



**Intake Form**

We respectfully ask that you complete this form prior to arriving for your scheduled appointment time.

Successful health care and preventive medicine are only possible when the naturopathic doctor has a complete understanding of the patient. Your time, thoughtfulness and honesty in completing this overview will go a long way in assisting our naturopathic doctors to determine the causes of your health condition(s) and individualize your health needs.

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ NB Medicare #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ ID#: \_\_\_\_\_

Telephone (home): \_\_\_\_\_ (work): \_\_\_\_\_ (cell): \_\_\_\_\_

Email address (for info sheets, newsletters, etc.): \_\_\_\_\_

Which is your preferred *contact method* for visit reminders (circle one)? email or phone

Which is your preferred *spoken language* during office visits (circle one)? English or Français

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: female \_\_\_\_\_ male \_\_\_\_\_

Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_ Single: \_\_\_\_\_ Partnership: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_ Retired: \_\_\_\_\_

Employer: \_\_\_\_\_

**How did you hear about our clinic (circle & be as specific as you can):**

Person - name(s): \_\_\_\_\_, Yellow Pages (in book/online),  
Internet (Google search, clinic website, Facebook, other: \_\_\_\_\_), Other: \_\_\_\_\_.

Has any other family member already been a patient at the clinic? \_\_\_\_\_.

Next of Kin or other to reach in an emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently receiving healthcare? Y N If yes, where & from whom: \_\_\_\_\_

If no, when & where did you last receive medical or health care? \_\_\_\_\_

What was the reason? \_\_\_\_\_

**When filling out the form, note that:**

**Y**=a condition you have now      **N**=Never had      **P**=Significant problem in the past

*Thank you for your time and effort. Our team looks forward to providing you with the best possible care.*

CONTEXT OF CARE REVIEW

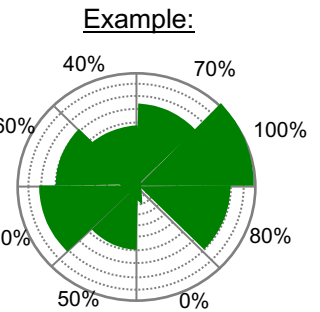
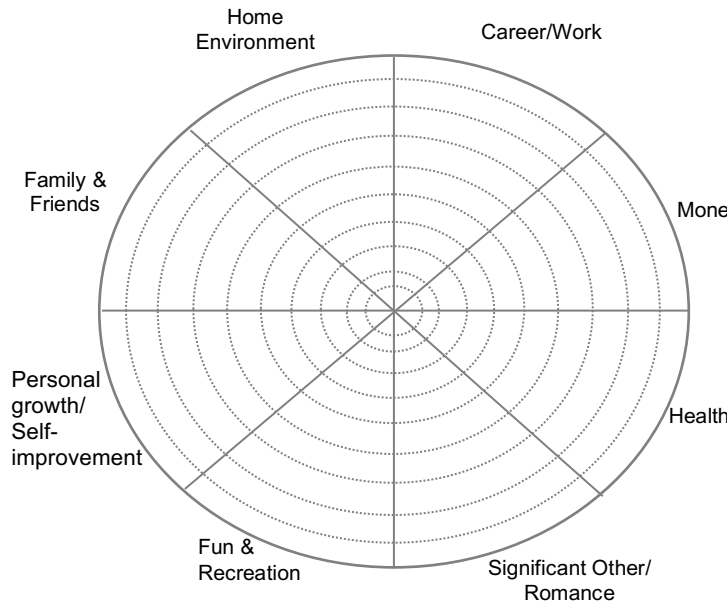
- 1) Why did you choose to come to this clinic?
  
- 2) What 3 expectations do you have from this visit?
  - 1.
  - 2.
  - 3.
  
- 3) What long-term expectations do you have from working with our clinic?
  
- 4) What expectations do you have of me personally as your naturopathic doctor?
  
- 5) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)  
0% 0 1 2 3 4 5 6 7 8 9 10 100%
  
- 6) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)
  
- 7) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)
  
- 8) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?
  
- 9) What are your **most important health concerns**? List as many as you can in order of importance:
  1. \_\_\_\_\_ onset: \_\_\_\_\_
  2. \_\_\_\_\_ onset: \_\_\_\_\_
  3. \_\_\_\_\_ onset: \_\_\_\_\_
  4. \_\_\_\_\_ onset: \_\_\_\_\_
  5. \_\_\_\_\_ onset: \_\_\_\_\_
  6. \_\_\_\_\_ onset: \_\_\_\_\_
  7. \_\_\_\_\_ onset: \_\_\_\_\_
  8. \_\_\_\_\_ onset: \_\_\_\_\_
  9. \_\_\_\_\_ onset: \_\_\_\_\_
  10. \_\_\_\_\_ onset: \_\_\_\_\_

**Wheel of Balance**

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



**General**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Weight 1 year ago: \_\_\_\_\_ lbs.  
 Maximum weight: \_\_\_\_\_ when: \_\_\_\_\_ What is your *ideal* weight? \_\_\_\_\_

**Family History (please circle)**

**Heart Disease:** high blood pressure, stroke, heart attack, other \_\_\_\_\_.

**Autoimmune Disease:** rheumatoid arthritis, celiac disease, Hashimoto's thyroiditis, other: \_\_\_\_\_.

**Mental Illness, Asthma, Allergies, Eczema, Psoriasis, Vitiligo.**

**Cancer** - list all types & write down your connection: mother (M), father (F), sibling (S), child (C), maternal grandparent (MG), paternal grandparent (PG), other (O): \_\_\_\_\_

**Any other relevant family history?** \_\_\_\_\_

**Hospitalization, Surgery, Imaging**

What hospitalizations, surgeries, X-rays, CAT scans, EEG, ECG/EKG's, etc...have you had?

\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_  
 \_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_  
 \_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_

**Allergies - Are you hypersensitive or allergic to...**

Any drugs? \_\_\_\_\_  
 Any foods? \_\_\_\_\_  
 Any environmental or chemicals? \_\_\_\_\_  
 Any anaphylactic reactions? \_\_\_\_\_

**Current Medications & Supplements**

Please list **any** prescription medications (including those for pain relief), over-the-counter medications, vitamins or other supplements you are taking (please give dosages & use an extra page if needed)?

- 1) \_\_\_\_\_ 6) \_\_\_\_\_
- 2) \_\_\_\_\_ 7) \_\_\_\_\_
- 3) \_\_\_\_\_ 8) \_\_\_\_\_
- 4) \_\_\_\_\_ 9) \_\_\_\_\_
- 5) \_\_\_\_\_ 10) \_\_\_\_\_

If any, please list natural supplements that you reacted to in a negative way: \_\_\_\_\_

If any, please list natural supplements that you tried and were not effective: \_\_\_\_\_

## Typical Food Intake

**Breakfast:** \_\_\_\_\_

**Lunch:** \_\_\_\_\_

**Supper:** \_\_\_\_\_

**Snacks:** \_\_\_\_\_

**Desserts/treats/junk foods:** \_\_\_\_\_

**Water** intake (circle): low, adequate (~8cups), in excess of. **Other drinks:** \_\_\_\_\_

**Alcohol** (# of drinks - per day or week): \_\_\_\_\_ **Coffee** (# of 6 oz cups - per day or week): \_\_\_\_\_

**Pop** or other sodas (cans or mL - per day or week): \_\_\_\_\_

Do you have a good **appetite** (circle)? No, sometimes, yes, always hunger

What food(s) do you **crave** (circle)?: sugar (chocolate, candy, desserts, other: \_\_\_\_\_), salty (add salt to food, chips, other: \_\_\_\_\_), grains (bread, pasta, pastries, other: \_\_\_\_\_), condiment(s): \_\_\_\_\_, tobacco, alcohol, coffee, pop, Redbull, other: \_\_\_\_\_.

Do you **skip meals**? never, sometimes, often. If so, which meals do you skip (circle): breakfast, lunch, dinner

Do you have **3 sit-down meals**? Y N or do you rather **snack** throughout the day? Y N

Eat **on the run**? Y N **Cook your own** meals (circle one)? never, sometimes, frequently, almost always

Are there any **foods that do not agree** with you or aggravate you? Explain: \_\_\_\_\_

**Specific diet** (circle): religious, vegetarian, vegan, Weight Watchers, SFL, other: \_\_\_\_\_

**Dietary restriction** (circle): salt, dairy (lactose, casein), gluten, wheat, egg, soy, other: \_\_\_\_\_

<b>Y</b> =a condition you <u>have now</u>	<b>N</b> =Never had	<b>P</b> = <u>Significant</u> problem in the past
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### Gastrointestinal/Liver/Gallbladder (note: fill out both sides)

Bowel movements: How often? \_\_\_\_\_

Constipation?	Y N P	Reflux?	Y N P
Heartburn	Y N P	Abdominal pain?	Y N P
Diarrhea?	Y N P	Abdominal cramps?	Y N P
Passing gas?	Y N P	Bloated (distended abdomen)?	Y N P

### Toxicity Risk Assessment

Have you ever been exposed to **toxic substances** such as pesticides, herbicides, solvents, sprays, paints, heavy metals, oils, etc...(from work, home, hobbies, etc.)? If yes, list & give details: \_\_\_\_\_

# of teeth amalgam fillings (mercury/silver): \_\_\_\_\_ #/week consume big fish (e.g. tuna): \_\_\_\_\_

Do you use **tobacco**? Y N P Use recreational drugs? Y N P

if so, between what years did you smoke (e.g. 1992-2010 & 2012-2014 or 1970-present): \_\_\_\_\_

how many cigarettes or packs per day did/do you smoke? \_\_\_\_\_

**Sleep**

Sleep well? always, often, rarely, never. Ideal hours of sleep per night? \_\_\_\_\_  
Do you take sleeping pills? Y N      Take nap(s)? Y, at times, N      Sleep apnea? Y N P  
Difficulty falling asleep? Y, at times, N      When is the average time that you fall asleep?: \_\_\_\_\_

**Habits**

Main interests, hobbies & what you do for fun: \_\_\_\_\_

Do you **exercise**? \_\_\_\_\_ Y N  
if yes, what kind? \_\_\_\_\_ how often (#/day or week)? \_\_\_\_\_  
What time during the day is your **energy** the best? \_\_\_\_\_ worst? \_\_\_\_\_  
when your energy is the worst, how low is it from 0-10 (with 10 being the best)?: \_\_\_\_\_

**Mental / Emotional**

Depression? Y N P  
Anxiety or nervousness? Y N P  
How do you manage stress?: \_\_\_\_\_

**Immune/Respiratory**

Recurring infections?	Y N P	Reactions to vaccinations?	Y N P
Many colds & flus?	Y N P	Night sweats?	Y N P
Seasonal allergies?	Y N P	Stiffness (nose)?	Y N P
Asthma?	Y N P	Difficulty breathing	Y N P

**Endocrine**

Excessive hunger? Y N P  
Diabetes? Y N P  
Hair loss? Y N P

**Neurologic**

Memory problems?	Y N P	Poor concentration?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

**Musculoskeletal**

Muscle cramps?	Y N P	Muscle pain?	Y N P
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**Skin**

Rashes?	Y N P	Eczema?	Y N P
Acne?	Y N P	Itching?	Y N P
Lumps?	Y N P	Dry skin?	Y N P

**Urinary**

Pain on urination? Y N P  
Inability to hold urine? Y N P  
Frequent urinary infections? Y N P

**Head**

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P		

**Y=a condition you have now      N=Never had      P=Significant problem in the past**

**Cardiovascular/Circulation**

High blood pressure?	Y N P	Palpitations/fluttering?	Y N P
Low blood pressure?	Y N P	Low iron blood levels	Y N P

**Male Reproduction**

Prostate disease?	Y N P	Impotence?	Y N P
Sexually transmitted disease?	Y N P	Premature ejaculation?	Y N P
		Erection problems?	Y N P

**Female Reproduction**

Are cycles regular?	Y N P	Difficulty conceiving?	Y N P
Bleeding between cycles?	Y N P	Birth control?	Y N P
Duration of menses (bleeding)? _____ days		what type? _____	
Heavy or excessive flow?	Y N P	Number of pregnancies: _____	
PMS?	Y N P	Number of miscarriages: _____	
if yes, what are your symptoms?		Menopausal symptoms?	Y N P
_____		Breast pain/tenderness?	Y N P
_____			

**Y=a condition you have now      N=Never had      P=Significant problem in the past**

**Is there anything else you would like to add or comment on (use area below)?**



**Statement of Acknowledgement of Visit Fees Schedule:**

Printed name of patient: \_\_\_\_\_

**FEE SCHEDULE**

Initial visits: \$250 (75-90 min. visits)  
- if extends longer: as per time needed

Return visits:

Visit fees are based on time spent with the naturopathic doctor: \$15 per 5 minutes. For example:

30 min. shorter visits: \$90

40 min. visits: \$120

45 min. visits: \$135

50-60 min. typical visits: \$150-\$180

Phone/email consults: Based on time required as per visit fees.

Please note:

Our naturopathic doctors try their best to be as efficient as possible and keep visits length within proposed time frames: e.g. 75-90 minutes for initial visits (\$250) and 50-60 minutes for typical return visits (\$150-\$180). Because of the complexity of each person's health issues this can be challenging and may require longer consults.

**For upcoming return visits, the length of the appointment may take longer than 50-60 minutes (should extra time be needed to fully address your health concerns),** in which case visit fees will reflect the additional time taken per 5 minutes increments (e.g. 70 minutes return visits = \$210). Likewise, should less time be needed, the shorter appointment will be based on your time spent with the naturopathic doctor (e.g. 40 minutes return visits = \$120).

**Please let your naturopathic doctor know at the start of the appointment should you have timing/financial restrictions and prefer a shorter or longer appointment.**

I consent to receive naturopathic treatment. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### Declaration and Informed Consent for Naturopathic Care

We would like to take this opportunity to welcome you. Your naturopathic doctor will conduct a thorough case history, physical examinations (when indicated) and may recommend specific blood, urinary or other laboratory reports as part of the treatment work-up. Your naturopathic doctor integrates supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, physical medicine and lifestyle counseling to assist the body's ability to heal and to improve the quality of life and health.

### Statement of Acknowledgement

Printed name of patient: \_\_\_\_\_

As a patient, I have read this information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided in this intake form is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. Slight health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing symptoms;
- allergic reactions and other adverse effects to supplements, homeopathics, nutraceuticals, injectables or herbs;
- pain, fainting, bruising, infection, or injury from acupuncture, venipuncture (blood drawn from a vein as conducted by naturopathic doctor or medical lab assistant/phlebotomist), musculoskeletal injections, intramuscular injections, and/or joint injections.

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient is **not mutually exclusive** from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. It is highly recommended that I update my health care providers of any new treatments.
- I also confirm that I have the ability to accept or reject this care of my own free will and choice. I understand results are not guaranteed. I accept full responsibility for any fees incurred during care and treatment.
- I understand that a record will be kept of my visits. This record will be kept confidential and **will not be released** without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- No recording devices shall be used during a consultation without the express permission of both parties.
- I am responsible for **payment at the time services are rendered**. Dispensary items must be paid for in full before leaving the office.
- I am aware that **24 hours notice** must be given for all cancelled appointments or a **cancellation fee** will be applied.
- I understand that my naturopathic doctor reserves the right to determine which cases fall outside of his scope of practice, in which case the **appropriate referral will be recommended**.
- I have read and understand the **Privacy Policy** which is available on the clinics website at [www.monctonnaturopathic.com](http://www.monctonnaturopathic.com) (see Forms).

I consent to receive naturopathic treatment. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_