Oakville Chiropractic and Family Health
2525 Old Bronte Road, Suite # 380
Oakville, Ontario L6M 4J2
289-837-3777

Naturopathic Treatment Adult Intake

(Please print clearly)

Name _____ Date (mm/dd/yy): ___/___/___

Birthdate (mm/dd/yy): ___/___/___ Sex ☐ M ☐ F Preferred Pronoun ☐ He ☐ She Other _____

Address: _____

E-mail Address _____ Phone Number _____

May we leave messages relating to your visits? ☐ Y ☐ N

Emergency contact: Name _____

Phone number _____ Relation _____

How did you hear about our Clinic? Please check one of the following:

- ☐ Media/TV Article
- ☐ Corporate Health/Wellness Event
- ☐ Clinic staff
- ☐ Clinic patient
- ☐ Website

Other _____

Referred by: _____

Other health care providers you are seeing and their contact information (name, phone number, address,):

1. _____ _____

   _____

2. _____ _____

   _____

3. _____ _____

   _____

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What are your health concerns, in order of importance to you:

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

If you are female are you currently pregnant? ☐ Y ☐ N (Please check one)

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.

_____

_____

_____

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

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

Please list past prescription medications. _____

_____

How many times have you been treated with antibiotics? _____

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Do you frequently use any of the following? (check box)

☐ Aspirin ☐ Laxatives ☐ Antacids ☐ Diet pills ☐ Birth control pills ☐ Implants ☐ Injections

☐ Alcohol – *how much / day or week* _____

☐ Tobacco – *form and amount / day* _____

☐ Caffeine – *form and amount / day* _____

☐ Recreational drugs – *what and how often* _____

Please indicate what immunizations you have had

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

Other _____

Please indicate if any caused adverse reactions: _____

_____

Do you get regular screening tests done by another doctor? (pap, blood tests, etc.)? ☐ Y ☐ N

Diet

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

_____

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

_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Beverages (and total quantity) _____

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Family History

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

Please indicate which family member

Allergies _____
Asthma _____
Heart Disease _____
High Blood Pressure _____
Cancer _____
Diabetes _____
Depression _____
Other Mental Illness _____
Drug Abuse/Alcoholism _____
Kidney Disease _____
Other _____

☐ I don't know my family medical history

Environment

Occupation _____
Hobbies _____

Do you exercise regularly? ☐ Y ☐ N *What do you do for exercise. How much? How often?*

_____

Are you exposed to significant tobacco smoke (work, home, etc.)? ☐ Y ☐ N

Are you frequently exposed to animals (work, pets, etc.)? ☐ Y ☐ N

How is your home heated? _____

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 stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

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

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Naturopathic Treatment Informed Consent

Please note that this form must be signed prior to your first appointment.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history and perform a physical examination. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

Your Naturopathic Doctor is trained to handle emergencies should the need arise.

There are some slight health risks associated with treatment by naturopathic medicine.

These include but are not limited to:

- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from acupuncture.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa.
- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.

I understand:

- The clinic does not guarantee treatment results.
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- I am free to withdraw my consent and to discontinue treatment at any time.

Patient Name (please print): _____

Signature of Patient: _____ Date: _____
mm / dd / yy