes	☐Hypertension	☐Tuberculosis	☐Autoimmune
☐Epilepsy	☐Arthritis	☐Heart disease	☐Birth defects	☐Alcoholism
☐Anxiety	☐Kidney disease	☐Stroke	☐Cancer	☐Drug addiction

FAMILY HISTORY

Please put an "L" for living, "D" for deceased and include present age or age at time of death.

Relationship	L/D	Age	Diseases/Illness/Cause of Death
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Father			
Mother			
Sibling			
Sibling			

CHILDHOOD ILLNESSES

Have you ever had any of the following?

□Chicken Pox	□Ear infections	□Frequent colds	□Impetigo
□Measles	□Mumps	□Pneumonia	□Mono
□Polio	□Rheumatic fever	□Rubella	□Strep Throat
□Scarlet Fever	□Tonsillitis	□Whooping cough	□_____

IMMUNIZATIONS

□MMR: Measles, mumps, rubella	□Haemophilus	□Hepatitis A
□DPT: Diphtheria, pertussis, tetanus	□Flu Shot	□Hepatitis B
□Tetanus booster	□Polio	□Chicken Pox

Have you had any adverse reactions to any immunizations? _____

SLEEP

Bedtime: _____ Hours of sleep per night:_____ Quality of sleep: _____

Trouble falling asleep? Yes No Sometimes Problems staying asleep? Yes No Sometimes

Do you feel refreshed upon waking? _____

LIFESTYLE / ENVIRONMENTAL FACTORS

What are your hobbies? _____

What is your energy level? Rate on scale of 1 to 10 (1=very low; 10=excellent) _____

Emotional climate at home: □*very stable* □ *stable* □*stressful* □*very stressful*

Explain: _____

Do you exercise regularly? □Yes □No Please list what type of exercise you do, for how long and often:

_____

Do you have a religious or spiritual practice? If yes, what?_____

How old is your residence? _____ Type of heating: _____

Are you exposed to any chemicals at home or in the workplace? Explain:_____

_____

Environmental allergies (dust, molds, strong odours, pets, etc.) _____

SOCIAL HISTORY

Occupation: _____ □Full-time □Part-time □Currently not working

Do you enjoy your work?_____ Relationship with your co-workers:_____

How stressful is your work and other aspects of your life? How well do you handle stress? _____

_____

Do you have a good social support system?_____

Do you get along with your family? _____

Are you currently in an intimate relationship? □ Yes □ No If so, for how long?_____

FEMALE

Age of puberty onset? _____ Any problems/symptoms experienced?_____

Are you currently pregnant? ☐Yes ☐No Are you currently on birth control? ☐Yes ☐No

If so, what kind and for how long?_____

Age of first menstruation: _____ Did you have a normal puberty: _____

Is your cycle regular? ☐Yes ☐No Periods occur every _____ days and last _____days.

Date of last period:_____ Date of last PAP:_____ ☐Normal ☐ Abnormal

Is your sexual energy: ☐Non-existent ☐Low ☐Medium ☐High ☐Very High

Have you ever had any troubles with fertility?:_____

Number of pregnancies: _____ Number of children: _____

Have you ever had any pregnancy complications?_____

Have you ever had an abortion? If yes when? _____ Any sexually transmitted infections_____

If so, please list. _____

MEN

Age of puberty onset? _____ Any problems/symptoms experienced?_____

Do you ever have difficulties getting and maintaining erections? _____

Do you have difficulties with premature ejaculation while having intercourse? _____

Is your sexual energy: ☐Non-existent ☐Low ☐Medium ☐High ☐Very High

Are your erections ever painful?_____ Do you have any difficulty voiding (urinating) completely?_____

How often do you get up to go to the bathroom at night? _____

Do you have any other issues concerning sex? If yes, please describe. _____

Do you have any sexually transmitted infections? _____

Number of children fathered: _____Problems with fertility? _____

NUTRITION: ***Typical Day's Diet***

Breakfast _____

Lunch _____

Dinner _____

Snacks_____

Beverages_____

Dietary restrictions? (religious, vegetarian/vegan, etc.)? _____

Favorite foods/cravings? _____

Food Aversions? _____ Food allergies/sensitivities?_____

What is your relationship to food? _____

ADDITIONAL QUESTIONS

*Do you have any fears/worries?*_____

*Have you experienced major incidents of grief/loss in your life?*_____

If you could change something in your life what it be? _____

What is the most misunderstood aspect of you? _____

*What do you enjoy doing?*_____

What is the most important thing for you in your life right now? _____

CHRONOLOGICAL HEALTH HISTORY

This sort of health history helps to establish trends in a person's health that may be relevant to present conditions. Indicate below any accidents, broken bones, falls, illnesses, hospitalization, surgeries, and any emotional traumas such as deaths, loss of jobs, divorces, relationship breakups etc.

Year 1-5 _____
Year 6-10 _____
Year 10-15 _____
Year 16-20 _____
Year 21-25 _____
Year 26-30 _____
Year 31-35 _____
Year 36-40 _____
Year 41-45 _____
Year 46-50 _____
Year 51-55 _____
Year 55-60 _____
Year 61-65 _____
Year 66-70 _____
Year 71-75 _____
Year 76-80 _____
Year 81-90 _____

REVIEW OF SYSTEMS

Please check off any conditions you currently have (✔ in Y – for Yes) or have had in the past (✔ in P for Past)

SKIN	Y	P
Rashes		
Hives		
Acne		
Boils		
Eczema		
Psoriasis		
Dry skin		
Itching		
Lumps		
Night sweats		
Other		

EARS	Y	P
Impaired hearing		
Earache		
Dizziness		
Discharge		
Infections		
Excessive wax		
Other		

NECK	Y	P
Lumps		
Swollen glands		
Goiter		
Pain or stiffness		
Other		

EYE	Y	P
Impaired vision		
Use of contact lenses		
Eye pain		
Tearing		
Dryness		
Double vision		
Glaucoma		
Cataracts		
Blurring		
Light sensitive		
Itching		
Redness		
Discharge		
Blind spot		
Other		

CARDIOVASCULAR	Y	P
Angina		
Murmurs		
Chest pain		
Swelling in ankles		
Palpitation, fluttering		
Last ECG		
Other		

NOSE & SINUSES	Y	P
Frequent colds		
Nose bleeds		
Stuffiness		
Hay fever		
Infections		
Other		

MOUTH & THROAT	Y	P
Hoarseness		
Gum problems		
Difficulty swallowing		
Dental problems		
Sores		
Dryness		
Sore throat		
Loss of taste		
Other		

BREASTS	Y	P
Do you do breast self-exam?		
Lumps		
Pain (or tenderness)		
Nipple discharge		
Last mammogram		
Other		

GASTROINTESTINAL	Y	P
Trouble swallowing		
Heartburn		
Change in appetite		
Nausea		
Vomiting		
Vomiting blood		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		
Constipation		
Blood in stool		
Hemorrhoids		
Black, tarry stool		
Jaundice		
Liver disease		
Gallbladder disease		
Food allergy		
Hiatus hernia		
Last colonoscopy		
Other		

MUSCULOSKELETAL	Y	P
Broken bones		
Muscle spasms/cramps		
Weakness		
Joint swelling		
Backache		
Other		

MALE REPRODUCTIVE	Y	P
Hernia		
Testicular masses		
Testicular pain		
Impotence		
Premature ejaculation		
Venereal disease		
Discharge of sores		
Sexually active		
Check sexual preference:		
Heterosexual		
Homosexual		
Bisexual		
Last prostate exam		
Last PSA level		
Other		

RESPIRATORY	Y	P
Cough		
Sputum		
Spitting up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Difficulty breathing		
Pain on breathing		
Shortness of breath		
Shortness of breath at night		
Shortness of breath when lying		
Positive tuberculin test		
Last TB test		
Last chest X-ray		
Other		

PEREPHERAL VASCULAR	Y	P
Deep leg pain		
Cold hands/feet		
Varicose veins		
Thrombophlebitis		
Leg cramps		
Extremity numbness		
Extremity coldness		
Extremity swelling		
Extremity ulcers		
Other		

NEUROLOGIC	Y	P
Fainting		
Seizure/Convulsions		
Paralysis		
Muscle weakness		
Numbness or tingling		
Loss of memory		
Involuntary movements		
Loss of balance		
Speech problems		
Other		

ENDOCRINE	Y	P
Heat or cold intolerance		
Thyroid trouble		
Excessive thirst		
Excessive hunger		
Excessive urination		
Excessive sweating		
Diabetes		
Hypoglycemia		
Hormone therapy		

BLOOD/LYMPHATIC	Y	P
Anaemia		
Easy bleeding/bruising		
Past transfusions		
Lymph node swelling		
Other		

URINARY	Y	P
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced urine flow		
Other		

FEMALE REPRODUCTIVE	Y	P
Age of first menses		
Last menstrual period		
Number of days of menses		
Length of cycle		
Bleeding between periods		
Irregular cycles		
Pain during intercourse		
Painful menses		
Excessive flow		
PMS		
Number of pregnancies		
Number of life births		
Number of miscarriages		
Number of abortions		
Difficulty conceiving		
Sexual difficulties		
Vaginal discharge		
Vaginal itching		
Sexually active		

Check sexual preference:		
Heterosexual		
Homosexual		
Bisexual		

Menopause
Age of onset
Hormone therapy
Last gynaecological exam
Last pap smear
Other

Privacy Policy

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my naturopathic doctor may discuss my case with other healthcare providers. I understand that I may look at my medical record at any time and can request a copy of my file with a fee of $0.20 per page.

Consent Regarding Personal Information
Our privacy policy outlines what our clinic is doing to ensure that:
• Only necessary information is collected about you;
• We only share your information with your consent;
• Storage, retention and destruction of your personal information complies with the existing legislation, and privacy protection protocols;
• Our privacy protocols comply with privacy legislation and standards of our regulatory body, The College of Naturopaths of Ontario.

How our clinic collects, uses and discloses patients' personal information:
To help you understand how we protect your personal information, we have outlined here how our clinic is using and disclosing your information:
• To assess your health concerns and provide health care.
• To advise you of treatment options.
• To establish & maintain contact with you.
• To remind you of upcoming appointments.
• To communicate with other treating health-care providers.
• To allow us to efficiently follow-up for treatment, care and billing.
• To complete claims for insurance purposes.
• To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the Drugless Practitioners Act.
• To invoice for goods and services.
• To process credit card payments.
• To collect unpaid accounts.
• To assist this clinic to comply with all regulatory requirements.
• To comply generally with the law.
• To allow potential purchasers, practice brokers or advisors to conduct and audit in preparation for a practice sale.

☐ I would like to receive newsletters and other information mailings

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

Patient Name: (Please print name):_____

Signature of Patient or Guardian:_____

Date:_____ Naturopathic Doctor: _____

ND Signature: _____

572 Weber Street North, Unit 3F • Waterloo, Ontario N2L5C6 • 1-888-454-4667
572 Weber Street North • Unit 3A • Waterloo, Ontario • N2L 5C6
www.touchstonehealth.ca • info@touchstonehealth.ca

Informed Consent

Consent Regarding Treatment

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Your ND will take a thorough case history and perform a relevant physical examination.

It is very important that you inform your naturopathic doctor of any medical concerns or medication and supplements you may be taking. Please advise your ND if you are pregnant, suspect you are pregnant or if you are breastfeeding. As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.
As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine including acupuncture. By signing this sheet, you acknowledge your understanding of the associated risk and grant permission to proceed.

Possible side effects of naturopathic medical care include:

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

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. With this knowledge, I voluntarily consent to Naturopathic care. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to discontinue participation in these procedures at any time.

I declare that I have received a full and complete explanation of the treatment or services that I may receive at TouchStone Health 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 as well as other applicable fees.

Parents/Guardians
I agree that I am solely responsible for the safety of my child/children while on the premise of TouchStone Health. Children are to be supervised at all times and never left unattended by the parent.

Cancellation Policy
I agree that if I am unable to make my appointment, I must provide advance notification within 2 business days. Failure to provide notice will result in a charge equivalent to the cost of the appointment that was missed.

Patient Name: (Please print name):_____

Signature of Patient or Guardian:_____

Date:_____ Naturopathic Doctor: _____

ND Signature: _____

572 Weber Street North, Unit 3F • Waterloo, Ontario N2L5C6 • 1-888-454-4667
572 Weber Street North • Unit 3A • Waterloo, Ontario • N2L 5C6
www.touchstonehealth.ca • info@touchstonehealth.ca