NATUROPATHIC MEDICINE INTAKE FORM

Yellow Gazebo Natural Health Care
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Date:______________________

Time:______________________

Welcome to Yellow Gazebo! The information we are requesting below will assist us in treating you safely. All of your answers will be held strictly confidential, and your written permission will be required to release any of the information. If you have any questions, please ask. Thank you, and enjoy your session!

First Name:__________________________ Last Name:____________________________________ DOB: _________

Address:______________________________________ City:_________________ Postal Code:________________

Phone:______________________ Business Phone:_______________________ Occupation:___________________

Email:____ How did you find us?______________________________

Would you like to receive our paperless, absolutely free, highly educational monthly newsletter? ◻ yes ◻ no

Have you had naturopathy before? Yes / No How often? ____

What is your primary complaint?____

Blood Type:___________________________ How do you feel at a seashore? ◻ better ◻ worse ◻ no change

Major complaints (in order of Importance to you):

Complaint	For How Long	Cause

What medications are you currently taking?

Medication	For How Long	Adverse Effects

What other treatments or regimes are you presently undergoing?

Treatment or Regime	For How Long	Results

Which of the following conditions have you had?

□ abscesses	□ depression	□ heart disease	□ mononucleosis	□ rheumatic fever	□ syphilis
□ alcoholism	□ diabetes	□ hepatitis	□ mumps	□ rubella	□ tonsillitis
□ allergies	□ emphysema	□ herpes	□ parasites	□ scarlet fever	□ tuberculosis
□ anaemia	□ epilepsy	□ influenza	□ pelvic inflammatory	□ sexual abuse	□ typhoid fever
□ arthritis	□ gallstones	□ kidney disease	disease	□ skin disease	□ venereal warts
□ asthma	□ goitre	□ leukemia	□ peritonitis	□ strep throat	□ warts
□ cancer	□ gonorrhoea	□ malaria	□ pleurisy	□ sinusitis	□ whooping cough
□ chicken pox	□ gout	□ measles	□ pneumonia	□ sunstroke	□ worms
□ cold sores	□ hay fever	□ miscarriage	□ prostatitis	□ stroke	□ yellow fever

Please list any other major conditions:____

Have you felt an incomplete recovery from any of your preceding conditions? Or have any been exceptionally severe?

Please describe:____

Primary Care Physician: ____________________ Phone: ____________________

Address: ____

What operations have you had?

Injury	When	Long Term Effects

What major injuries have you had?

Injury	When	Long Term Effects

Age of first menses: ____________________ Number of pregnancies: ____________________

What vaccinations have you had?

____

Have you had any adverse reactions to these vaccines? ____________________

Have you taken antibiotics? □ yes □ no When? ____________________ For what condition(s)?

____

Have you experienced any weight loss? □ yes □ no How many pounds? ____________________

Do you exercise? □ yes □ no Frequency: ____________________

Which of the following substances are you using?

□ tobacco	Amount: ____________	□ coffee	Amount: ____________	□ tea	Amount: __________
□ alcohol	Amount: ____________	□ recreational drugs	Amount: ____________		

Metabolic Screening Chart

Rate each of the following symptoms based on your typical health profile.

Point Scale:
0 = never or almost never have the symptom
1 = occasionally have it, effect is not severe
2 = occasionally have it, effect is severe
3 = frequently have it, effect is not severe
4 = frequently have it, effect is severe

Digestion: ___ nausea or vomiting ___ diarrhea ___ constipation ___ bloated feeling ___ belching or passing gas ___ heartburn Total: _____	Ears: ___ itchy ears ___ earaches, ear infections ___ drainage from ear ___ ringing in ears, hearing loss Total: _____
Emotions: ___ mood swings ___ anxiety, fear or nervousness ___ anger, irritability or aggressiveness ___ depression Total: _____	Energy/Activity: ___ fatigue/sluggishness ___ apathy/lethargy ___ hyperactivity ___ restlessness Total: _____
Eyes: ___ watery or itchy eyes ___ swollen, reddened or sticky eyelids ___ bags or dark circles under eyes ___ blurred or tunnel vision (not including near- or far-sightedness) Total: _____	Head: ___ headaches ___ faintness ___ dizziness ___ insomnia Total: _____

Heart: ___ irregular or skipped heartbeat ___ rapid or pounding heartbeat ___ chest pain Total: _____	Joints/Muscles: ___ pain or aching in joints ___ arthritis ___ stiffness or limitation of movement ___ pain or aching in muscles ___ feeling of weakness or tiredness Total: _____
Lungs: ___ chest congestion ___ asthma or bronchitis ___ shortness of breath ___ difficulty breathing Total: _____	Mouth/Throat: ___ chronic coughing ___ gagging, frequent need to clear throat ___ sore throat, hoarseness, loss of voice ___ swollen or discoloured tongue, gums or lips ___ canker sores Total: _____
Mind: ___ poor memory ___ confusion, poor comprehension ___ poor concentration ___ poor physical coordination ___ difficulty in making decisions ___ stuttering or stammering ___ slurred speech ___ learning disability Total: _____	Nose: ___ stuffy nose ___ sinus issues ___ hay fever ___ sneezing attacks ___ excessive mucous Total: _____

Skin: ___ acne ___ hives. rashes or dry skin ___ hair loss ___ flushing or hot flashes ___ excessive sweating Total: _____	Weight: ___ binge eating/drinking ___ craving certain foods ___ excessive weight ___ water retention ___ underweight Total: _____
Other: ___ frequent illness ___ frequent or urgent urination ___ genital itch or discharge Total: _____	**Grand Total**: __________

Consent to Treatment

This is to acknowledge that I have been informed and I understand that:

1. I am aware that any treatment or advice provided to me as a patient of the naturopathic doctor and Yellow Gazebo Natural Health Care is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare practitioner.

2. I am at liberty to seek or continue medical care from a medical doctor or other healthcare provider licensed to practice in Ontario.

3. I am aware that no part of my treatment is covered by OHIP and that I am solely responsible for payment at the time services are rendered.

4. I accept that less than 12 hours notice for cancellation will result in a fee of 100% of the treatment cost, and that 12-24 hours notice will result in 50% of the treatment fee. I will do my best to give more than 24 hours notice to change or cancel any appointment. Also, I accept that lateness on my part will result in a full charge for the requested session even if the treatment cannot be extended to my desired appointment length. The originally requested appointment length will be granted if and when the therapist is able to, and chooses to provide the extra time.

5. I understand that the naturopathic doctor reserves the right to determine which cases fall outside of their scope of practice, in which event the appropriate referral will be recommended.

6. I am not an agent of any private or governmental agency attempting to gather information without so stating my intentions.

7. While changes in dietary habits are not an absolute prerequisite for treatment, failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.

8. There are fees for completing insurance forms, letter writing, telephone consultations, and email consultations if greater than 10 minutes in length.

I hereby authorize and consent to treatment by the licensed naturopathic doctor practicing at Yellow Gazebo Natural Health Care.

Print Name: ____ Date: ____

Patient Signature ____

For Office Use Only:

I have answered any questions that the above signatory had regarding this consent and have ascertained that he/she fully understood its contents.

____

Signature of Naturopathic Doctor

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