BROADWAY WELLNESS

Dr. Krista Moyer, Naturopathic Doctor
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ADULT INTAKE FORM

General Information

Name: ______________________________________ Date: __________________________ MSP#: _____________
Address: ______________________________ City, Province: ___________________ Postal Code: ______________
DOB: DD/MM/YY _______________________ Telephone (Primary): ______________________________________
Email: ____ (optional)
Occupation: ________________________________ Marital Status: _____________________________________
Emergency Contact and telephone #: _____________________________________ Relation: ________________
How did you hear about Dr. Moyer at Broadway Wellness? ____

Please list all other current health care providers:
____
____
____

Health Overview

Please list in order of importance your primary health concerns:
1. ____ 4. ____
2. ____ 5. ____
3. ____ 6. ____

Are you currently taking any prescription or non-prescription drugs? Yes / No

Name:	Reason:	Dosage:	Date Started:

Are you currently taking any nutritional supplements? Yes / No

Name:	Reason:	Dosage:	Date Started:

Height: ___________ Present weight: ____________ Weight 1 year ago: __________ Ideal weight: ___________

Medical History

Do you have any ALLERGIES or sensitivities? (include medications, environmental, foods, chemicals, etc)

Allergen:	Reaction:

Please list all Hospitalizations, Surgeries, Accidents, and Major illnesses (include year):

____
____
____
____

How many times have you been treated with antibiotics? ______________________________
When was the last time you had blood work? ______________________________________

Please indicate Yes (Y), No (N) or Past (P) for each of the following:

Slow wound healing	Y N P	Skin colour change	Y N P	Itching	Y N P
Rashes	Y N P	Acne	Y N P	Easy bruising	Y N P
Eczema / Psoriasis	Y N P	Skin Cancer	Y N P	Dry skin	Y N P
Headache	Y N P	Head injury	Y N P	Hearing Loss	Y N P
Ear infections	Y N P	Excessive hair loss	Y N P	Ringing in ears	Y N P
Jaw / TMJ problems	Y N P	Loss of hearing	Y N P	Earaches	Y N P
Muscle weakness	Y N P	Muscle cramps	Y N P	Joint pain / stiffness	Y N P
Muscle tremors	Y N P	Muscle pain	Y N P	Abnormal lumps	Y N P
Muscle paralysis	Y N P	Sciatica	Y N P	Seizures	Y N P
Numbness / tingling:	Y N P	Fainting	Y N P	Carpal tunnel syndrome	Y N P
Dry eyes	Y N P	Blurry vision	Y N P	Glaucoma	Y N P
Spots in eyes	Y N P	Eye pain or strain	Y N P	Cataracts	Y N P
Watery eyes	Y N P	Eye discharge	Y N P	Glasses or contacts	Y N P
Double vision	Y N P	Styes	Y N P		
Frequent colds	Y N P	Frequent nosebleeds	Y N P	Nasal polyps	Y N P
Swollen glands	Y N P	Seasonal allergies / Hayfever	Y N P	Nasal congestion / stuffiness	Y N P

Oral canker sores	Y N P	Cold Sore	Y N P	Dentures	Y N P
Frequent sore throat	Y N P	Gum disease	Y N P	Dental caries	Y N P

Frequent cough	Y N P	Painful breathing	Y N P	Pneumonia	Y N P
Recurrent bronchitis	Y N P	Asthma	Y N P	Shortness of breath	Y N P
Spitting up blood	Y N P	Difficulty breathing when lying down	Y N P	Cold hands / feet	Y N P

High Blood Pressure	Y N P	Rheumatic Fever	Y N P	Edema	Y N P
Low Blood Pressure	Y N P	Heart Murmurs	Y N P	Angina / Chest pain	Y N P
Heart Arrhythmias	Y N P	Heart Palpitations	Y N P	Phlebitis	Y N P

Heartburn	Y N P	Diarrhea	Y N P	Changes in appetite	Y N P
Excessive Gas	Y N P	Constipation	Y N P	Peptic ulcer	Y N P
Bloating	Y N P	Hemorrhoids	Y N P	Nausea or vomiting	Y N P
Pancreatitis	Y N P	Gall stones	Y N P	Liver disease	Y N P
# of daily bowel movements:	______	Blood / Mucous in stool	Y N P	Undigested food in stool	Y N P

Urinary incontinence	Y N P	Pain with urination	Y N P	Frequency at night	Y N P
Urinary tract Infections	Y N P	Kidney stones	Y N P	Urinary discharge or blood	Y N P

Depression	Y N P	Highly stressed	Y N P	Insomnia	Y N P
Anxiety	Y N P	Mood swings	Y N P	Poor memory	Y N P

Dizzy when stand quickly	Y N P	Crave breads & sugars	Y N P	Motion sickness	Y N P
Shaky if miss meals	Y N P	Mental fogginess	Y N P	Worse eating fatty food	Y N P
Excessive thirst	Y N P	Yeast infections	Y N P	Headache over forehead	Y N P

Abnormal pap smear	Y N P	Heavy menstrual flow	Y N P	Light menstrual flow	Y N P
Bleeding between cycles	Y N P	Long menstrual cycle	Y N P	Short menstrual cycle	Y N P
Clots during cycle	Y N P	Discharge	Y N P	Cravings before menses	Y N P
Menstrual cramps	Y N P	Moody before menses	Y N P	Depressed before menses	Y N P
Water retention before menses	Y N P	Tender breasts before menses	Y N P	Anemia	Y N P
Regular cycle	Y N P	Irregular or no cycle	Y N P	History of breast cancer	Y N P
Length of cycle (ie 28 d)	________	Duration of Menses:	________		
Age of first period:	________	Number of pregnancies:	________		
Age at menopause:	________	Number of births:	________		

Birth control method: ____

Other menstrual symptoms: ____

Please indicate with Yes (Y) or No (N) if YOU have been diagnosed with any of the following conditions:

Diabetes	Y N	Cancer	Y N	Parasites	Y N	AIDS	Y N	Phlebitis	Y N
Arthritis	Y N	Colitis	Y N	MS	Y N	Pneumonia	Y N	Epilepsy	Y N
Stroke	Y N	Jaundice	Y N	Polio	Y N	Varicosities	Y N		
Heart problems	Y N	Thyroid disease	Y N	Chronic bronchitis	Y N	Bleeding tendency	Y N	Clotting disease	Y N
Eating disorder	Y N	Auto-immune disease	Y N	Chronic fatigue syndrome	Y N	High blood pressure	Y N	Dental abscess	Y N

Childhood illnesses (check all that apply):

Chicken Pox	Y N	Mumps	Y N	Measles	Y N	Rubella	Y N
Diphtheria	Y N	Scarlet Fever	Y N	Others: ______________________			

Immunization History (check all that apply):

Tetanus	Y N	Pertussis	Y N	Diphteria	Y N	Flu shot	Y N
Hepatitis A	Y N	Hepatitis B	Y N	Polio	Y N		
Measles / Mumps / Rubella			Y N	Others: ______________________			

Family History

	Mother	Father	Siblings	Grandparents	Children	Spouse
Age, if living						
Age at death						
Cause of Death						
Check all that apply:						
Glaucoma						
High Blood Pressure						
Asthma						
HIV/AIDS						
Tuberculosis						
Cancer (list type)						
Epilepsy						
Stroke						
Heart Disease						
Allergies						
Thyroid Problems						
Obesity						
Osteoporosis						
Other (pleast list)						

Diet and Lifestyle

Please list the foods you consume most often:
Breakfast: ______________________________
Lunch: ______________________________
Dinner: ______________________________
Snacks/Treats: ______________________________

Please list any foods you currently avoid consuming: ______________________________
Please list any common food cravings: ______________________________

Average Daily Water Intake (mL or L): ______________

Please indicate how often you partake in the following (Often, Sometimes, Rarely, Never):

Coffee	________	Added Salt	________	Pain Relievers	________
Alcohol	________	Pop	________	Laxatives	________
Cigarettes	________	Sugar	________	Sleeping Pills	________
Marijuana	________	Tea - black	________	Antacids	________
Steroids	________	Artificial Sweeteners	________	Appetite Suppressants	________

Other drugs: ______________________________

How often do you exercise per week? ________ Length of exercise? ________
Types of exercise? ______________________________

What is the average **time** you go to bed & average **# of hours** you sleep per night? ______________
Difficulty falling asleep? ________ Staying asleep? ________
Do you wake feeling rested? ______________________________

Rate your: Stress level? ________ Energy level? ________ (1-10 with 10 being the highest)
Do you feel you are able to appropriately manage your stress levels? Yes / No / Sometimes
Do you have any hobbies or interests you partake in? ______________________________

Context of Care

In receiving Naturopathic care what expectations do you have **short-term** and **long-term**?
____
____
____

What is your current level of commitment to addressing your health issues?
- ☐ I am willing to make any changes and do whatever is necessary
- ☐ I am willing to make some changes in my lifestyle to feel better
- ☐ I may consider change if absolutely necessary to feel better
- ☐ I am here to learn more about my healthcare options and what Naturopathic Medicine can offer

Declaration and Consent for Naturopathic Care

I would like to take this opportunity to welcome you to Broadway Wellness. As a naturopathic doctor ("ND") I will conduct a thorough case history, a focused physical exam and may utilize specific blood, urinary or other laboratory reports as part of the treatment work-up. I integrate supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, physical medicine and lifestyle counseling to assist the body's ability to heal and to improve the quality of life and health.

Statement of Acknowledgement

Printed name of patient: ____

As a patient of Dr. Krista Moyer, I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. Slight health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing symptoms
- allergic reaction to supplements and herbs
- pain, fainting, bruising or injury from venipuncture or acupuncture
- muscle strains and spasms, disc injury from spinal manipulation

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient of Dr. Krista Moyer is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed health care provider. I am at liberty to seek or continue medical care from a MD, or other health care providers. I understand results are not guaranteed.
- I understand that a record will be kept of my visits. This record will be kept confidential and will not be released without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am responsible for payment at the time services are rendered. Dispensary items must be paid for in full before leaving the office.
- I am aware that 24 hours notice must be given for all cancelled appointments or a cancellation fee will be applied.
- I understand that Dr. Krista Moyer reserves the right to determine which cases fall outside her scope of practice, in which case the appropriate referral will be recommended.

I consent to receive naturopathic treatment from Dr. Krista Moyer. I understand this consent is voluntary and may be revoked at any time.

Signature of patient (or guardian): ______________________________________ **Date:** ____________