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NATUROPATHIC INTAKE FORM

Patient Information

Date: _____

First Name _____ Last Name _____

Date of Birth (DD-MMM-YYYY) _____ Age _____ Gender _____

Contact Information

Cell Phone _____ Other Telephone _____

What number may we leave messages at? ☐ *Cell* ☐ *Other*

Email Address _____

Address _____

City _____ Postal Code _____

Would you like to receive awesome health tips by email? Select all that apply.
☐ *General Health* ☐ *Fertility* ☐ *Baby's First Year* ☐ *Thyroid*

*W*ould you like to be invited to our private Facebook community? ☐ *Yes* ☐ *No*

Other Information

Occupation _____ Hours of Work _____

Emergency Contact Name _____ Emergency Contact Phone Number _____

How Did You Find Us?

☐ Seminar/Event ☐ Social Media/Facebook ☐ Friend/Family: _____
☐ Webpage/Google ☐ Professional Referral ☐ Other: _____

Whom should we thank? _____

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Health Care Team

Have you seen an ND before? _____

Who? When?

_____ _____

Family Physician Other Health Care Providers

_____ When was your last blood test done? _____

Date of Last Physical Exam

Do you get regular screening tests done by a doctor (pap, blood, etc?) ☐ Yes ☐ No

What *three* expectations do you have from *this visit* to our clinic?

1. _____
2. _____
3. _____

What *long term* expectations do you have from working with our clinic?

1. _____
2. _____
3. _____

Chief Health Concerns

What are your health concerns in order of importance?

_____

_____

_____

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Health History

This sort of health history helps to establish trends in a person's health that may be relevant to present conditions. Indicate below any accidents, broken bones, falls, illnesses, hospitalization, surgeries, CTs, MRIs, X-Rays, and note any emotional circumstances such as deaths, loss of jobs, marriage, divorces, abuse, addictions, etc..

Age	**Event (stress, accident, imaging, illness, etc.)**
1-5	
5-10	
10-15	
15-20	
20-25	
25-30	
30-35	
35-40	
40-45	
45-50	
50-55	
55-60+	

Please note health conditions of close relatives.
(Examples may include allergies, arthritis, asthma, autoimmune disease, cancer, diabetes, digestive disorders, heart disease, high blood pressure, mental illness, multiple sclerosis, stroke, thyroid conditions, etc.)

	Health Conditions
Parents	
Siblings	
Grandparents	
Children	

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General History

For the following list of symptoms: √ for currently experiencing and P for those you've had in the past

SKIN:
- ❑ Rashes
- ❑ Eczema
- ❑ Psoriasis
- ❑ Vitiligo
- ❑ Dryness
- ❑ Hives
- ❑ Acne
- ❑ Warts
- ❑ Recent moles
- ❑ Skin cancer

HEAD:
- ❑ Head injury
- ❑ Headaches/Migraines
- ❑ Vertigo/Dizziness
- ❑ Hair loss
- ❑ Change in hair texture

EYES:
- ❑ Redness
- ❑ Excessive tearing
- ❑ Double/Blurred vision
- ❑ Spots/floaters
- ❑ Flashing lights
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Discharge/infection

EARS:
- ❑ Infection
- ❑ Ringing
- ❑ Hearing loss

NOSE & SINUSES:
- ❑ Frequent colds
- ❑ Nasal stuffiness
- ❑ Loss of smell
- ❑ Nose bleeds
- ❑ Nasal polyps
- ❑ Sinus infections
- ❑ Chronic runny nose
- ❑ Peculiar smells

MOUTH & THROAT:
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Periodontal disease
- ❑ Thrush
- ❑ Enlarged lymph nodes
- ❑ Peculiar tastes
- ❑ Production of mucus

RESPIRATORY:
- ❑ Chronic cough
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Emphysema
- ❑ Coughing blood
- ❑ Tuberculosis

CARDIOVASCULAR:
- ❑ Rapid heart beat
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain
- ❑ Palpitations
- ❑ Heart murmurs
- ❑ Difficult breathing
- ❑ Leg cramps
- ❑ Clotting disorder
- ❑ Edema/swollen ankle
- ❑ Cold hands/feet

INTESTINAL
- ❑ Trouble swallowing
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn/acid reflux
- ❑ Indigestion
- ❑ Bad breath
- ❑ Bloating
- ❑ Abdominal pain
- ❑ Excessive gas
- ❑ Ulcer
- ❑ Hypoglycemia
- ❑ Diabetes
- ❑ Jaundice/hepatitis
- ❑ Colitis or Crohn's
- ❑ Constipation
- ❑ Blood in stool
- ❑ Diarrhea
- ❑ Hemorrhoids
- ❑ Eating disorder

GENITOURINARY:
- ❑ Urgency
- ❑ Dribbling/leaking
- ❑ Frequency
- ❑ Incontinence
- ❑ Burning pain
- ❑ Urinary tract infections
- ❑ Kidney infections
- ❑ Kidney stones
- ❑ STDs (HPV, etc.)

GENERALS:
- ❑ Weight loss
- ❑ Weight gain
- ❑ Fatigue
- ❑ Night sweats
- ❑ Profuse perspiration
- ❑ Weakness
- ❑ Insomnia/poor sleep

FEMALE:
- ❑ PMS
- ❑ Low libido
- ❑ Yeast infections
- ❑ Vaginal dryness
- ❑ Painful periods
- ❑ Irregular Periods
- ❑ Heavy periods
- ❑ Excessive discharge
- ❑ Miscarriage(s)
- ❑ Pregnancy(s)
- ❑ Abortion(s)
- ❑ Birth control use
- ❑ Abnormal PAP results
- ❑ Endometriosis
- ❑ Uterine Fibroids
- ❑ Fibrocystic breasts
- ❑ Cysts on ovaries

MALE:
- ❑ Enlarged prostate
- ❑ Prostatitis/infection
- ❑ Discharge
- ❑ Low libido
- ❑ Erectile dysfunction

HAEMATOLOGICAL
- ❑ Anemia
- ❑ Easy bleeding
- ❑ Easy Bruising
- ❑ Varicose/spider veins
- ❑ Hep. A, B, or C

MUSULOSKELETAL
- ❑ Muscle pains/cramping
- ❑ Joint pains/swelling
- ❑ Osteo-arthritis
- ❑ Back pain
- ❑ Gout

NEUROLOGICAL:
- ❑ Fainting/Black-outs
- ❑ Numbness
- ❑ Tremors
- ❑ Pins & needles
- ❑ Loss of balance
- ❑ Paralysis
- ❑ Speech problems
- ❑ Memory loss
- ❑ Nervousness/tension
- ❑ Irritability
- ❑ Depression
- ❑ Anxiety

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Do you have any allergies (food, environmental, medications)? Please list:

Allergy	What problems do they give you? Diarrhea, stuffy nose, anaphylaxis, etc.	How often are you exposed? Daily, weekly, monthly, etc.	When did you first become aware of the allergy/problem?

Please list all current prescription medications:

Name of Medication	Dose	Frequency	Duration	Side Effects (if any)

Please list all vitamins, herbs, homeopathics, and non-prescription medications that you take on a regular basis:

Name and Brand	Dose	Frequency	Duration	Side Effects (if any)

Approximately how many times *per year* have you been treated with antibiotics?

As a child? _____

As an adult? _____

How often do you use the following:

	Per Day	Per Week	Per Month
Caffeine			
Cigarettes			
Diet pills			
Pain relievers			
Sleeping pills/aids			
Antacids			
Laxatives			
Alcohol			
Marijuana			
Other recreational drugs			
Fast food			

Do you follow any special dietary plans? (Religious, vegetarian, vegan, gluten free, paleo, etc.)

List any foods you crave or make you feel better:

Food/Drink you crave	Approximately how often do you have them?

List any foods that you avoid or make you feel worse:

Food/Drink you avoid	What do you notice when you eat them?

Environment and Lifestyle

Do you exercise regularly? ☐ Yes ☐ No

What types:

How often?

Who sincerely and consistently supports you in a positive and beneficial way?

Do you live: ☐ Alone ☐ With partner ☐ With friends ☐ Children ☐ Other:

How would you describe the emotional climate of your home?

How is your stress? Rate stress from 0-10, 10 is very stressed: ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

What causes you the most stress/worry in life?

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How do you manage your stress? (Include positive and negative ways)

What are your hobbies? What do you love to do?

How is your sleep? Rate sleep from 0-10, 10 is great sleep: ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Tell us what you ate/drank in the last 24 hrs:
This is not a test ☺but a starting point to discuss how nutrition may impact your health concerns.

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages	

Is there anything else that you would like to add but weren't sure where it fit?

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Consent & Doctor Patient Agreement

I give my informed consent to Rooted Naturopathic Clinic to provide me with naturopathic medical consultation, assessment and treatment. I recognize that this consent covers the entire course of treatment for my present condition as well as any future conditions for which I seek treatment. I acknowledge that no guarantees have been given to me concerning the results intended from the treatment. I further confirm that I am free to withdraw my consent and to discontinue naturopathic treatment at anytime.

I understand that telemedicine (appointments via phone or video) may be utilized in specific situations only if it is in the best interest of myself (the patient). I understand that Rooted will take all necessary steps to ensure the privacy and confidentiality of my personal health information, however no medium can be considered 100% secure.

Our Expectations:

- Please arrive on time.
    - We are usually booked back to back so there won't be any extra time if you show up late
    - As the time was set aside for you, you will be billed for booked time.
    - 24 hours notice is required to cancel appointments. If less than 24 hours notice is given, a $50 charge will be applied. **Please Initial _____**
- Payment is due at the end of your visit. We accept cash, credit cards and debit for your convenience.

What you can expect from us at Rooted:

- We respect your time and therefore run on time for your appointments. However, there may be times when we run late with a patient that requires more attention.
- We will be clear about the costs and the reasons for or against the treatments, labs, procedures and supplements that we recommend.
- Specialty supplements are available to be purchased at Rooted for your convenience, or health stores can be recommended based on the prescription, your location or preference.

A note on email communication:

- Your ND likes to be available to their patients. Please note though that email communications cannot be guaranteed secured and private.
- Email communications must be limited to clarify something already prescribed, or for you to provide further information. New treatment cannot be provided over email, this would require an in person visit to properly assess your health concerns.

We are looking forward to serving you and helping you along your path to wellness.

_____
Patient Name

_____ _____
Patient Signature Date