☐**Dr. Elizabeth Cherevaty BScH, ND, R.Ac, Doula**
☐**Dr. Katie Thomson Aitken BAS, ND**

# Naturopathic & Acupuncture Intake Form (Age 14+)

## Contact Information

Name: _____Sex: _____ Age: _____ Birth Date: (dd/mm/yy)_____
Address: _____ City: _____Postal Code:_____
Phone - Home: (_____)_____ Work: (_____)_____Ext:____ Cell: (_____)_____
Okay to leave a message? No / Yes (which number?)_____ Email: _____
May we email you regarding appointments and information that may be useful to you? Y / N
Occupation:_____Employer:_____
How did you find us?_____

Emergency contact: _____ Relationship: _____Phone:(___)_____

Family Physician:_____Phone: (_____)_____ Fax: (_____)_____
Address: _____Date of last visit:_____Blood work done?_____
Findings of concern?_____
Do you receive an annual physical exam? No / Yes, from: _____
Specialist Physician(s) and city: _____

## Health History

**What is your <u>main</u> reason for coming in today?**
1._____
_____
_____Date of onset:_____
**What treatments are you currently trying/have you tried and what were the results?**
_____
_____
_____
_____

**Please list in order of importance any other health concerns that are troubling you:**
2. _____ Date of onset:_____
_____
3. _____ Date of onset:_____
_____
4._____ Date of onset:_____
_____
5._____ Date of onset:_____
_____

**MEDICAL HISTORY:**

The general state of your health is currently: excellent / good / fair / poor

What is your current level of energy from 1 to 10 (10 being the best you have ever felt)?_____

Your Height:_____ Weight (approx): _____ Wt. one year ago?_____ Highest Wt.? _____
Lowest Wt.? _____ Ideal healthy wt.?_____ When were you last at your ideal Wt.? _____
Allergies:_____
Sensitivities:_____
Hospitalizations; surgeries; major injuries (please include dates): _____
_____
_____
_____
_____

Were you vaccinated as a child? Yes / No Any adverse reaction? _____

Please indicate your history of use of the following (how much, how often, and for how long?):
Alcohol_____Tobacco_____
Hormones_____ Coffee _____
Tea_____ Pain killers _____
Cortisone/steroids _____ Laxatives _____
Sedatives _____ Antacids _____
Recreational drugs (please list) _____

What do you think is your weakest organ system and why?_____
What do you think is your strongest organ system and why?_____
How is your body temperature compared to others? Warmer / Cooler / Average
How does weather affect you, if at all? _____
How often do you get colds, sore throats or flus during a year?_____

**Please outline the 5 most significant stressful events in your life:**

1._____
_____Date:_____

2._____
_____Date:_____

3._____
_____Date:_____

4._____
_____Date:_____

5._____
_____Date:_____

Are any of the above situations continuing to affect your life? No / Yes (please circle numbers)

Are you working or have you worked with a professional counselor, psychologist, social worker, energy healer, pastor or other therapist? No /Yes, with: _____

**Which over-the-counter, prescription and/or natural health products do you use?**

| **Taking CURRENTLY:** | **Dose:** | **Reason for Use:** | **Dates of Use:** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
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| **Taken in the PAST:** | **Dose:** | **Reason for Use:** | **Dates of Use:** |
|---|---|---|---|
| | | | |
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| | | | |

**FAMILY HISTORY**

| **Relative:** | **Age if Living:** | **Health Conditions:** | **Age at Death:** | **Cause of Death:** |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Sister(s) | | | | |
| | | | | |
| | | | | |
| Brother(s) | | | | |
| | | | | |
| | | | | |
| Maternal Grandmother | | | | |
| Maternal Grandfather | | | | |
| Paternal Grandmother | | | | |
| Paternal Grandfather | | | | |
| Other blood relatives with notable health history (e.g. cancer, heart disease, stroke, mental illness, etc.): | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Please indicate which of the following conditions you have NOW or have had in the PAST:**

| Condition | Now | Past | Condition | Now | Past | Condition | Now | Past | Condition | Now | Past |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Allergies | | | Strep throat | | | Tonsillitis | | | Poor memory | | |
| Anemia | | | Measles | | | Whooping cough | | | Ringing in ears | | |
| Asthma | | | Mumps | | | Canker sores | | | Balance problems | | |
| Arthritis | | | Rubella | | | Herpes | | | Speech problems | | |
| Eczema | | | Chicken pox | | | Gout | | | Hepatitis | | |
| Ear infections | | | Diphtheria | | | Gall stones | | | Jaundice | | |
| Psoriasis | | | Scarlet fever | | | Kidney stones | | | Epilepsy | | |
| Hayfever | | | Rheumatic fever | | | Fainting | | | Diabetes | | |
| Sinusitis | | | Small pox | | | Addiction | | | Alcoholism | | |
| Acne | | | Polio | | | Thyroid problem | | | High blood pressure | | |
| Pneumonia | | | Yeast infections | | | Cancer | | | Stroke | | |
| Bronchitis | | | Gas/ Bloating | | | Migraine | | | Heart disease | | |
| Tuberculosis | | | Hemorrhoids | | | Headaches | | | Heart attack | | |
| Malaria | | | Rectal bleeding | | | Infertility | | | Varicose veins | | |
| Mono | | | Parasites | | | Venereal disease | | | Gonorrhea | | |
| Warts | | | Broken bones | | | Numbness/ tingling | | | Syphilis | | |
| Miscarriage | | | Blackouts | | | Visual problems | | | Cold hands/feet | | |
| Depression | | | Anxiety | | | Physical abuse | | | Emotional abuse | | |
| Child abuse | | | Sexual abuse | | | Rape | | | Other: | | |

Is there any condition or event in your life from which you feel you have been **never well since?**_____

**SLEEP:**

On a scale of 1 to 10 (ten being the best) how would you rate the quality of your sleep?_____
Do you have difficulty falling asleep? Yes / No Staying asleep? Yes / No How much do you sleep?_____hrs
How many hours of sleep do you feel you need?_____hrs Do you wake refreshed?_____
Do you nap or rest horizontally during the day? Yes / No For how long?_____

Please circle any of the following that occur during your sleep: snoring / sleepwalking / talking / laughing / shouting / moaning / grinding or clenching teeth / twitching or jerking / sweating / other:

**DIGESTIVE:**

Number of bowel movements per day: _____
Foods that you do not digest well: _____
How frequently do you experience:
Abdominal discomfort_____ Abdominal cramps _____
Heartburn_____ Indigestion _____ Burping _____
Flatulence_____ Nausea _____ Vomiting _____
Painful stool _____ Difficulty passing stool _____ Loose stool/diarrhea _____
Pale stool _____ Blood in stool _____ Black/tarry stool _____

**FEMALE:**

Age of first period _____ If periods have stopped, at what age did they stop?_____
Are your cycles regular? Yes / No # of days of bleeding _____ Total # of days of cycle _____
# light / regular / super tampons / pads / Diva cup used per day? _____

| **Menstrual Symptom** | **Day of Cycle?** | **Comments** |
|---|---|---|
| **Menstrual flow:** | | |
| ☐Bright red | | |
| ☐Red | | |
| ☐Dark red | | |
| ☐Brown | | |
| ☐Black | | |
| ☐Pink/pale | | |
| ☐Light flow | | |
| ☐Heavy flow/flooding | | |
| ☐Spotting | | |
| ☐Interrupted (flow stops then resumes) | | |
| ☐ Clots | | |
| ☐**Menstrual cramps:** | | |
| Location of cramps: | | |
| **PMS symptoms:** | | |
| Bloating | | |
| Breast tenderness | | |
| Irritability/impatience/anger | | |
| Weepiness/crying | | |
| Fatigue | | |
| Acne | | |
| Depression | | |
| Anxiety | | |
| Headaches | | |
| Cravings | | |
| Mood swings | | |
| Other: | | |

Gynecological surgeries & dates:_____
Number of pregnancies:_____ Number of abortions: _____ Number of miscarriages: _____

Number of live births: _____ Difficulty becoming pregnant?_____
Do you receive regular PAP tests? Yes/ No Any abnormal PAPs? Yes / No If yes, when?_____
Do you have any sores on your vulva or vagina? Yes / No _____
Have you observed any abnormal vaginal discharge? Yes / No _____
History of sexually transmitted illness: Yes / No_____

**MALE:**

How often do you get up during the night to urinate?_____ Has this increased recently? Yes / No
Difficulty achieving or maintaining an erection? Yes / No _____
Do you have any sores on your penis or scrotum? Yes / No _____
Have you observed any abnormal discharge from the penis? Yes / No _____
History of sexually transmitted illness: Yes / No_____
Date of last prostate exam?_____ Any prostate problems? Yes / No _____

**REPRODUCTIVE:**

Are you sexually active? Yes / No Number of current partners: _____
Sexual orientation: Heterosexual _____ Bisexual _____ Homosexual _____
Method of contraception, if any: _____
Method of sexually transmitted illness protection, if any: _____

**SOCIAL HISTORY & PERSONAL HABITS:**

Marital Status: Sgl Mar Div Sep CL Widowed Number of children: _____
Are you currently in a happy and supportive relationship? very / mostly / somewhat / not
You currently live with? alone / spouse / partner / roommate(s) / parent(s) / child(ren)
How would you describe the emotional climate in your home? _____
Your general daily stress level (0=no stress, 10=maximum stress): _____
Stress level in the home: _____ Stress level at work/school:_____
How do you handle stress? _____
How do you express your emotions? _____
Who/what are your sources of support? _____
How would you describe your personality or temperament? _____
_____
What do you enjoy most in your life?_____
What do you worry about most in your life?_____
What nurtures you?_____
What are your main interests and hobbies?_____
_____
Do you enjoy your work? Yes / No Do you take regular vacations? Yes / No
Describe your exercise habits? _____
_____
What is your learning style? Visual / Audial / Reading / Experiential/Kinesthetic or Physical / Other:
Do you have a religious or spiritual practice? Yes / No _____
Do you have regular relaxation practice? Yes / No _____
Any other questions or concerns you would like me to be aware of? _____
_____
_____

**HEALTH GOALS:**

Please outline your goals in working with me as your Naturopathic Doctor, and note the dates or timelines that you have in mind for your goals:

**Goals:** **Timeline for Goals:**

-_____
-_____
-_____
-_____
-_____

What is your level of commitment to these goals?_____

Are there any obstacles to you reaching these goals? _____

_____

*Thank you for taking the time to complete this detailed questionnaire. This information is kept confidential and will be a valuable resource for us as we work together to create an individualized plan for optimizing your short- and long-term health as a whole person – including the physical, mental and emotional. Looking forward to meeting with you in the near future!*

**Sincerely,**

**Dr. Elizabeth J. Cherevaty BScH, ND, RAc, Doula**
**Dr. Katie Thomson Aitken BAS, ND**
www.guelphnaturopathic.ca

# INFORMED CONSENT TO TREATMENT

Please note that this form must be signed in our office prior to the rendering of any treatment or service. At any time during the course of your naturopathic care or acupuncture, you may discuss with your Naturopathic Doctor (ND)/Registered Acupuncturist (RAc) any questions or concerns that you may have regarding your treatment.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors are regulated primary health care providers who assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. The gentlest and most non-invasive techniques available are generally used in order to stimulate the body's inherent healing capacity and achieve health care goals. Acupuncture is the assessment, diagnosis and treatment of health concerns using the principles of Traditional Chinese Medicine and acupuncture points selected on the basis of the individual's condition and symptoms. Acupuncture may be performed by a Naturopathic Doctor or Registered Acupuncturist.

Your practitioner will take a thorough case history, perform a relevant physical examination and may order blood or urine testing. If required, the physical exam may include more specific examinations such as gynecological, breast, rectal, or genital exam.

It is very important that you inform your Naturopathic Doctor/Acupuncturist immediately of any illness from which you or your child are/is suffering and any medications or over-the-counter drugs that you or your child are/is taking. As a patient, or parent of your child who is a patient, you will receive information about diagnosis and/or treatment, alternative courses of action, expected benefits, risks, side effects, costs, and the consequences of not having the diagnosis and/or treatment acted upon.

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

Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short and temporary.

Some individuals may experience allergic reactions to supplements and herbs. Please advise your ND of any known or suspected allergies.

Acupuncture treatment may be associated with pain, bruising around the insertion site; fainting; or puncturing of an organ with acupuncture needles. Your ND/RAc is trained to handle emergencies should the need arise.

**I, (print name)_____, confirm that I have read, understood and agree:**

-That treatment results cannot be guaranteed.

-That I am free to withdraw my consent in full or in part, and to discontinue treatment at any time.

-That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.

-That I have read and understood the Fee Schedule and Cancellation Policy outlined in the "Information for New Patients" document (available at: www.guelphnaturopathic.ca) and I agree take responsibility for the fees incurred in treatment.

_____ _____

**Patient Signature** **Date**

# PRIVACY POLICY

Privacy of personal information is important at Norfolk Chiropractic Wellness Centre/Two Rivers (hereafter: "the clinic"). In providing you with quality naturopathic care and acupuncture, we are committed to the responsible collection, use and disclosure of your personal information in accordance with current regulations (*Personal Health Information Protection Act* (PHIPA), Ontario 2004). In this office, Elizabeth Cherevaty ND, RAc acts as the health information Custodian and is the contact person regarding your personal health information.

Your personal information will be collected and used for the following purposes:

- ✓To assess your health concerns
- ✓To provide health care
- ✓To advise you of treatment options
- ✓To establish and maintain contact with you
- ✓To send you newsletters and other information mailings
- ✓To remind you of upcoming appointments
- ✓To communicate with other treating healthcare providers
- ✓To allow us to efficiently follow-up for treatment, care and billing
- ✓To complete claims for insurance purposes
- ✓To invoice for goods and services
- ✓To process credit card payments
- ✓To collect unpaid accounts
- ✓Disclosure: to comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others
- ✓To use for educational and research purposes (this includes case summaries, photographs, lab results and other pertinent medical information).

Your identity will be protected at all times and, where required, identifying information will be altered to protect your privacy in all the above instances. In the event that your file with us becomes inactive, your personal information will be retained securely for a period of 10 years after your last visit, at which time it will be destroyed.

By signing this Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

**CONSENT TO COLLECTION AND USE OF PERSONAL INFORMATION:**

**I, (print name)_____,** have reviewed the above information and agree that my practitioner and the clinic can collect, use and disclose my personal information for the purposes outlined in this privacy policy, as described above.

_____ _____

**Patient Signature** **Date**