

Adult Intake Form



Wild Heart Medicine Therapies and Pharmacy

Family Focused Naturopathic Care
Dr. Karley Denoon, ND

571b (upstairs) 2nd Ave. Fernie, BC

Phone: (250) 531-0154

Fax: 1-800-858-8623

drdenoon.ca

Thank you for taking the time to complete the following new patient forms to the best of your ability. They are an important step towards defining your health care needs and achieving your health goals.

Please email this form in advance for review, drop in off in advance, or bring this form to your first appointment. Please also include any relevant blood work or health reports.

All the answers on this form will be held absolutely confidential.

Name: _____ Birthdate: _____

Address with P.O. Box #: _____

City: _____ Prov: _____ Postal Code: _____

Phone (Home): _____ Phone (Cell): _____ Phone (Work): _____

Email: _____ Occupation: _____

Family Doctor: _____ Phone #: _____

Referring Professional: _____ Phone #: _____

Care Card #: _____

Emergency Contact (Name, Relationship): _____

Phone #: _____

Spouse's Name: _____

Children's Names & Ages: _____

Preferred Method of Communication: _____

Why did you choose to come to this clinic?: _____

Have you seen a Naturopathic Doctor before? (Y/N) _____ Dr: _____

PRESENT HEALTH CONCERNS:

	Please list most important health concerns in their order of significance.	Please list any prior diagnosis including when and by whom.
1		
2		
3		
4		
5		

ALLERGIES:

(Please list your allergy, your reaction and severity on a scale of 1-10)

Medications:

Food:

Environmental:

PAST MEDICAL HISTORY:

Have you ever been hospitalized? Y/N Why and which dates?

Have you ever had any major accidents, traumas or surgeries? Y/N Explain and which dates?

Your birth history (prolonged labour, forceps, breastfed, etc.):

OCCUPATIONAL STRESS:

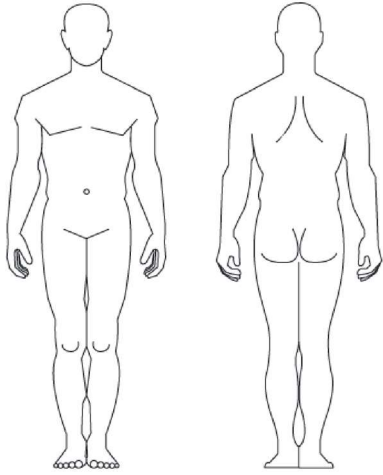
Chemical:

Physical:

Psychological/emotional:

PHYSICAL CONDITION:

(Please indicate on the diagram the nature of your symptoms using the provided symbols.)

	Aching	O
	Stabbing	X
	Shooting	=
	Burning	~
	Numbness or Tingling	^

If you have indicated pain above, please use the next 2 lines to explain the onset, duration and frequency with which you experience this pain:

Please describe your current physical condition (Truth please):

Exercise: Daily 5x Week 3x Week Weekly Monthly or Never

Type (length, aerobic, strength, intensity):

FAMILY HEALTH HISTORY:			
RELATION	MEDICAL CONDITION	AGE AT DEATH	CAUSE OF DEATH
Father			
Mother			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			
Paternal GF			
Paternal GM			
Maternal GF			
Maternal GM			

Please mark conditions you previously or currently experience with P or C

P = past
C = current

GENERAL SYMPTOMS	
<input type="checkbox"/>	Loss of consciousness
<input type="checkbox"/>	Numbness/tingling
<input type="checkbox"/>	Fever
<input type="checkbox"/>	Sweats
<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Loss of sleep/insomnia
<input type="checkbox"/>	Frequent colds/flu
<input type="checkbox"/>	Loss of weight

HEAD AND NECK	
<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Type
<input type="checkbox"/>	Vision problems
<input type="checkbox"/>	TMJ concerns
<input type="checkbox"/>	Ear aches
<input type="checkbox"/>	Decreased hearing
<input type="checkbox"/>	Sinus problems

SKIN	
<input type="checkbox"/>	Rashes/eczema
<input type="checkbox"/>	Itching
<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	Dryness
<input type="checkbox"/>	Boils/hives
<input type="checkbox"/>	Contagious skin disease

RESPIRATORY	
<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Smoking
<input type="checkbox"/>	Breathing problems
<input type="checkbox"/>	Asthma/bronchitis

CARDIO VASCULAR	
<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	Bleeding disorders
<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Artery hardening
<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	Swelling of the ankles
<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	Angina
<input type="checkbox"/>	Heart disease

GENITOURINARY	
<input type="checkbox"/>	Trouble urinating
<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	Kidney infection
<input type="checkbox"/>	Bed wetting
<input type="checkbox"/>	Prostate trouble

GASTROINTESTINAL	
<input type="checkbox"/>	Poor digestion
<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	Excessive hunger
<input type="checkbox"/>	Belching or gas
<input type="checkbox"/>	Nausea/vomiting
<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Liver concerns
<input type="checkbox"/>	Gall bladder trouble
<input type="checkbox"/>	Bladder concerns
<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	Diabetes

INFECTIONS/ILLNESSES	
<input type="checkbox"/>	Herpes
<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Plantar warts
<input type="checkbox"/>	TB
<input type="checkbox"/>	HIV/AIDs
<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Allergies

MUSCLES & JOINTS		
<input type="checkbox"/>	Stiff neck	
<input type="checkbox"/>	Backache	
<input type="checkbox"/>	Swollen joints	
<input type="checkbox"/>	Painful tailbone	
<input type="checkbox"/>	Foot trouble	L - R
<input type="checkbox"/>	Shoulder pain	L - R
<input type="checkbox"/>	Elbow pain	L - R
<input type="checkbox"/>	Wrist pain	L - R
<input type="checkbox"/>	Hip pain	L - R
<input type="checkbox"/>	Knee pain	L - R
<input type="checkbox"/>	Arthritis	
<input type="checkbox"/>	Weakness/lost strength	

WOMEN'S HEALTH	
<input type="checkbox"/>	Painful menstruation
<input type="checkbox"/>	Excessive flow
<input type="checkbox"/>	Irregular cycle
<input type="checkbox"/>	Hot flushes
<input type="checkbox"/>	Cramps or backache
<input type="checkbox"/>	Vaginal discharge
<input type="checkbox"/>	Swollen breasts
<input type="checkbox"/>	Lumps in breast
<input type="checkbox"/>	Are you pregnant
<input type="checkbox"/>	Birth control
<input type="checkbox"/>	Number of pregnancies
<input type="checkbox"/>	Number of children

SEXUAL HEALTH HISTORY:

Have you ever had or are you currently experiencing:

<u>Had</u>	<u>Current</u>		<u>Had</u>	<u>Current</u>		<u>Had</u>	<u>Current</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Yeast Infections	<input type="checkbox"/>	<input type="checkbox"/>	Bacterial Vaginosis
<input type="checkbox"/>	<input type="checkbox"/>	Hep B	<input type="checkbox"/>	<input type="checkbox"/>	Hep C	<input type="checkbox"/>	<input type="checkbox"/>	Scabies
<input type="checkbox"/>	<input type="checkbox"/>	Pubic Lice	<input type="checkbox"/>	<input type="checkbox"/>	Human Papillomavirus (HPV-warts)			
<input type="checkbox"/>	<input type="checkbox"/>	Trichomoniasis	<input type="checkbox"/>	<input type="checkbox"/>	Lymphogranuloma Venereum (LGV)			

What kind of birth control do you use, if any?: _____

EXAM HISTORY:

(Please indicate when you most recently (if ever) had the following tests performed.)

<u>Tuberculin (TB) test:</u>	<u>Hearing Test:</u>
<u>Chest X-ray:</u>	<u>PAP or Gyne Exam:</u>
<u>CT, MRI, Ultrasound:</u>	<u>Prostate Exam:</u>
<u>ECG (heart):</u>	<u>Blood or Urine Tests:</u>
<u>Eye Exam:</u>	<u>Full Physical Exam:</u>

**Please report all medications on the medication history page, including vitamins/supplements.*

LIFESTYLE:

(Please describe a typical day's diet:)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____ Beverages: _____

How **MUCH** and **HOW OFTEN** do you consume:

Alcohol: _____ Caffeine: _____

Water: _____ Tobacco: _____

Recreational Drugs (which ones): _____

Please list your travel history in the past 3 years: _____

EMOTIONAL HEALTH:

(Please rate the following on a scale of 1 (low) to 10 (high))

Overall Stress: _____ **Overall Energy:** _____ **How happy are you generally:** _____
Stress in the Home: _____ **Satisfaction in Relationship:** _____

Time to Bed: _____ **Average Time of Waking:** _____
of Hours of Uninterrupted Sleep: _____ **Use of Sleep Aids (which ones?):** _____
Waking Feeling Rested (Y/N): _____ **Digital Electronics in Bedroom (Y/N)** _____
Pets in the Bedroom (Y/N): _____ **Co-Sleeping with Children:** _____

Have you ever felt sad or depressed for 2 weeks or more at a time in the past year: Y or N
Do you have concerns regarding your emotional or mental health (ie: anxiety, memory loss, voices, hallucinations, depression, binge eating etc)? :

SETTING THE STAGE:

What is your main expectation from this visit: _____
What long term expectations do you have: _____
What expectations do you have of me professionally: _____
What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle: [1 (low) – 10 (high)]: _____
Are self destructive or negative lifestyle habits: _____

What potential obstacles do you foresee in addressing lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which I will be sharing with you: _____
Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making: _____
What do you LOVE to do: _____

Best Possible Medication History

(Include all current and relevant past prescription medications, OTCs, and complementary medicines)

MEDICATIONS

Name: _____

Start Date	Name of Medication	Strength	How to take this medication				Purpose	Comment	Prescribed By
			Quantity?	Route?	Frequency?	Food?			
dd/mm/yyyy	Brand and Generic name (if available)		Quantity?	Route?	Frequency?	Food?			

Pharmacy:

Informed Consent For Treatment

Welcome to Naturopathic Medicine! As a doctor of Naturopathic medicine it is my honor to take your care and health seriously. The following document is an agreement between you and I that states that you are entitled to understand any detail you wish about your health condition, treatment and diagnosis. It states that you are aware of the costs of naturopathic medicine (including late cancellation policies), the benefits and potential risks and side effects. Your health is ultimately up to you, therefore you also have the right to refuse any suggested treatment. We are in this together, so be sure to ask any questions you have, no matter what they are, at anytime and I will do my best to fulfill the meaning of doctor (docere) "To Teach".

STATEMENT OF ACKNOWLEDGEMENT

I, _____ as a patient of _____ understand that I am being treated under the practice philosophy and scope of naturopathic principles and practices. I will disclose all health concerns, conditions, medications and medical interventions, including supplements and over the counter drugs to my naturopathic doctor because I understand that safe care requires that I truthfully and completely disclose this information. I also will inform my naturopathic doctor if I am pregnant or breastfeeding so that she can take proper precautions for treatment.

I am aware and understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side effects. I am entitled to know the consequences of not accepting treatment and of alternative treatments that may be applicable. I am encouraged to take an active role in my care and ask any questions needed. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that she has answered all of my questions to the best of her ability.

I understand that though naturopathic treatments re generally safe and gentle, there may be health risks associated with some treatments. This may include, but not limited to: aggravation of pre existing symptoms, allergic reactions to supplements, herbs or pharmaceuticals and bruising or injury from acupuncture or intravenous therapies.

I understand that my naturopathic doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at anytime. I accept full responsibility for any fees incurred during care and treatment, including a 50% late cancellation fee if providing less than 24 hours notice for cancellation of any appointments. I am aware that I am always at liberty to seek or continue care form another healthcare provider.

Signature (of patient, or legal guardian):

Date: _____

Witness: _____

Printed: _____