ROOTS TO HEALTH
NATUROPATHIC CLINIC

Dr. Chris Ford and Dr. Darcie Pawlick – Naturopathic Physicians

Although this form may seem long, please note that completion of each section of this intake form is optional, however, it is beneficial for us to have a full history in order to gain a better understanding of your health and how it may be affected by all aspects of your life. All answers are fully confidential. If you have any questions please mark them with a question mark. Thank you.

Name _____ **Date** _____

Date of birth _____ (M/D/Y) **Age**_____ **Gender**_____

Address_____

City_____ **Prov./State**_____ **Postal/Zip Code**_____

E-mail Address _____

Home Telephone Number _____ **Alternate** _____

May we leave messages relating to your visits? Yes____ / No____

Which Phone Number?_____

Occupation_____ **Hours/week**_____

Married____ Separated____ Divorced____ Widowed____ Single____ Partnership____

Live with: Spouse____ Partner____ Parents____ Children____ Friends____ Alone____

Names of Other Healthcare Providers: M.D. _____

Naturopaths_____ **Chiropractors**_____

Others_____

Emergency contact: Name _____

Phone number _____ **Relation**_____

How did you hear about our Clinic? Please check one of the following:

Media (Newspaper, radio) ____
Health/Wellness Event____
Website____

Clinic patient____
Other _____

Referred by_____

Please list your health concerns, in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

<u>Medical History</u> (Indicate dates when possible)

Please describe your general state of health? Excellent___ Good___ Fair___ Poor___

Childhood illnesses: Measles_____ Mumps_____ Rubella_____ Chicken pox_____
Rheumatic fever_____ Diphtheria_____ Other_____
Surgeries/Hospitalizations_____

_____

Diagnostic Testing (X-ray, CAT Scan, MRI, EEG, EKG, Ultrasound)_____

_____

Significant physical trauma (car accidents, falls, injuries, broken bones, etc.)

_____

_____

Significant emotional trauma (divorce, death of a loved one, loss of a job, etc.)

_____

_____

<u>Conditions</u>: High Blood Pressure_____ Heart Disease_____ High Cholesterol_____
Diabetes_____ Seizures_____ Thyroid Disease_____ Cancer_____ Hepatitis_____
Venereal Disease_____
<u>Immunizations</u>: Polio_____ Tetanus_____ Measles/Mumps/Rubella_____ Pertussis_____
Diphtheria_____ Meningitis_____ Hepatitis_____ Smallpox_____ Other_____
Have any major events impacted your life? If so, how?_____

_____

_____

<u>Family History</u> (Please indicate if on father's (F) or mother's (M) side of family)

Cancer___ Diabetes___ Heart Disease___ High Blood Pressure___ High Cholesterol___
Stroke___ Seizures___ Asthma___ Allergies___ Anemia___ Kidney Disease___
Tuberculosis___ Depression___ Schizophrenia___ Dementia___ Arthritis___
Alcoholism/Drug Use___ Autoimmune Disease___ Suicide___ Other_____

Current History

Height_____ Weight_____ 1 year ago_____ Allergies (food, drugs)_____

_____

Exercise (Type and Hours/Week)_____

_____

Hobbies_____

Occupational Stress (chemical, physical, psychological)_____

_____

Do you get regular screening tests done? (pap, blood tests, etc.)? Yes____ No____

If you are female are you currently pregnant? Yes____ No____

Sleep (Hours/Night)____ Quality_____ Wake rested?_____

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Coffee/Black Tea/Energy Drinks—amount/day_____

Recreational drugs—what and how often _____

Soft drinks/Juice—amount/day_____

Typical daily food intake (Please specify amounts):

Breakfast _____

Lunch _____

Dinner _____

Snacks_____

Water/Herbal Tea _____

Dietary Restrictions_____

Medications

Current medications (prescription, over-the-counter, etc.) - if more than five please list at bottom of intake form in the space given for the last question and/or bring with you for initial consult

Name	Dose	Date Prescribed	Reason

Supplements (Vitamins, minerals, herbs, etc.)

Name	Dose	Date Prescribed	Reason

Do you frequently use any of the following?

Aspirin___ / Tylenol___ / Laxatives___ / Antacids___ / Diet pills___ / Birth control___

<u>Review of Systems</u>: Please check if you have experienced any of the following symptoms now (N) or in the past (P).

<u>General</u>

Poor sleep____ **Night sweats____** **Sudden energy drop____**
Poor appetite____ **Sweat easily____** **Peculiar tastes/smells____**
Chills____ **Strong thirst____** **Fatigue____**
Fevers____ **Weight gain____** **Change in appetite____**
Cravings____ **Weight loss____**

<u>Neuropsychological</u>

Depression____ **Anxiety/nervousness____** **Tension____**
Mood swings____ **Loss of balance____** **Quick temper____**
Poor memory____ **Dizziness____** **Concussion____**
Seizures____ **Numbness/tingling____** **Considered suicide____**
Lack of co-ordination____

<u>Endocrine</u>

Hypothyroid____ **Hypoglycemia____** **Excess thirst____**
Heat/cold intolerance____ **Diabetes____** **Excess hunger____**
Seasonal depression____

<u>Immune</u>

Chronic Fatigue Syndrome____ **Swollen glands____** **Chronic infections____**
Slow wound healing____ **Muscle weakness____** **Frequent colds/flus____**

Skin and Hair

Rashes ____ **Itching____** **Eczema/hives____**
Acne____ **Colour change____** **Lumps____**
Hair loss____ **Dandruff____** **Changing moles____**
Ulcerations____

Musculoskeletal

Joint pain/stiffness____ **Broken bones____** **Arthritis____**
Muscle cramps/spasm____ **Weakness____** **Sciatica____**
Neck pain____ **Back pain____** **Hand/wrist pain____**
Shoulder pain____ **Knee pain____** **Hip pain____**
Foot/ankle pain____

Head/Eyes/Ears/Nose/Throat

Headaches____ **Head/Neck problems____** **Migraines____**
Head injuries____ **Spots in vision____** **Blurry vision____**
Glasses/contacts____ **Double vision____** **Cataracts____**
Night blindness____ **Tearing/dryness____** **Eye pain____**
Colour blindness____ **Earaches____** **Poor hearing____**
Glaucoma____ **Stuffiness____** **Sinus problems____**
Ringing in ears____ **Loss of smell____** **Chronic sore throat____**
Nose bleeds____ **Gum problems____** **Dental cavities____**
Teeth grinding____ **Facial pain____** **Lumps____**
Goiter____ **Swollen glands____** **Pain/stiff neck____**
Jaw/TMJ problems____

Respiratory

Cough____ **Difficult breathing____** **Bronchitis____**
Asthma____ **Pneumonia____** **Coughing of blood____**
Emphysema____ **Pain on breathing____** **Phlegm (colour) ____**
Wheezing____ **Shortness of breath____**

Cardiovascular

High/low blood pressure____ **Heart disease____** **Blood clots____**
Fainting____ **Irregular heart beat____** **Dizziness____**
Swollen feet____ **Rheumatic fever____** **Angina____**
Murmurs____ **Cold hands/feet____** **Chest pain____**
Palpitations____

Peripheral Vascular

Anemia____ **Deep leg/calf pain____** **Varicose Veins____**
Bleed/bruise easily____ **Cold hands/feet____**

Gastrointestinal

Indigestion____	Gas____	Bad breath____
Constipation____	Abdominal pain/cramps____	Nausea____
Vomiting____	Chronic laxative use____	Rectal pain____
Hemorrhoids____	Blood in stool____	Diarrhea____
Difficulty swallowing____	Black stools____	Jaundice (yellow skin) ____
Liver disease____	Heartburn____	Change in appetite____
Gall bladder disease____	Ulcer____	

Genito-Urinary

Frequent urination____	Unable to hold urine____	Pain on urination____
Wake to urinate____	Blood in urine____	Decrease in flow____
	Kidney stones____	Urgency to urinate____

Male Only

Hernias____	Testicular pain____	Herpes____
Impotency____	Premature ejaculation____	Testicular mass____
Prostate disease____	Discharge____	
STI____		

Female Only

Age of first menses____	Duration of menses____	Length of cycle_____
Menstrual cramps____	Heavy menses____	Light menses____
Irregular periods____	Vaginal discharge____	Vaginal sores____
Endometriosis____	Ovarian cysts____	Cervical dysplasia____
Sexual difficulties____		Herpes____
STI____		Birth control____
Bleeding between cycles____		
PMS____	If so, what symptoms? _____	
Number of pregnancies____	Number of live births____	Miscarriages____
Number of abortions____	Abnormal PAP____	
Menopausal symptoms____	If so, what symptoms_____	
Breast lumps____	Nipple discharge____	

General Questions

Why did you choose to come to our clinic?_____
_____

What do you know about our approach to healthcare?_____
_____

What are three expectations that you have from this visit to our clinic?

1. _____
2. _____
3. _____

What long term expectations do you have from working with us?_____
_____

What expectations do you have of me personally as your physician?_____
_____

What is your current level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Please rate for 1-10 with 10 being most committed)

1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___

What behaviours or lifestyle habits do you currently engage in that you believe are beneficial to your health?_____
_____

What behaviours or lifestyle habits do you currently engage in that you believe have a negative impact on your health?_____
_____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in following the treatment plans which we will be sharing with you?_____
_____

Who do you know that will sincerely support you with the beneficial lifestyle changes that you will be making?_____
_____

What do you love to do most?_____

Is there anything that you feel we have missed that is important to you?_____
_____
_____
_____
_____

All fees for services and supplements are the responsibility of the patient, payable in full at the end of the appointment. Payment can be made in the form of cash, personal cheque, Interac or credit card. Please note that MSP *does not cover Naturopathic services (except those on Premium Assistance at a rate of $23 per visit).* Many extended health care plans cover Naturopathic medical services; please check the specifics of your plan. You will be supplied with the necessary receipts to submit to your insurance company.

Important – Cancellation Policy

If you need to cancel or reschedule your appointment, 24 HOURS NOTICE *by phone* is required or there will be a cancellation fee incurred. This fee is equivalent to the cost of the appointment missed. This helps cover clinic operation costs and avoids the need to increase consultation fees.

Read and understood by:

Signature: _____ **Date:** _____