Acacia Health – Adult Naturopathic Intake and Consent Form.

Naturopathic Intake – Health History Form:

Name_____ Birth-date _____ Date_____ PHN#_____

Pronouns _____ Address_____ City _____ Prov/State_____

Postal Code_____ Phone (home)_____ Phone (work) _____

best time to call _____ Can we leave messages for you here? Y ☐ N ☐ Email _____

Occupation_____ full-time ☐ part-time ☐

Emergency contact _____relation? _____Phone_____

How did you hear about us?_____

Please list below all other health professionals you are currently seeing (complimentary and conventional), Include their area of practice: (GP, Chiropractor, etc...)_____

_____

_____

When was your last blood test?_____ What kind?_____

Current Health Concerns:

What is your main reason for seeking naturopathic care?._____

_____

_____

_____

_____

_____

_____

How long has this been troubling you? _____Has it been getting: better ☐ worse ☐ remaining the same ☐

List any treatments you have had for this condition (surgery, acupuncture, massage, etc...) and the results. Include dates:

_____

_____

_____

In order of importance, list any other health concerns that are troubling you:

1) _____Since when?_____

2) _____Since when?_____

3) _____Since when?_____

4) _____Since when?_____

Other concerns:_____

List all medications, supplements, herbs, and homeopathic medicines you are currently taking. Include dosage and results: _____

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_____

_____

Your Health History:

Your general state of health is: excellent ☐ good ☐ average ☐ fair ☐ poor ☐

Current weight_____ Height _____ Weight 1 year ago _____Max adult weight _____ Min adult weight _____

Please list the five most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (If so place a star next to the event)

1)_____ Date_____

2)_____ Date_____

3)_____ Date_____

4)_____Date_____

5)_____ Date_____

Are you currently working with a professional counselor, psychologist, social worker, pastor, rabbi, psychiatrist, or other therapist?
YES ☐ NO ☐ Have you in the past? YES ☐ NO ☐ If yes, when?_____

Childhood Diseases: (please circle if you have had the following):

measles	mumps	chickenpox	whooping cough	polio	diphtheria	roseola
rheumatic fever	scarlet fever	small pox	typhoid fever	tuberculosis	rubella	mono

Previous surgeries and hospitalizations not mentioned above (include dates):

_____

_____

Which of the following have you had and indicate when:

Chronic infections_____	Hypoglycemia_____	Asthma_____	Heart attack_____
Pneumonia_____	Diabetes_____	Gonorrhea_____	Heart Failure_____
Tonsillitis_____	Cancer_____	Syphilis_____	Anemia_____
Ear Infections_____	Eczema_____	Venereal warts_____	Obesity_____
Heart disease_____	Epilepsy_____	Canker sores_____	Hyperthyroidism_____
Oral herpes_____	Genital herpes_____	Hypertension_____	Hypothyroidism_____
Allergies_____	Hepatitis_____		

How often do you get colds and flus? _____

Do you have any allergies to any drugs, herbs, foods, animals or other? (yes / no)
Please list:

_____

_____

Do you currently use any of the following (indicate how often, how much and for how long):

Alcohol_____	Tobacco_____	Coffee _____
Soft drinks_____	Black tea _____	Marijuana _____
Laxatives _____	Other recreational drugs _____	Pain medication _ _____
Other intoxicants_____		

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Vaccination History:

Place the date of vaccination beside all that apply, and note any reactions or adverse effects.
Measles, Mumps, Rubella (MMR)_____
Polio_____ circle: oral live-virus polio vaccine killed-virus
Diphtheria, Pertussis, Tetanus (DPT)_____
Haemophilus Influenzae type B (Hib)_____Varicella (chicken pox_____
Hepatitis A _____ Hepatitis B_____ Other:_____

Mental Emotional Health:

Have you had in the past or have now, any of the following conditions (indicate n for now, and p for past):
Schizophrenia ____ Manic Depression ____ Major Depression ____ Minor Depression ____ Chronic Anxiety ____ Panic Attacks ____
Post Traumatic Stress Disorder ____ Dysthymic Disorder (chronic low level depression) ____ Obsessive-Compulsive Disorder ____
Other (please name)_____

Family History:

Please list ages, health problems and if deceased, cause of death:

	Living (age)?	Health Problems	Died(age)?	Cause
Parent(s)	_____	_____	_____	_____
Parent(s)	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Grandparent(s)	_____	_____	_____	_____
Grandparent(s)	_____	_____	_____	_____
Grandparent(s)	_____	_____	_____	_____
Grandparent(s)	_____	_____	_____	_____

What is your ethnicity? _____
Do you have children? _____ How many? _____Do they have any health problems? _____

Do you have any blood relatives who suffers from or has suffered from the following (circle):

allergies	arthritis	asthma	cancer	diabetes	anemia	Alzheimer's	syphilis
depression	eczema	heart disease	genetic disease	hypertension	stroke	bipolar disorder	gonorrhea
schizophrenia	cataracts	thyroid disease	hypoglycemia	seizures	sickle cells	tuberculosis	ulcers

What is your weakest organ system and why? _____

Your Lifestyle:

Describe your current living arrangements: _____

Describe the emotional environment at home:_____

Are you (circle): married separated divorced widowed single in a supportive relationship or other_____

What do you enjoy most in your life? _____

What are your main interests and hobbies? _____

What do you worry about most in your life? _____

How often do you exercise per week? _____ What kind and for how long? _____

Do you have a religious or spiritual practice and what is it? _____

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Do you have dietary restrictions, religious or ethical? _____

Do you meditate? _____ Do you enjoy your work? YES ☐ NO ☐ Do you take vacations? YES ☐ NO ☐

What is your level of education? _____

What is your level od Stress? (Circle one) 0 (no stress) 1 (mild stress) 2 (moderate stress) 3 (high stress) 4 (Severe Stress)

Reproductive Health Assessments:

Age of first period _____ Age at menopause _____ Length of cycles_____

Length of bleeds_____ Are they: heavy ☐ medium ☐ light ☐ clotted ☐ dark ☐ light color ☐

Do you have spotting or bleeding between periods and since when?_____

Do you have PMS? ____ (circle all that apply) bloating, breast tenderness, irritability, depression, headaches, mood swings, food cravings

Number of pregnancies _____ Number of abortions _____ Number of live births_____ Number of miscarriages _____

Have you had difficulty conceiving? (Please describe) _____

Date and results of last PAP smear _____ Mammogram _____Self breast exam_____

Have you ever had an abnormal pap/mammogram? YES ☐ NO ☐ If yes, when? _____

Are you sexually active? YES ☐ NO ☐ If you use birth control, what kind? _____

Have you ever been or are now physically or sexually abused? _____

Any problems with impotency? YES ☐ NO ☐ Any sores on your penis? YES ☐ NO ☐ Any discharge? YES ☐ NO ☐

Any problems urinating? YES ☐ NO ☐ Any known prostate problems? (if so describe)_____

Date of last prostate examination_____ Date of last self testicular examination _____

Are you sexually active? YES ☐ NO ☐ If you use birth control, what kind?_____

Have you ever been or are now physically or sexually abused? _____

Your Work and Home Environment:

How long have you lived at your present address?_____ Where have you lived previously?_____

Is your home damp or moldy? YES ☐ NO ☐ How is your home heated?_____

Can you open windows where you work? YES ☐ NO ☐ Is their air filtration systems at work? YES ☐ NO ☐

Does your work expose you to toxic chemicals and fumes? YES ☐ NO ☐ Describe_____

Do any of your hobbies expose you to toxic chemicals? YES ☐ NO ☐ Are you exposed to second hand smoke? YES ☐ NO ☐

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Consents for Care:

1.) Consent for treatment:

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors (NDs) assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history and conduct a screening physical examination. This may include a breast exam, gynaecological, rectal, prostate, and blood and urine samples as required. Treatment may involve such interventions as Botanical Medicine, Traditional Chinese Medicine, Bony manipulations, Massage, Hydrotherapy, Nutrition, Lifestyle Counselling, Psychological counselling, and Homeopathy.

I understand that I must inform the Naturopathic Doctor immediately of any disease process that I may be suffering from, if I am on any medication or over the counter drugs, if I am pregnant, suspect I may be pregnant or am breast-feeding.

I understand that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests. I understand that Naturopathic Medicine is not covered by MSP (Medical Services plan) and I will need to pay for my services.

I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of treatment with this Naturopathic Doctor. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

☐ I agree

2.) Privacy and Sharing of Information:

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that the physicians at this clinic are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. I understand that I may look at my medical record at

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anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

☐ I agree

3.) Cancellation Policy:

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

☐ I agree

4.) Collaborative Health Approach:

To provide me with truly integrated medical care I hereby give my consent to share my file and/or my medical history and current treatment plan options with any other practitioner that I am currently seeing (or may be referred to see in the future) at Acacia Integrative Health Clinic for the sole purpose of improving my current health condition and/or to discuss current and/or future treatment options.

☐ I agree ☐ I Disagree

x

Signed Name: Date:

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