BROADWAY WELLNESS

Dr. Krista Moyer, Naturopathic Doctor
2501 Spruce Street, Vancouver, BC V6H 2P8
t – 604-732-5222

NATUROPATHIC ADULT INTAKE FORM

General Information

Name: _____ Date: _____ MSP#: _____
Address: _____ City, Province: _____ Postal Code: _____
DOB: DD/MM/YY _____ Age: _____ Telephone (Primary): _____
Email: _____
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 NUTRITIONAL supplements? Yes / No

Name & Brand:	Reason:	Dosage:	Date Started:

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

Name & Brand:	Reason:	Dosage:	Date Started:

Height: _____ Present weight: _____ Weight 1 year ago: _____ Ideal weight: _____

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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)…or…in the *recent* Past (P) for each of the following:

Slow wound healing	Y	P	Suspicious mole(s)	Y	P	Itching	Y	P
Rashes	Y	P	Acne	Y	P	Easy bruising	Y	P
Recent changes to hair or nails	Y	P	Dry skin	Y	P	Eczema / Psoriasis	Y	P
Serious Head injury	Y	P	Excessive hair loss	Y	P	Hearing Loss	Y	P
Chronic Ear infections	Y	P	Earaches	Y	P	Ringing in ears	Y	P
Jaw / TMJ problems	Y	P	Loss of hearing	Y	P	Ear discharge	Y	P
Chronic Headaches	Y	P	Location of Headaches:	_____				
Muscle weakness	Y	P	Muscle cramps	Y	P	Joint pain / stiffness	Y	P
Muscle tremors	Y	P	Muscle pain	Y	P	Abnormal lumps	Y	P
Muscle paralysis	Y	P	Sciatica	Y	P	Seizures	Y	P
Numbness / tingling	Y	P	Carpal tunnel syndrome	Y	P			
Dry eyes	Y	P	Blurry vision	Y	P	Glaucoma	Y	P
Spots in eyes	Y	P	Eye pain or strain	Y	P	Cataracts	Y	P
Watery eyes	Y	P	Eye discharge	Y	P	Styes	Y	P
Double vision	Y	P	Tearing	Y	P	Floaters	Y	P
Frequent colds	Y	P	Frequent nosebleeds	Y	P	Nasal polyps	Y	P
Swollen lymph glands	Y	P	Seasonal allergies	Y	P	Nasal congestion	Y	P

Frequent runny nose	Y	P	Frequent sore throat	Y	P	Gum disease	Y	P
Oral canker sores	Y	P	Dental cavities	Y	P	Dentures	Y	P
Cold Sores	Y	P						
Frequent cough	Y	P	Painful breathing	Y	P	Pneumonia	Y	P
Recurrent bronchitis	Y	P	Asthma	Y	P	Shortness of breath	Y	P
Spitting up blood	Y	P	Cold hands / feet	Y	P	Difficulty breathing when lying down	Y	P
High Blood Pressure	Y	P	Rheumatic Fever	Y	P	Swollen ankles / Edema	Y	P
Low Blood Pressure	Y	P	Heart Murmurs	Y	P	Angina / Chest pain	Y	P
Heart Arrhythmias	Y	P	Heart Palpitations	Y	P	Phlebitis	Y	P
Heartburn	Y	P	Diarrhea	Y	P	Pancreatitis	Y	P
Excessive Gas / Bloating	Y	P	Constipation	Y	P	Peptic ulcer	Y	P
Parasites	Y	P	Hemorrhoids	Y	P	Nausea or Vomiting	Y	P
Changes in appetite	Y	P	Gall stones	Y	P	Undigested food in stool	Y	P
Blood or Mucous in stool	Y	P	Digestion worse after eating fatty food	Y	P	# of Daily bowel movements:		
Unusual Colour or Odour	Y	P	Description (if unusual):					
Urinary incontinence	Y	P	Pain with urination	Y	P	Frequency at night	Y	P
Urinary tract Infections	Y	P	Kidney stones	Y	P	Urinary discharge or blood	Y	P
Unusual Colour or Odour	Y	P	Description (if unusual):					
Depression	Y	P	Highly stressed	Y	P	Insomnia	Y	P
Anxiety	Y	P	Mood swings	Y	P	Poor memory	Y	P
Dizzy when stand quickly	Y	P	Crave carbs & sugars	Y	P	Severe Motion sickness	Y	P
Shaky if miss meals	Y	P	Mental fogginess	Y	P	Fainting	Y	P
Excessive thirst	Y	P	Chronic Yeast infections	Y	P			

FEMALES ONLY:

Abnormal pap smear	Y	P	Heavy menstrual flow	Y	P	Light menstrual flow	Y	P
Bleeding between cycles	Y	P	Long menstrual cycle	Y	P	Short menstrual cycle	Y	P
Clots during cycle	Y	P	Unusual Discharge	Y	P	Cravings before menses	Y	P
Menstrual cramps	Y	P	Anemia	Y	P	Recent changes to breasts	Y	P
Water retention before menses	Y	P	Tender breasts before menses	Y	P	Mood changes before menses	Y	P
Regular cycle	Y	P	Irregular or no cycle	Y	P	Length of cycle (eg 28 d)		
Duration of Menses:			Age of first period:			Age at menopause:		
Number of pregnancies:			Number of births:			Birth control method:		

Other menstrual/menopausal symptoms: _____

Please indicate Yes (Y) or <u>leave blank</u> if inapplicable if YOU have been diagnosed with any of the following:

Diabetes	Y	Cancer	Y	STI(s)	Y	HIV/AIDS	Y	Phlebitis	Y
Arthritis	Y	Colitis	Y	MS	Y	Epilepsy	Y		
Stroke	Y	Jaundice	Y	Polio	Y	Varicosities	Y		
Clotting disease	Y	Thyroid disease	Y	Chronic bronchitis	Y	Liver disease	Y		
Eating disorder	Y	Auto-immune disease	Y	Chronic fatigue syndrome	Y	Dental abscess	Y		

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	Diphtheria	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						
<u>Check all that apply:</u>						
Glaucoma						
High Blood Pressure						
Heart Disease						
Stroke						
High Cholesterol						
Asthma						
HIV/AIDS						
Tuberculosis						
Cancer (list type)						
Epilepsy						
Allergies						
Thyroid Problems						
Obesity						
Osteoporosis						
Other (please list)						

Diet and Lifestyle

Please list the foods you realistically 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	_____	Black Tea	_____	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? _____ Difficulty 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

Dr. Krista Moyer, Naturopathic Doctor
Broadway Wellness

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 your health and overall life.

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:** _____