



*Wild Heart*  
**Therapies and Farmacy**  
 Family Focused Naturopathic Care  
 561 M Highway 3 Fernie, BC  
 Phone: (250) 531-0154  
 Fax: 1-800-858-8623  
 info@wildheartTandF.ca  
 wildheartTandF.ca

## Adult Intake Form

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.*

**Full Name (Last, First, Middle Initial):** \_\_\_\_\_ **Birthdate (dd/mm/yyyy):** \_\_\_\_\_

**Address with P.O. Box #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Prov:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Phone (Home):** \_\_\_\_\_ **Phone (Cell):** \_\_\_\_\_ **Phone (Work):** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Sex (circle one):** Male/ Female/ Other/ Prefer Not to Say **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**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:**

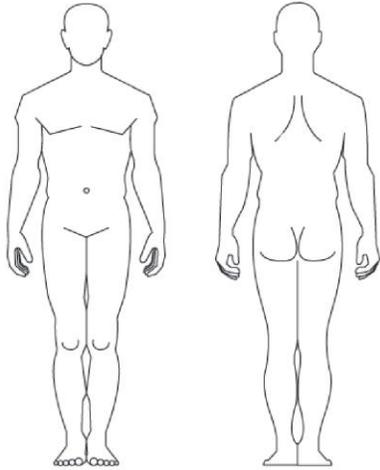
**Chemical:**

**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):

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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

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

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

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

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

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	

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

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

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

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.)

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

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

**LIFESTYLE:**

(Please describe a typical day's diet:)

<b>Breakfast:</b>	
<b>Lunch:</b>	
<b>Dinner:</b>	
<b>Snacks:</b>	<b>Beverages:</b>

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

<b>Alcohol:</b>	<b>Caffeine:</b>
<b>Water:</b>	<b>Tobacco:</b>
<b>Recreational Drugs (which ones):</b>	
<b>Please list your travel history in the past 3 years:</b>	

**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)? :**

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**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:** \_\_\_\_\_



## **Informed Consent For Treatment**

Welcome to Naturopathic Medicine! As a doctor of Naturopathic medicine it is my honour 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 fulfil 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 as regulated by the Canadian college of Naturopathic Physicians and the Health Professions act of Canada. 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, 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 consent to email as a form of communication and have provided the best email to do so with on my intake form. I acknowledge that some of the professionals that Naturopathic Doctors refer to are a part of unregulated professions in Canada, and that my ND will always disclose the nature of their referrals, the reason for their referral along with the benefits of seeing this practitioner. I consent to appropriate interoffice verbal communication amongst practitioners when my ND feels it is appropriate and relative to the outcome of my care if I am being cared for by more than one practitioner in the clinic. My primary ND will be the only practitioner that has access to my chart unless I request otherwise. I am aware that I am always at liberty to seek and/or continue care form another healthcare provider.

Signature (of patient, or legal guardian): \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Printed: \_\_\_\_\_