NATUROPATHIC PATIENT INTAKE FORM

This information is strictly confidential and is only used in accordance with our privacy policy.

CONTACT INFORMATION

Full Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ Province: _____ Postal Code: _____

Home #: _____ Work #: _____ Other #: _____

Personal Email: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Common-Law

Number of Children: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Relation To You: _____

Emergency Contact #: _____

How did you hear about our clinic? _____

HEALTH CARE PROVIDER INFORMATION

Other health care providers (family physician, specialists, complementary and alternative therapy):

1. _____ 2. _____ 3. _____

Tel: _____ Tel: _____ Tel: _____

HEALTH CONCERNS

What are your main health concerns that you would like addressed?

1. _____
2. _____
3. _____
4. _____
5. _____

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MEDICAL HISTORY

How would you describe your general state of health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates. If "yes" indicate current with "C", past with "P"

	Yes	No		Yes	No		Yes	No
Anemia			Diabetes			Kidney Disease		
Arthritis			Epilepsy			Liver Disease		
Asthma			Gallbladder Disorder			Multiple Sclerosis		
Cancer			Heart Disease			Rheumatic fever		
Crohn's or Ulcerative colitis			Hepatitis			STD (please specify)		
Depression			HIV/AIDS			Thyroid disorder		

Other: _____

_____

Please list all current medications, including dosages, duration of use and why you are taking them.

Medication	**Dose**	**Duration**	**Condition Treating**

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Please list all natural health products you are taking and feel free to write on the reverse side of page (vitamins, supplements, herbs, homeopathics)

Natural Health Product	Dose	Duration	Condition Treating

Please list **past** prescription medications: _____

_____

_____

How frequently are you treated with antibiotics? _____

Do you regularly use any of the following?

☐ Aspirin ☐ Laxatives ☐ Antacids ☐ Diet pills

☐ Birth control pills ☐ Implants ☐ Injections

Please list any surgeries, dates of surgery and any complications (please include all cosmetic and elective surgeries as well as dental surgery).

_____

_____

_____

_____

Do you have any allergies (medicines, environmental, etc.)?

_____

_____

_____

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Alcohol—how much/ day or week: _____

Tobacco—form and amount/day: _____

Caffeine—form and amount/day : _____

Recreational drugs—what and how often: _____

Please indicate which immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Tetanus booster; when? _____
- ☐ MMR (measles, mumps, rubella)
- ☐ Haemophilus influenza B
- ☐ "Flu"
- ☐ Polio
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Smallpox
- ☐ Other _____

Please indicate if any caused adverse reactions: _____

_____

_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc? ☐ Yes ☐ No

When were your most recent tests performed? _____

CURRENT CONDITIONS - Please check conditions that affect you presently.

Skin and Hair

- ☐ Rashes
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Itching
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Changing moles
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Any other hair or skin problems? _____

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses/contact
- ☐ Eye strain
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night Blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Spots in front of eyes
- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ Recurrent sore throats

☐ Grinding teeth ☐ Facial pain ☐ Sores on lips or tongue
☐ Teeth problems ☐ Jaw clicks ☐ Macular degeneration
☐ Headaches (where and when)? _____
☐ Any other head or neck problems? _____

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain
☐ Irregular heartbeat ☐ Dizziness ☐ Fainting
☐ Cold hands or feet ☐ Swelling of hands ☐ Swelling of feet
☐ Blood clot ☐ Phlebitis ☐ Difficulty in breathing
☐ Any other heart or blood vessel problems? _____

Respiratory

☐ Cough ☐ Coughing blood ☐ Bronchitis ☐ Pneumonia
☐ Pain with deep breath ☐ Asthma ☐ Difficulty in breathing when lying down
☐ Production of phlegm (what colour)? _____
☐ Any other lung problems? _____

Gastrointestinal

☐ Nausea ☐ Indigestion ☐ Black stools ☐ Vomiting
☐ Belching ☐ Blood in stools ☐ Constipation ☐ Gas
☐ Rectal pain ☐ Diarrhea ☐ Hemorrhoids ☐ Abdominal pain
☐ Itchy rectum ☐ Bad breath ☐ Chronic laxative use
☐ Any other problems with your stomach or intestines? _____

Genito-Urinary

☐ Pain on urination ☐ Freq. urination ☐ Blood in urine ☐ Urgency to urinate
☐ Kidney stones ☐ Decrease inflow ☐ Impotency ☐ Unable to hold urine
☐ Recurrent UTIs ☐ Sores on genitals ☐ Yeast infections
☐ Do you wake to urinate (how often)? _____
☐ Any particular colour to your urine? _____
☐ Any other problems with your genital or urinary system? _____

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Musculoskeletal

☐ Neck pain ☐ Muscle pain ☐ Knee pain ☐ Back pain
☐ Muscle weakness ☐ Foot/ ankle pain ☐ Hand/ wrist pain
☐ Shoulder pain ☐ Any other joint or bone problems? _____

Neuropsychological

☐ Seizures ☐ Dizziness ☐ Loss of balance ☐ Numbness
☐ Lack of coordination ☐ Poor memory ☐ Concussion ☐ Depression
☐ Easily susceptible to stress ☐ Quick temper ☐ Irritable ☐ Anxiety
☐ Have you ever been treated for emotional problems? ☐ Yes ☐ No
☐ Have you ever considered or attempted suicide? ☐ Yes ☐ No
☐ Any other neurological or psychological problems? _____

Pregnancy and Gynecology – Women only

Age at first menses: _____ Length of cycle: _____ Duration of menses: _____
☐ Unusual menses ☐ Painful periods ☐ Clots ☐ Heavy ☐ Light
☐ Irregular periods ☐ Last PAP: _____ ☐ Vaginal discharge
☐ Vaginal sores ☐ Breast lumps
☐ Changes in body / psyche prior to menses: _____
Do you practice birth control? ☐ Yes ☐ No
What type and for how long? _____
Could you be pregnant now? ☐ Yes ☐ No (choose Yes if it is possible)
1st day of last menses: _____
Number of pregnancies: _____
These pregnancies resulted in (please indicate the number of times):
☐ Premature birth(s): _____ ☐ Abortion(s): _____ ☐ Miscarriage(s): _____
☐ Full term birth(s): _____ ☐ Postdate birth(s): _____
Any other obstetrical or gynecological issues? _____

_____

_____

_____

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DIET

Do you have any food allergies or intolerances? Please list.

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

FAMILY HISTORY

☐ I don't know my family medical history

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		**Who?**
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

ENVIRONMENT

Occupation:

Hobbies:

Do you exercise regularly? ☐ Yes ☐ No

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If yes, what do you do for exercise, for what duration and how often?

Are you exposed to significant tobacco smoke (at work, home, etc.)? ☐ Yes ☐ No

Are you frequently exposed to animals (work, pets, etc.)? ☐ Yes ☐ No

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

How would you describe the emotional climate of your home?

How would you rate your stress levels?

☐ Overwhelming ☐ High ☐ Moderate ☐ Low ☐ Minimal

OTHER CONCERNS

Is there anything that you feel is important that has not been covered?

WOULD YOU LIKE TO LEARN MORE ABOUT:

☐ Yearly Detoxification and Cleansing Strategies
☐ EFT & Stress Management
☐ BIE & Allergy Desensitization
☐ The Bowen Technique
☐ Kundalini Yoga and Workshops

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CONSENT TO TREAT, COMMUNICATION & COLLABORATION

NATUROPATHIC CONSENT TO TREAT

I consent to treatment and understand that my doctor is a licensed Doctor of Naturopathic Medicine who will conduct a thorough case history with me before initiating any treatment protocols. Doctors of Naturopathic Medicine are recognized as primary care doctors in Alberta, Canada with the ability to diagnose and treat disease conditions. Naturopathic Doctors utilize principles and practices that treat the whole person and assist the body's own ability to heal.

Evaluation and diagnoses will be based on consultation, pertinent physical exam and modern laboratory techniques that may include, but are not limited to Saliva, Blood, Urine and Stool testing and reports. Evaluation of these laboratory reports may be interpreted differently from other practitioners and treatment protocols may or may not be consistent with mainstream medical tests/evaluations and are based on clinical experience and scientific/medical literature.

Treatments may include, but are not limited to, Homeopathic medicine, Botanical medicine, Nutritional advice and Supplementation, Emotional Freedom Technique (EFT), The Original Bowen Technique, Niromathe, Bio-Intolerance Elimination (BIE), Bioscan and BEMER Treatment. I understand that my doctor will inform me of the potential risks of treatment and answer any questions that I may have.

I understand that even "natural" treatments may have side effects and it is my responsibility to inform my doctor in a timely manner of any side effects or adverse effects that I may be experiencing. I will make sure to inform my doctor of all dietary supplements, non-prescriptive and prescriptive medicines that I am taking; as well as updating any changes to this list. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. I understand that the results are not guaranteed and therefore, I do not expect the Naturopath to be able to anticipate and explain all risks and complications.

COMMUNICATION CONSENT

May we leave messages by telephone relating to your visits? ☐ Yes ☐ No

Do you want to receive our newsletter? ☐ Yes ☐ No

May we have your permission to communicate with you via email? ☐ Yes ☐ No

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PERMISSION TO COLLABORATE

☐ I agree, or ☐ I do not agree to allow my Radiant Health & Wellness (RH&W) practitioner(s) to discuss with another RH&W practitioner(s) details of my health information for the purpose of collaboration in support of individual diagnoses, treatment or referral.

I acknowledge that if I have any questions or concerns about my lab evaluation and/or treatment protocol, I will address them with my doctor in a timely manner. My consent to treatment is voluntary and informed.

I have read and understand the above-stated Consent To Treat and Communication policies of Dr. Christine Perkins.

Patient Signature (or legally authorized individual/guardian)	**Patient DOB (Date of Birth)**
Patient Name – Printed	**Date Signed**
Printed Name If Signed on Behalf of Patient	**Relationship to Patient**

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FINANCIAL, CANCELLATION & CLINICAL POLICIES

EXTENDED HEALTH BENEFITS & THIRD PARTY INSURANCE COVERAGE

Extended health benefits cover many types of health care services provided at our clinic. It is your responsibility to confirm coverage for our services. We will provide all necessary documentation for you to submit to your extended health care provider.

PAYMENT

Our Financial Policy is that payment is expected when goods and/or services are rendered. If you have extended health benefits, payment is still expected at the time of service. It is the policy of Radiant Health & Wellness (RH&W) that all fees charged for services rendered and products purchased are to be paid by cash, cheque, debit, Visa, or MasterCard at the time of each visit. We charge an additional $35.00 for NSF cheques.

PAYMENT INFORMATION

Name On Card: _____

Number: _____

☐ Visa ☐ Mastercard Expiry Date: _____

CLINIC VISITS

Scheduled time with your practitioner, regardless of whether treatment is rendered or not, will be billed as a clinic visit.

CANCELLATION POLICY

In the event that a scheduled appointment with one of the RH&W practitioners is unattended, the following policy will apply:

1. We require 24-hour notice for cancellations. Please be advised that e-mail reminders are a courtesy only and appointments are the responsibility of the client.
2. A “No-show” with no notification, as in #1, will be charged the full fee for the missed visit.
3. If there is a cancellation the same day of the appointment, the full fee will be charged for the missed visit.
4. We require credit card information to be retained on file in the event of missed appointments.

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NATUROPATHIC / CHINESE HERBAL MEDICATIONS

You may be prescribed medications, which may be purchased at our clinic or elsewhere. Please be aware that most insurance companies will NOT cover the medicinary items that are prescribed or dispensed. There are no refunds or returns for purchased medicinary items as we can only guarantee potency and quality of products that have been stocked and inspected in our office at all times.

Thank you for respecting your practitioner's schedule and time in following this policy. Should you have any questions, kindly speak with one of our front desk assistants, or directly with your practitioner.

I have read and agree to my financial obligations with regards to receiving services/products at RH&W

Name: _____ Date: _____

Signature: _____ Witness: _____

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