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OPTIMAL HEALTH NATUROPATHIC & WELLNESS CLINIC
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Patient Intake Form

Full Name:_____ Date: _____
(First) (Middle) (Last)

Date Of Birth:_____ Age:_____ Gender: _____ Marital Status: _____
(dd/mm/yy)

Address: _____ City: _____
Street No. Street Name Apt. No.

Postal Code: _____ Tel (Home): _____ (Work/Mobile): _____

Fax No. _____ Email: _____ Occupation: _____

Extended Healthcare Insurance Company (if applicable): _____

Emergency Contact (name and phone number): _____

Relationship to patient: _____

How did you find out about the naturopathic services at this clinic? _____

Last physician or health care practitioner seen and when? _____

When was your last blood test and what was it for? _____

Blood Type: _____

What are your chief health concerns? (in order of importance)_____

_____

_____

_____

General State of health: ☐ *poor* ☐ *fair* ☐ *good* ☐ *very good* ☐ *excellent*

Indicate which of the following you have or may have had:

☐ abscess	☐ digestive ailments	☐ leukemia	☐ rubella
☐ abortion	☐ eczema	☐ lung afflictions	☐ sexual abuse
☐ alcoholism	☐ epilepsy/seizures	☐ malaria	☐ skin diseases
☐ anemia	☐ frequent colds	☐ mental illness	☐ sinusitis
☐ anxiety	☐ gallstones	☐ miscarriage	☐ stroke
☐ arthritis	☐ genital herpes	☐ mononucleosis	☐ strep throat
☐ asthma	☐ gonorrhea	☐ parasites	☐ syphilis
☐ blood pressure problems	☐ gout	☐ peritonitis	☐ thyroid disease
☐ cancer	☐ hayfever	☐ PMS	☐ tonsillitis
☐ cholesterol (high)	☐ heart disease	☐ pneumonia	☐ tuberculosis
☐ cold sores	☐ hepatitis	☐ prostatitis	☐ venereal warts
☐ depression	☐ HIV/AIDS	☐ rheumatic fever	☐ warts
☐ diabetes	☐ kidney disease	☐ rubella	☐ yellow fever

Others: _____

Accidents, Injuries, and Hospitalizations (including type and year of occurrence): _____

_____

_____

Please list any known allergies (including: food, drugs, herbs, supplements, environmental, chemical, etc.)

_____

_____

Do you use any of the following? If yes, please state amount, frequency and duration of use:

□ alcohol _____

□ tobacco _____

□ caffeine _____

Are you currently working with a Doctor of conventional medicine (MD)? □ YES □ NO

Please list any medical treatments you are undergoing and/or any medications you are currently using (if applicable), including dosage and duration of use:_____

_____

_____

Please indicate if you have worked or are currently working with other practitioners. If in the past, please state when and duration of treatment _____

_____

_____

_____

Screening tests (include year of test and results): _____

Immunizations (including date): _____

_____

_____

Please indicate whether you have been or are exposed to:

□ Tobacco Smoke □ Chemicals □ Recreational Drugs □ Excess Stress

What do you feel is your weakest organ system and why? _____

Family Health History: Please list any health conditions that have afflicted any members of your family (i.e. parents, siblings, children, grandparents, etc.) _____

_____

Please list age and health or age and cause of death of:

Mother _____ Father _____

Maternal grandmother _____ Maternal grandfather _____

Paternal grandmother _____ Paternal grandfather _____

Children _____

Siblings _____

Please describe your family/work relationships: _____

_____

CONTEXT OF CARE OVERVIEW

1. a) Why did you choose to come to this clinic?

b) What do you know about our approach?

2. What three expectations do you have from this visit to our clinic?

3. a) What long-term expectations do you have from working with our clinic?

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

4. 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, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

5. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

6. 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?

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

8. What do you LOVE to do?

Thank you for taking the time to fill out this form

Statement of Acknowledgement and Informed Consent to Treatment

N.B. This form must be completed before any treatment will be rendered.

Naturopathic medicine is personalized, complete, and co-ordinated system of healthcare which utilizes natural therapies and gentle techniques in order to empower an individual to achieve optimal health and well-being.

In order to clarify my position as your health care practitioner, as well as to establish our mutual responsibilities in your health care, I ask for you co-operation in signing this statement of acknowledgement and informed consent. In doing so, you understand that:

1. Any treatment prescribed or recommended to you is not mutually exclusive from any treatment or advice that you are now receiving or that you may receive in the future from another licensed health care practitioner.

2. Treatment and or/referral to other health care practitioners is based on the assessment of your health as determined by: personal history, physical examination, laboratory testing and other appropriate methods of evaluation. You are at liberty to seek or continue medical care from a doctor of conventional medicine (M.D.) or any other licensed healthcare practitioner in Ontario.

3. I reserve the right to determine which cases fall outside my scope of practice, in which case an appropriate referral will be recommended.

4. While the treatment prescribed or recommended to you, including, but not limited to, changes in dietary habits, lifestyle changes, and exercise programs are not mandatory, failure to follow sound nutritional advice and lifestyle modification programs will hinder expected positive results.

5. You are accepting or rejecting this care of your own free will

6. The ultimate responsibility for your health care is your own and that I am here to guide you in your journey towards better health. I reserve the right to discontinue treatment, should it be apparent that your expectations and what I can provide are not in agreement.

7. You understand that all fees for services and supplements are payable at the time of the appointment by the patient or guardian. As well, notice of **24 hours is required for appointment cancellation, otherwise, the full fee will be charged.**

I, _____, have read, understood, and acknowledge the above statements.
(please print)

Signature: _____ Date: _____