

Adult Intake

(please print clearly)

Name: _____

Date: _____

Date of birth _____ (M/D/Y)

Sex: M F

Address: _____

E-mail Address: _____

Telephone number: Home: _____ Work: _____

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

Emergency contact: Name: _____

Phone number: _____ Relation: _____

How did you hear about our Clinic: _____

Referred by: _____

Other health care providers you are seeing:

1. _____ 2. _____ 3. _____

() _____ () _____ () _____

1. _____ 2. _____ 3. _____

() _____ () _____ () _____

PLEASE COMPLETE THIS FORM AND RETURN TO CLINIC RECEPTION

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

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

If you are female are you currently pregnant? Yes No (Please circle 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? _____

Do you frequently use any of the following? (circle)

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.

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Tetanus booster; when? _____ | <input type="checkbox"/> "Flu" | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Polio | <input type="checkbox"/> 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.)?

Family history

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

	Who?		Who?
Asthma		Other mental illness	
Heart disease		Drug abuse, alcoholism	
High blood pressure		Kidney disease	
Cancer		Diabetes	
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

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?

For file use only.

**PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO
YOUR 1ST APPOINTMENT**

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths 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. Naturopaths at Health & Wisdom Naturopathic Family Clinic will take a thorough case history, do a screening physical examination, and take blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important therefore that you inform your Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Doctor immediately.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting during acupuncture treatment, puncturing of an organ with acupuncture needles.
- Muscle strains and sprains, disc injures from spinal manipulation.
- The potential for stroke is a concern in neck manipulation, but tests will be done to screen for this possibility. Clinical research has shown that stroke-like occurrences are rare – approximately 1 in 1.5 million manipulations.

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 unless law requires it. I understand that I may look at my medical record at 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 understand that the results are not guaranteed. I do not expect the naturopath to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: _____.

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

Patient Name: (Please Print) _____

Signature of Patient or Guardian: _____

Date: _____

Signature of Treating Naturopathic Doctor: _____ (Leah Oster, ND)

_____ (David Oster, ND)