Naturopathic Adult Intake Form

Dr. Tiffany Sahakian Heikkila, Naturopathic Doctor

Full Name _____

Date of Birth: _____/_____/_____ (mm/dd/yyyy) Age_____

Gender: Male ☐ Female ☐ Weight_____ Height_____

Complete Address _____

_____

Postal Code _____

Type	Phone Number	OK to leave a message on answering machine or voicemail?	OK to leave a message with other people at this number?
Home		☐ Yes ☐ No	☐ Yes ☐ No
Cell		☐ Yes ☐ No	☐ Yes ☐ No
Work		☐ Yes ☐ No	☐ Yes ☐ No

Email Address _____

Emergency Contact: _____

Relation _____ Phone number _____

Fee Schedule

Patients are responsible for the total charges incurred (visit fees plus any medicines) for each visit.

15-minute Follow up	30-minute Follow up	45-minute Follow up	60-minute Follow up	60-minute Initial Visit
$45.00	$85.00	$130.00	$160.00	$170.00

Missed appointments and cancellations made with less than 24 hours notice will be charged 100% of the Naturopathic visit fee. In case of lateness, your treatment time will be reduced appropriately, and the full treatment charge will apply.

Initial _____

All information provided to your Naturopathic Doctor will remain confidential and will not be released unless you have authorized us to do so

Please list your main health concerns below:

1._____

2._____

3._____

4._____

Please list the supplements &/or medications you are <u>currently</u> taking:

Supplement/Medication	Dosage	Reason for taking

Please list any surgeries, hospitalizations, injuries or medications used in the <u>past</u>:

History	Date

Please list any known allergies or sensitivities to food, medications, environmental or other:

1._____ 3._____

2._____ 4._____

Please check the appropriate boxes for medical conditions you currently have or previously experienced:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cervical Dysplasia
- ☐ Crohn's
- ☐ Diabetes
- ☐ Eczema
- ☐ Endocrine disorders
- ☐ Endometriosis
- ☐ Enlarged prostate
- ☐ Gallstones
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ HPV
- ☐ Kidney stones
- ☐ Mental illness
- ☐ Migraines
- ☐ Miscarriage
- ☐ Osteoporosis
- ☐ Polycystic Ovaries
- ☐ Reflux
- ☐ Seizures
- ☐ STI
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcerative colitis

How would you rate your current health status on a scale of 1 (worst) to 10 (best)? _____

Please check the appropriate boxes for symptoms you experience <u>currently</u>:

Adrenal Stress & Endocrine:

- ☐ Low blood sugar
- ☐ High blood sugar
- ☐ Sluggish after meals
- ☐ Poor concentration
- ☐ Craving coffee or sweets
- ☐ Sleepy in the afternoon
- ☐ Slow start in the morning
- ☐ Crave salt
- ☐ Recent weight gain? How much _____
- ☐ Recent weight loss? How much _____
- ☐ How would you rate your stress level (1-low, 10-high)?_____
- ☐ How would you rate your energy level (1-low, 10-high)? _____

Cardiovascular:

- ☐ Chest paint
- ☐ Irregular heartbeat
- ☐ Dizziness or fainting
- ☐ Chest pain
- ☐ Anemia
- ☐ Easy bruising or bleeding
- ☐ Varicose veins
- ☐ Hemorrhoids
- ☐ Heart palpitations
- ☐ Cold hands & feet

Environmental Toxins:

- ☐ Sensitive to perfume or other scents
- ☐ Mercury dental fillings

Gastrointestinal:

- ☐ Ulcers
- ☐ Nausea
- ☐ Blood/mucous in stool
- ☐ Undigested food in stool
- ☐ Change in appetite
- ☐ Hernia
- ☐ Bloating
- ☐ Indigestion
- ☐ Gas
- ☐ Change in thirst
- ☐ Burping
- ☐ Chronic diarrhea
- ☐ Chronic constipation
- ☐ Bad breath
- ☐ Heartburn
- ☐ Hard stool
- ☐ Black stool
- ☐ Stomach pain

How often do you have a bowel movement?_____

Ears/Nose/Throat:

- ☐ Earaches
- ☐ Chronic migraine
- ☐ Poor sense of smell
- ☐ Hoarseness
- ☐ Enlarged thyroid
- ☐ Chronic runny nose
- ☐ Jaw pain
- ☐ Poor night vision
- ☐ Colour blindness
- ☐ Cataracts
- ☐ Chronic headache
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Recurrent sore throat
- ☐ Sores in mouth
- ☐ Itchy ear canal
- ☐ Sinus infections
- ☐ Loss of taste

Immune:

- ☐ Chronic infections
- ☐ Slow wound healing
- ☐ Frequent use of antibiotics
- ☐ Herpes
- ☐ Poor childhood immune health

Lifestyle Factors:

- ☐ Use of recreational drugs
- ☐ Current or previous smoker

How often do you exercise in a week?_____

Men's Health:

- ☐ Testicular masses
- ☐ Testicular pain
- ☐ Impotence
- ☐ Low sex drive
- ☐ Prostate issues
- ☐ Sexual difficulties

Are you sexually active ☐ Yes ☐ No

Mental & Emotional Factors:

☐ Anxiety ☐ Depression ☐ Irritability ☐ Memory problems ☐ Lack of coordination
☐ Panic attacks ☐ Mood swings ☐

Musculoskeletal & Neurological:

☐ Back pain ☐ Muscle spasms/cramps ☐ Arthritis ☐ Joint pain/stiffness ☐ Paralysis
☐ Loss of balance ☐ Tingling ☐ Vertigo

Respiratory:

☐ Difficulty breathing ☐ Chronic cough ☐ Shortness of breath ☐ Chronic bronchitis ☐ Pneumonia
☐ Wheezing ☐ Chronic phlegm ☐ Coughing blood

Sleep:

☐ Restless sleep ☐ Insomnia ☐ Sleep Apnea ☐ Wake up feeling groggy

How many hours of sleep do you get per night? _____

Skin, Hair & Nails:

☐ Rashes ☐ Eczema ☐ Loss of hair ☐ Strong body odour ☐ Excessive perspiration
☐ Psoriasis ☐ Nail changes ☐ Dandruff
☐ Brittle nails ☐ Night sweats ☐ Change in mole ☐ Dry skin ☐ Warts

Urinary:

☐ Frequent urination ☐ Urgent urination ☐ Pain on urination ☐ Incontinence ☐ Bladder infections
☐ Wake to urinate ☐ Genital sores ☐ Blood in urine ☐ Kidney infections

Women's Health:

☐ Irregular cycles ☐ Painful periods ☐ Heavy flow ☐ Blood clots ☐ Vaginal discharge
☐ Itching ☐ Pain mid-cycle ☐ Light flow ☐ Pain during intercourse ☐ Nipple discharge
☐ Vaginal dryness ☐ Sexual difficulties ☐ Breast lumps ☐ Odour ☐ Abortions ☐ Water retention
☐ Breast tenderness ☐ Cravings ☐ Menopausal symptoms ☐ Miscarriage ☐ Bleeding between periods
☐ Bloating ☐ Low sex drive ☐ Headaches
☐ Mood swings ☐ Birth control Brand_____ ☐ Low back pain

Are you sexually active ☐ Yes ☐ No

How long is your cycle (days)? _____ Date of last pap test?_____
Age of first menses?_____ Age of last menses (if applicable)?_____
Number of pregnancies?_____

Family Health History:

	Age (if alive)	Age at Death	Medical Conditions
Mother			
Her Mother			
Her Father			
Father			
His Mother			
His Father			
Siblings			