Naturopathic Intake Adult

HOLISTIC WELLNESS OTTAWA

Today's Date: (DD/MM/YY) 12/12/36

First Name:_____ Last Name:_____

Date of Birth (DD/MM/YY): _____ Age:_____

Address: _____ City: _____Province: _____ Postal Code:_____

Home Phone: _____ Alternate phone:_____

Email:_____

Occupation:_____

Referred by: family/friend(Who?) _____ Online/internet _____

Health care provider (Who?) _____ Other _____

Family Doctor/Specialists

Name	Occupation	Phone
Name	Occupation	Phone
Name	Occupation	Phone
Name	Occupation	Phone

Current Health Concerns

What health concerns brought you here today, in order of importance.

1.
2.
3.

Personal Medical History

Please list any serious conditions, injuries, surgeries, hospitalizations and their approximate dates

Date	*Condition, injury, surgery, hospitalization*

Please list any known allergies below

Please list any **current medication** with dose below

Name	Dose	Reason

Please list any **current supplements** with dose below

Name	Dose	Reason

Lifestyle and Environmental Factors

How much alcohol do you consume per week?

How much tobacco do you consume per week?

How much caffeine do you consume per week?

How much water do you consumer per day?

How much exercise do you get per week?

What kind of exercise do you do?

How would you rate your stress on a scale of 1-10 (10=worst)

How would you rate your energy on a scale of 1-10 (10=best)

Are you regularly exposed to animals?

Are you regularly exposed to smoke?

Are you regularly exposed to chemicals?

Family Medical History: Please list close relatives who suffer from any of the following conditions

Allergies	High cholesterol
Anxiety	Kidney disease
Asthma	Migraines
Arthritis	Obesity
Autoimmune disorder	Psychiatric illness
Cancer	Stroke
Depression	Substance abuse
Diabetes	Thyroid disease
Epilepsy	Tuberculosis
Heart disease	Other (please list)
High blood pressure	

Please describe anything else you feel is important and of which your Naturopathic Doctor should be aware.

REVIEW OF SYSTEMS Please indicate Y (Yes) if you are currently experiencing the symptom or P (Past) if it is a past symptom.

SKIN	**Y**	**P**	**MOUTH/THROAT**	**Y**	**P**	**DIGESTIVE SYSTEM**	**Y**	**P**	**FEMALE REPROD.**	**Y**	**P**
Rashes			Gum problems			Difficulty swallowing			Low libido		
Dryness			Sores in mouth			Nausea			Irregular periods		
Hives			Periodontal disease			Vomiting			Painful periods		
Itching			Sore tongue/mouth			Diarrhea/loose stools			Spotting		
Change in lump/mole			Thrush			Constipation			Excessive flow		
Acne			Frequent sore throat			Blood in stool			Vaginal discharge		
Easy bruising			Enlarged lymph nodes			Mucous in stool			Vaginal itching		
Other			Loss of taste			Poor appetite			STD's		
HEAD/NECK	**Y**	**P**	Hoarseness			Excessive hunger			PMS		
Headaches			Other			Excessive belching			Painful intercourse		
Head injury			**RESPIRATORY**	**Y**	**P**	Bloating/gas			Fibroids		
Vertigo/Dizziness			Chronic cough			Indigestion			Breast lump		
Jaw pain			Coughing mucous			Acid reflux			Breast pain		
Neck pain			Coughing blood			Hemorrhoids			Fibrocystic breasts		
Other			Difficulty breathing			Eating disorder			Nipple discharge		
EYES	**Y**	**P**	Shortness of breath			Ulcer			Breast cancer		
Impaired vision			Pain on inhalation			Abdominal pain			Hot flashes		
Eye pain			Asthma			Hernias			Difficulty conceiving		
Redness			Bronchitis			Other			Age of first menses		
Excessive tearing			Pneumonia			**MUSCLES & JOINTS**	**Y**	**P**	# days of menses		
Dryness			Frequent colds			Muscle pain			# of pregnancies		
Blurred/Double vision			Other			Muscle cramps			# of live births		
Spots or floaters			**CARDIOVASCULAR**	**Y**	**P**	Joint pain			# of miscarriages		
Discharge			Heart disease			Joint stiffness			# of abortions		
Glaucoma			Angina			Low back pain			Last PAP test		
Cataracts			High blood pressure			Arthritis			Last menses		
Other			High cholesterol			**URINARY GENITAL**	**Y**	**P**	**MENTAL/EMOTIONAL**	**Y**	**P**
EARS	**Y**	**P**	Rapid heart rate			Painful urination			Difficult concentration		
Impaired hearing			Murmurs			Difficult urination			Irritability		
Infection			Chest pain			Frequent urination			Frustration/anger		
Ringing			Palpitations			Incontinence			Personality changes		
Pain			Heart attack			Frequent infections			Poor memory		
Discharge			Stroke			Blood in urine			Anxiety/panic		
Other			**NERVOUS SYSTEM**	**Y**	**P**	Kidney stones			Stress		
NOSE/SINUSES			Fainting			**MALE REPRODUCTIVE**	**Y**	**P**	Depression		
Nose bleeds			Paralysis			Low libido			**GENERAL**	**Y**	**P**
Nasal discharge			Tremors			Discharge			Fatigue		
Frequent sneezing			Poor balance			Hernia			Chills		
Loss of smell			Seizures			Enlarged prostate			Insomnia		
Sinus infections			Dizziness			Testicular mass			Excessive sleep		
Other			Weakness			PSA test			Night sweats		
			Numbness			STD's			Weight loss		
			Other			Other			Weight gain		

Naturopathic Consent Form

Adult Patient

Informed Consent

Welcome to Ottawa Holistic Wellness Clinic. This clinic utilizes the principles and practices of Naturopathic Medicine provided by our licensed Naturopathic Doctors. Naturopathic medicine is a distinct branch of primary health care that focuses on treating the root cause of disease by stimulating the healing power of the body. It blends modern and traditional medicine with natural forms of medicines while minimizing the use of surgery and drugs. Treating both acute and chronic conditions, naturopathic therapies are chosen based on the individual patient and their case history while taking into account physiological, psychological, environmental, and lifestyle factors.

Modalities used for treatment include botanical medicine, clinical nutrition and supplementation, homeopathy, hydrotherapy, physical medicine, traditional Chinese medicine and acupuncture and lifestyle counseling.

During your first visit, your naturopathic doctor will conduct a thorough case history. A physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. Because some therapies must be used with caution when dealing with particular conditions (for eg. pregnancy, heart disease), it is very important that you inform your naturopathic doctor immediately of any disease that you are suffering from or any medications, drugs or supplements you are taking.

Statement of Consent

As a patient of this practice I, _____ have read the information and understand that the medical care is based on naturopathic medical principles and practices. I acknowledge that my naturopathic doctor endeavours to provide the best possible diagnosis and course of treatment, but that no warranty is made with respect to any treatment, action, or medical advice, because many factors are important in determining actual results. I also recognize that even the gentlest of therapies might have complications (in certain physiological conditions or in very young children or those on multiple medications). The information that I provided is complete and includes all health concerns including possibility of pregnancy; and all medications, including over-the-counter drugs and supplements. The possible health risks of some naturopathic medical treatment include but are not limited to: aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture, muscle strains and sprains, disc injuries from spinal manipulations.

I also acknowledge that I have the right to accept or reject this medical care of my own free will and choice. I give permission and consent to _____ (insert name of doctor) to provide naturopathic medical consultation, assessment and/or treatment.

With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above. I intend this consent to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue my participation in these procedures at any time.

Patient Name _____ Date: _____

Patient Signature_____

Payment For Services

I understand that naturopathic medicine is not covered by the provincial government, yet naturopathic expenses may be covered by private insurance plans and may be tax deductible. The fees and services have been clarified in advance.

- Services are currently HST exempt. See Service Fees page for further details.
- Laboratory services are HST exempt; Products are charged 13% HST.

Payment is due in full at the end of each visit and a receipt will be given when payment is received. Fees may be paid by Visa, MasterCard, debit, cash or cheque. Any fees incurred by Ottawa Holistic Wellness in regard to dishonoured (NSF) cheques will be paid by the individual who wrote the cheque. Please note that refunds are not available on medical services rendered, including lab tests performed. Extended health insurance plans often offer coverage for naturopathic medicine. Plans and policies differ, so please check with your insurance provider regarding your specific coverage and claim procedures.

Cancelled or Missed Appointments

I understand that 48hrs notice is required when cancelling or changing an appointment. Otherwise, I understand that I may be charged for the missed appointment. Visits that begin late due to a patient's late arrival will be charged the full visit fee. Consideration will be given for unforeseeable circumstances, at the discretion of the naturopathic doctor.

Privacy Policy

Privacy of your personal information is an important part of the naturopathic care provided. We are committed to collecting, using and disclosing your personal information responsibly. All staff member who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in appropriate use and protection of your information. Our privacy protocols comply with privacy legislation (PHIPA) and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

Confidentiality

Everything that is communicated directly or indirectly to the naturopathic doctor is confidential unless you give written permission to disclose information to a third party. Confidentiality is respected at all times. It is important to note that there are exceptions to confidentiality that include legal and/or ethical obligations to: 1) report incidents of child abuse (physical, sexual, emotional) and neglect; 2) comply with a court ordered subpoena; 3) present harm to yourself or another person should such plans be disclosed; 4) report a health professional who has sexually abused a patient.

Consent to Email

Communication by email between visits can have certain risks. We use reasonable means to protect the security and confidentiality of email information sent and received. However, we cannot guarantee the security and confidentiality of email communication and will not be liable for improper disclosure of confidential information that is not caused by our intentional misconduct. Any emails and/or questions regarding a current treatment plan will be recorded and transferred to the patient medical record.

In Case of Emergency

Emergency services are not available at Ottawa Holistic Wellness. In case of emergency, please contact your nearest health care facility or hospital emergency room.

Statement of Acknowledgement: I have read, understood and agree to the contents herein.

Patient Name _____ Date: _____

Patient Signature_____