Dr. Barbara Dao, N.D.
Dr. Devangi Patel, N.D.

24 George St. N Cambridge, ON N1S 2M8
Tel: (519) 623-7800

NATUROPATHIC ADULT INTAKE FORM

Name_____ Date _____

Date of Birth_____(M/D/Y) Gender: ☐M ☐F

Address_____

_____ Postal Code_____

Email _____Would you like to join our e-newsletter? Yes☐ No☐

Telephone: Home _____Work _____Cell_____

Preferred method to reach you (and best times) _____

Occupation _____ Number of children _____

Marital status: ☐ single ☐ partner ☐ married ☐ separated ☐ divorced ☐ widowed

Emergency Contact Name_____ Relation_____

Emergency Contact Number_____

How did you hear about us? _____

Current Health Care Providers:

Name_____	Name_____
Phone_____	Phone_____
Specialty_____	Specialty_____

Reasons for seeking Naturopathic Care:

Ailment	Date Started	Brief description

Current Medications

Medication	Dose	Date Started	For Which Condition	Any Side Effects

Current Supplements (Vitamins, Minerals and Herbs)

Supplement	Dose	Date Started	For Which Condition	Any Side Effects

PERSONAL MEDICAL HISTORY

Are you vaccinated? ❑ Yes ❑ No Do you get the Flu shot? ❑ Yes ❑ No

Have you taken antibiotics in the past 5 years? ❑ Yes ❑ No If yes, how many times? _____

Please list all known allergies (medication, foods, environmental)

_____

_____

Please list any hospitalizations, surgeries or serious injuries or illness

Description	**Date**	**Description**	**Date**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Illness Please check which of the following conditions you had in the past

- ❑ Allergies
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Cold Sores
- ❑ Eating Disorder
- ❑ Herpes
- ❑ Malaria
- ❑ Mumps
- ❑ Mononucleosis
- ❑ Parasites
- ❑ Rheumatic Fever
- ❑ Rubella
- ❑ Scarlet Fever
- ❑ Sexual Abuse
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Whooping Cough
- ❑ Worms

CURRENT HEALTH PROFILE

Height _____ Weight _____

Have you recently ❑ gained or ❑ lost any weight? If so, how much ? _____

What is your blood type? (Please circle) ❑O ❑A ❑B ❑AB ❑Not sure

Dietary Restrictions: ❑ Vegetarian ❑ Vegan ❑ Dairy/lactose intolerant ❑ Other: _____

How much water do you consume per day _____

Please indicate if you use any of the following:

Y	N		If yes, please state frequency, type and amount
❑	❑	Alcohol	
❑	❑	Tobacco	
❑	❑	Recreational Drugs	
❑	❑	Sedatives	
❑	❑	Laxatives	
❑	❑	Antacids	
❑	❑	Pain Relief Medication	
❑	❑	Coffee/Tea/Soft Drinks	
❑	❑	Artificial sweeteners	

Are you exposed to significant tobacco smoke? ❑YES ❑NO

Are you regularly exposed to toxins or other hazards? (through work, home, hobbies, etc)

_____

Do you exercise regularly? ❑YES ❑NO

What do you do for exercise, how much, how often?

_____

_____

How is your energy level? (circle one) ❑Low ❑Fair ❑Good ❑High

Circle the level of stress you are experiencing on a scale of 1 to 10 (10 being the highest):

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Circle the major cause(s) of your stress: ❑Money ❑Relationship ❑Family ❑Work ❑Health

FAMILY HEALTH HISTORY (Grandparent, parent, sibling, child)

❑ Allergy
❑ Asthma
❑ Alcoholism
❑ Cancer
❑ Celiac Disease
❑ Depression
❑ Diabetes
❑ Drug addiction
❑ Genetic disorder
❑ High cholesterol
❑ High blood pressure
❑ Heart disease
❑ Mental illness
❑ Neurologic disorder
❑ Osteoporosis
❑ Stroke
❑ Suicide
❑ I don't know my family health history
❑ Other _____

REVIEW OF SYSTEMS

Please circle either **Y=Yes** (I have this symptom) or **P=in past** (I've had this symptom in the past) or **N=No**.

GENERAL

Change in appetite Y P N
Change in thirst Y P N
Fever/chills Y P N
Fatigue/weakness Y P N
Excessive sweating Y P N
Slow wound healing Y P N

SKIN/HAIR/NAILS

Rash Y P N
Itch Y P N
Dry skin Y P N
Acne Y P N
Cold sores Y P N
Eczema Y P N
Psoriasis Y P N
Warts Y P N
Athlete's foot Y P N
Hair loss Y P N
Dandruff Y P N
Brittle nails Y P N
Nail ridges/spots Y P N
Other : _____

HEAD

Headache Y P N
Migraine Y P N
Dizziness Y P N
Fainting Y P N
Injury Y P N
Other : _____

EARS

Pain Y P N
Infection Y P N
Itching Y P N
Hearing loss Y P N
Ringing in ears Y P N
Other: _____

EYES

Near sightedness Y P N
Far sightedness Y P N
Pain Y P N
Double vision Y P N
Blurry vision Y P N
Glaucoma Y P N
Sties Y P N
Cataract Y P N
Itching Y P N
Seeing spots Y P N
Sensitivity to bright lights Y P N
Droopy eyelid Y P N
Dry eyes Y P N
Discharge Y P N
Redness Y P N
Date of last eye exam : _____
Other : _____

NOSE/SINUSES

Nose bleeds Y P N
Runny nose Y P N
Sinus pain Y P N
Sinus infection Y P N
No. of colds/year _____
Other : _____

MOUTH

Canker sores Y P N
Loss of taste Y P N
Dry mouth Y P N
Bleeding gums Y P N
Bad taste in mouth Y P N
No. of dental fillings _____
Type: ❑ Silver ❑ White
Date of last dental exam: _____

THROAT

Sore throats Y P N
Hoarseness Y P N
Swollen glands Y P N
Other : _____

RESPIRATORY

Cough Y P N
Wheezing Y P N
Shortness of breath Y P N
Snoring in sleep Y P N
Asthma Y P N
Bronchitis Y P N
Pneumonia Y P N
Other: _____

CARDIOVASCULAR

Chest Pain Y P N
Palpitations Y P N
Heart murmur Y P N
High blood pressure Y P N
High cholesterol Y P N
Swollen ankles Y P N
Varicose veins Y P N
Other: _____

GASTROINTESTINAL

Abdominal pain Y P N
Difficulty swallowing Y P N
Heartburn Y P N
Indigestion Y P N
Bloating Y P N
Nausea Y P N
Vomiting Y P N
Belching/flatulence Y P N
Constipation Y P N
Diarrhea Y P N
IBS Y P N
Hemorrhoids Y P N
Liver disease Y P N
Gall Bladder disease Y P N
No. of bowel movements per day: _____

MALE

Penile discharge ☐Y ☐P ☐N
Lesions/sores ☐Y ☐P ☐N
Testicular pain ☐Y ☐P ☐N
Testicular mass ☐Y ☐P ☐N
Impotence ☐Y ☐P ☐N
Decreased libido ☐Y ☐P ☐N
STI ☐Y ☐P ☐N
Other : _____

FEMALE

Age at first period: _____
Date of last period:
_____
Length of cycle: _____
Loss of cycle ☐Y ☐P ☐N
Irregular cycles ☐Y ☐P ☐N
Excessive flow ☐Y ☐P ☐N
Painful periods ☐Y ☐P ☐N
PMS ☐Y ☐P ☐N
Are you currently pregnant?
☐Y ☐N ☐
Sexually active ☐Y ☐P ☐N
Contraception used:
_____
Painful intercourse ☐Y ☐P ☐N
Decreased libido ☐Y ☐P ☐N
Difficulty conceiving ☐Y ☐P ☐N
Miscarriage ☐Y ☐N
No. of pregnancies: _____
Vaginal discharge ☐Y ☐P ☐N
Vaginal itch ☐Y ☐P ☐N
STI ☐Y ☐P ☐N
Date of last PAP: _____
Other : _____

BREAST

Tenderness ☐Y ☐P ☐N
Lump ☐Y ☐P ☐N
Nipple discharge ☐Y ☐P ☐N
Other: _____

URINARY

Frequent urination ☐Y ☐P ☐N
Frequent urination at night
☐Y ☐P ☐N
Incomplete urination ☐Y ☐P ☐N
Urgency ☐Y ☐P ☐N
Burning ☐Y ☐P ☐N
Blood in urine ☐Y ☐P ☐N
Passage of stone ☐Y ☐P ☐N
Urinary tract infection
☐Y ☐P ☐N
Other: _____

ENDOCRINE

Thyroid problems ☐Y ☐P ☐N
Cold intolerance ☐Y ☐P ☐N
Hot intolerance ☐Y ☐P ☐N
Increased thirst ☐Y ☐P ☐N
Increased hunger ☐Y ☐P ☐N
Hypoglycemia ☐Y ☐P ☐N
Diabetes mellitus ☐Y ☐P ☐N
Other: _____

MUSCULOSKELETAL

Neck pain ☐Y ☐P ☐N
Back pain ☐Y ☐P ☐N
Carpal tunnel syndrome
☐Y ☐P ☐N
Tendonitis ☐Y ☐P ☐N
Muscle pain ☐Y ☐P ☐N
Joint pain ☐Y ☐P ☐N
Arthritis ☐Y ☐P ☐N
Gout ☐Y ☐P ☐N
Other: _____

NEUROLOGIC

Seizures ☐Y ☐P ☐N
Involuntary movement
☐Y ☐P ☐N
Muscle weakness ☐Y ☐P ☐N
Paralysis ☐Y ☐P ☐N
Numbness ☐Y ☐P ☐N
Clumsiness ☐Y ☐P ☐N
Memory loss ☐Y ☐P ☐N
Learning difficulty ☐Y ☐P ☐N
Other: _____

BLOOD/LYMPH

Anemia ☐Y ☐P ☐N
Easy bruising ☐Y ☐P ☐N
Low Iron ☐Y ☐P ☐N
Low B12 ☐Y ☐P ☐N
Blood clots ☐Y ☐P ☐N
Blood transfusion ☐Y ☐P ☐N
Swollen glands ☐Y ☐P ☐N
Other: _____

MENTAL/EMOTIONAL

Problems sleeping ☐Y ☐P ☐N
Anxiety ☐Y ☐P ☐N
Phobias ☐Y ☐P ☐N
Panic episodes ☐Y ☐P ☐N
Depression ☐Y ☐P ☐N
Mood swings ☐Y ☐P ☐N
Addiction ☐Y ☐P ☐N
If so, what type?
_____
Other: _____

MY HEALTH GOALS:
(check all that apply)

☐ Have more energy
☐ Get better sleep
☐ Be free of pain
☐ Improve sex drive
☐ Have less colds and flu
☐ Get rid of allergies
☐ Reduce use of medication

☐ Lose weight
☐ Have more muscle tone
☐ Burn more body fat

☐ Reduce stress
☐ Be less depressed
☐ Be less moody
☐ Improve memory
☐ Think more clearly
☐ Feel more motivated

☐ Reduce my risk of disease
☐ Slow down accelerated aging
☐ Maintain a healthier life longer

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POLICIES AND PROCEDURES

Fee Schedule:

Type of Visit	Duration	Cost
First visit	90 minutes	$170.00
Follow up visits	15 minutes 30 minutes 45 minutes 60 minutes	$ 40.00 $ 70.00 $ 95.00 $135.00
Missed appointment fee		$ 40.00

We offer direct billing for most insurance providers, please ask for more details.

Otherwise payment is due at time of service, payable by Debit, Mastercard, Visa or cash.

Lab Services

Lab tests are available as part of your health assessment. Cost is dependent on the test and may be covered by your insurance provider. These include:

- Food sensitivity test
- Microbiology test (including Candida)
- Comprehensive stool analysis
- Saliva hormone test
- Adrenal function test
- Heavy metal test (hair and urine tests)
- Organic Acid test
- Blood tests

Please note we cannot bill directly to insurance companies for laboratory expenses.

Professional Supplements

You may be prescribed supplements at some of your visits. For your convenience we carry a variety of professional grade supplements. You may purchase them in office, or you may purchase your supplements from a health food store of your choice.

Cancellations

If you need to cancel your appointment, please call us as soon as possible.
Failure to give 24 hours notice will result in a missed appointment charge.

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INFORMED CONSENT

The principles and practices of Naturopathic Medicine and other supportive therapies will be practiced to assist the body's own ability to heal and to improve the quality of life and health through natural means. Your ND will conduct a thorough case history and a physical exam. She may also request additional blood and/or urinary laboratory or functional tests as part of your naturopathic work-up.

It is important to recognize that even the gentlest therapies come with some health risk. These risks include:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from acupuncture or intramuscular injection

Although generally safe, some treatments have the potential for complications in certain physiological conditions. Thus, it is important to provide a complete health history and advise the ND of:

- all current medications (including over the counter drugs and supplements) and any changes in these medications
- pregnancy or breastfeeding status

PRIVACY POLICY

Protecting your personal information is of vital importance to us. Our privacy policy is as follows:

- only necessary information is collected about you
- only with your consent do we share information with others outside the clinic
- storage, retention and destruction of your information complies with existing law
- our policy conforms to privacy legislation and standards of the College of Naturopaths of Ontario

We collect personal information in order to:

- assess your health and provide treatment
- establish and maintain contact with you for appointments, billing and follow-up care
- facilitate your insurance claims
- comply with regulatory requirements and laws under the College of Naturopaths of Ontario

I have read the Naturopathic Pricing Policy posted, and I understand that I am fully responsible for any fees relating to any services rendered or products sold to me.

I have read the cancellation policy and understand that 24 hours notice is required to avoid charges.
I have also read and understood the consent form and privacy policy.

Date: _____

Patient Name: _____

Patient (or Guardian) Signature: _____

Naturopathic Doctor's Signature: _____