BROADWAY WELLNESS

Dr. Mark Cseszko, ND

610 ï 2525 Willow Street
Vancouver, BC V5Z 3N8
Tel. 604-732-5222
www.broadwaymassageandtherapy.com

NEW PATIENT INTAKE FORM

Thank you for your co-operation in completing this intake form as completely as possible; it is essential to providing the highest standard of care. All information is confidential. PLEASE PRINT

PERSONAL INFORMATION

Name: _____ Todayôs Date: _____
(First) (Middle) (Last) dd mm yy

Date of Birth: _____/_____/_____ Age: _____ e-mail: _____
dd mm yy

Home Address: _____ City: _____

Postal Code: _____ Home Telephone: ( )_____ Work: ( )_____

May we leave messages on your home phone relating to our visits? Y N

Emergency contact (name): _____ Phone: ( ) _____

How did you find out about our clinic? _____

CHIEF HEALTH CONCERNS

What are your health concerns? (List in order of importance to you):

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

MEDICAL HISTORY

How would you describe your general state of health? (circle) Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, injuries, and any hospitalizations along with approximate dates.

_____

_____

Do you have any allergies (medicines, environmental, reaction to immunizations, etc.)?

_____

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.).

_____

_____

Please list all past prescription medications.

_____

_____

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (circle)

Aspirin Laxatives Antacids Diet pills Birth control pills/implants/injections

Alcohol ï how much/day or week _____

Caffeine ï form and amount/day _____

Recreational drugs ï what and how often _____

Smoking history ï past or present; how much _____

Do you get regular screening tests done by another doctor (Pap, blood tests, etc.)? Y N

If you are female, are you currently pregnant? Y N

GENERAL HISTORY

Check the symptoms/conditions which apply to you:

General

_____ noticeable weight loss
_____ noticeable weight gain
_____ fatigue
_____ weakness

Skin

_____ rashes
_____ changes in hair/nails
_____ eczema
_____ boils
_____ colour change
_____ itching
_____ hives
_____ moles
_____ lumps
_____ dryness
_____ psoriasis

Head

_____ head injury
_____ hair loss
_____ headaches
_____ dandruff

Eyes

_____ redness
_____ specks
_____ double vision
_____ cataracts
_____ discharge
_____ spots
_____ excessive tearing
_____ glaucoma
_____ crossed eyes
_____ bothered by the sun
_____ pain
_____ flashing lights
_____ blurred vision
_____ blind spot

Do you wear glasses/contacts? _____

Ears

_____ infection
_____ discharge
_____ ringing in ears (tinnitus)
_____ earaches
_____ vertigo
_____ hearing loss

Do you use hearing aids? _____

Nose and Sinuses

_____ frequent colds
_____ nasal stuffiness
_____ loss of smell
_____ hay fever
_____ discharge
_____ sinus infections
_____ nosebleeds
_____ itching

Mouth and Throat

_____ dry mouth
_____ sore tongue
_____ spots/sores in mouth
_____ heat/cold intolerance
_____ lumps in neck
_____ tonsillitis
_____ stiff neck
_____ bleeding gums
_____ hoarseness
_____ dental cavities
_____ sore throat
_____ loss of taste
_____ enlarged thyroid

Date of last dental exam? _____

Respiratory

_____ sputum
_____ hemoptysis
_____ wheezing
_____ asthma
_____ tuberculosis
_____ chest pain
_____ cough
_____ bronchitis
_____ emphysema
_____ pneumonia
_____ pleurisy
_____ difficulty breathing

Results of spirometry tests or other lung tests: _____

Cardiovascular

_____ rapid heart beat
_____ high blood pressure
_____ low blood pressure
_____ chest pain
_____ palpitations
_____ blueness of skin (cyanosis)
_____ slow heart beat
_____ heart murmurs
_____ rheumatic fever
_____ edema/swollen ankles
_____ difficulty breathing
_____ thrombophlebitis
_____ leg cramps
_____ cold hands/feet
_____ extremity numbness
_____ deep leg pain

Results of electrocardiogram or other heart tests: _____

Gastrointestinal

_____ trouble swallowing
_____ heart burn
_____ excessive hunger/thirst
_____ poor appetite/thirst
_____ diabetes
_____ nausea
_____ indigestion
_____ ulcer
_____ hemorrhoids
_____ constipation
_____ diarrhea
_____ hypoglycemia
_____ abdominal pain
_____ regurgitation
_____ excessive bloating
_____ hernias
_____ food intolerance/allergy
_____ excessive belching
_____ passing of gas
_____ jaundice
_____ colitis
_____ vomiting
_____ hepatitis
_____ liver/gallbladder issues

How often do you have a bowel movement? _____

Genito-Urinary

_____ dark-coloured urine
_____ excessive urination
_____ burning/pain on urination
_____ pus in urine
_____ urgency
_____ dribbling
_____ urinary infections
_____ blood in urine
_____ frequency at night
_____ kidney infection
_____ foul smelling urine
_____ hesitancy
_____ incontinence
_____ kidney stones

Musculoskeletal

_____ muscle or joint pains
_____ arthritis
_____ back pain
_____ broken bones
_____ general muscle weakness
_____ stiffness
_____ gout
_____ artificial joints/limbs
_____ muscle spasms/cramps
_____ joint swelling

Neurological

_____ fainting/blackouts	_____ loss of balance
_____ weakness	_____ paralysis
_____ numbness/loss of sensation	_____ tingling/pins and needles
_____ tremors/involuntary motion	_____ speech problems
_____ nervousness	_____ tension
_____ depression	_____ memory changes/loss
_____ difficulties concentrating	_____ irritability
_____ convulsions/seizures	_____ loss of sleep

Hematological

_____ anemia	_____ any past transfusions
_____ easy bleeding	_____ easy bruising

Any other conditions?

_____

_____

CONSENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the bodyôs inherent healing capacity. Dr. Mark Cseszko will take a thorough case history and do a screening physical examination. It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your ND immediately.

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Adverse reactions or side effects to scheduled and non-scheduled substances
- Pain, bruising or injury from venipuncture, intramuscular injection or acupuncture
- Fainting or puncturing of an organ with acupuncture needles

I understand that my identity will be protected at all times and if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: _____. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (*please print*) _____

Signature of Patient: _____ (*or guardian if a minor*)

Date: _____ **Naturopathic Doctor:** _____

FEE SCHEDULE (prices are subject to change without notice)

Initial consultation *(up to 75min).....**$225.00***
Follow up visits *(up to 30 minutes).....**$110.00***
Follow up visits *(up to 15 minutes).....**$65.00***

New Patient Acupuncture**…….**$155.00
Acupuncture** …… **$100.00