MONCTON NATUROPATHIC
MEDICAL CLINIC - CLINIQUE MÉDICALE

www.monctonnaturopathic.com
12 Fifth Street, Moncton, NB, E1E 3G9
Ph: 506-382-1329 Fax: 506-382-1828

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*:

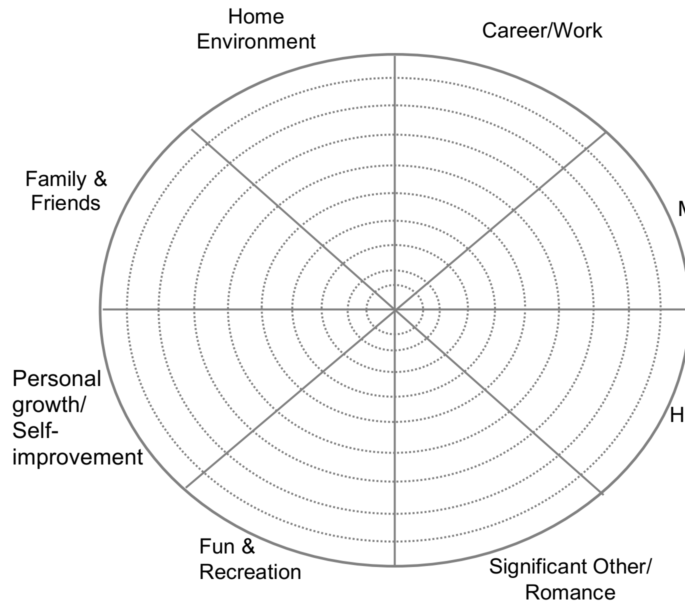
1. ______________________ onset: ______________
2. ______________________ onset: ______________
3. ______________________ onset: ______________
4. ______________________ onset: ______________
5. ______________________ onset: ______________
6. ______________________ onset: ______________
7. ______________________ onset: ______________
8. ______________________ onset: ______________
9. ______________________ onset: ______________
10. ______________________ onset: ______________

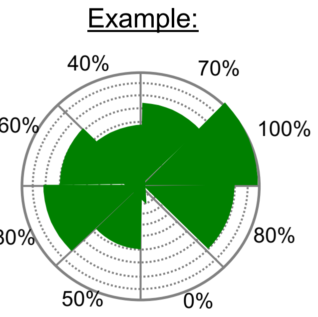
Wheel of Balance

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, Red Bull, 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: _____________

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

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 (distented 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	Stuffiness (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

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
Bleeding between cycles? Y N P
Duration of menses (bleeding)? _______ days
Heavy or excessive flow? Y N P
PMS? Y N P
if yes, what are your symptoms?
____
____

Difficulty conceiving? Y N P
Birth control? Y N P
what type? _________
Number of pregnancies: __________
Number of miscarriages: ________________
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)?

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Statement of Acknowledgement of Visit Fees Schedule:

Printed name of patient: ________________________

FEE SCHEDULE

Initial visits:	*$250 (75min. visits)*
- if extends longer:	*$295 will apply if the consultation extends beyond 90 minutes due to complex health issues or at your request to allow additional time for your questions.*

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 minutes for initial visits ($250) and 60 minutes for typical return visits ($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 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: _____________

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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 (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: _____________