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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: (First) (Middle) (Last) Today's Date: dd mm yy

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

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.

Blank lines for medical history details

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

Blank lines for allergies

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

Blank lines for current medications

Please list all past prescription medications.

Blank lines for past medications

Mouth and Throat

- | | |
|--|---|
| <input type="checkbox"/> dry mouth | <input type="checkbox"/> bleeding gums |
| <input type="checkbox"/> sore tongue | <input type="checkbox"/> hoarseness |
| <input type="checkbox"/> spots/sores in mouth | <input type="checkbox"/> dental cavities |
| <input type="checkbox"/> heat/cold intolerance | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> lumps in neck | <input type="checkbox"/> loss of taste |
| <input type="checkbox"/> tonsillitis | <input type="checkbox"/> enlarged thyroid |
| <input type="checkbox"/> stiff neck | |

Date of last dental exam? _____

Respiratory

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> sputum | <input type="checkbox"/> cough |
| <input type="checkbox"/> hemoptysis | <input type="checkbox"/> bronchitis |
| <input type="checkbox"/> wheezing | <input type="checkbox"/> emphysema |
| <input type="checkbox"/> asthma | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> pleurisy |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> difficulty breathing |

Results of spirometry tests or other lung tests: _____

Cardiovascular

- | | | |
|--|---|---|
| <input type="checkbox"/> rapid heart beat | <input type="checkbox"/> slow heart beat | <input type="checkbox"/> leg cramps |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> heart murmurs | <input type="checkbox"/> cold hands/feet |
| <input type="checkbox"/> low blood pressure | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> extremity numbness |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> edema/swollen ankles | <input type="checkbox"/> deep leg pain |
| <input type="checkbox"/> palpitations | <input type="checkbox"/> difficulty breathing | |
| <input type="checkbox"/> blueness of skin (cyanosis) | <input type="checkbox"/> thrombophlebitis | |

Results of electrocardiogram or other heart tests: _____

Gastrointestinal

- | | | |
|--|---|---|
| <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> food intolerance/allergy |
| <input type="checkbox"/> heart burn | <input type="checkbox"/> constipation | <input type="checkbox"/> excessive belching |
| <input type="checkbox"/> excessive hunger/thirst | <input type="checkbox"/> diarrhea | <input type="checkbox"/> passing of gas |
| <input type="checkbox"/> poor appetite/thirst | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> colitis |
| <input type="checkbox"/> nausea | <input type="checkbox"/> regurgitation | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> indigestion | <input type="checkbox"/> excessive bloating | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> ulcer | <input type="checkbox"/> hernias | <input type="checkbox"/> liver/gallbladder issues |

How often do you have a bowel movement? _____

Genito-Urinary

- | | |
|--|--|
| <input type="checkbox"/> dark-coloured urine | <input type="checkbox"/> blood in urine |
| <input type="checkbox"/> excessive urination | <input type="checkbox"/> frequency at night |
| <input type="checkbox"/> burning/pain on urination | <input type="checkbox"/> kidney infection |
| <input type="checkbox"/> pus in urine | <input type="checkbox"/> foul smelling urine |
| <input type="checkbox"/> urgency | <input type="checkbox"/> hesitancy |
| <input type="checkbox"/> dribbling | <input type="checkbox"/> incontinence |
| <input type="checkbox"/> urinary infections | <input type="checkbox"/> kidney stones |

Musculoskeletal

- | | |
|--|--|
| <input type="checkbox"/> muscle or joint pains | <input type="checkbox"/> stiffness |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> gout |
| <input type="checkbox"/> back pain | <input type="checkbox"/> artificial joints/limbs |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> muscle spasms/cramps |
| <input type="checkbox"/> general muscle weakness | <input type="checkbox"/> joint swelling |

Neurological

- | | |
|---|--|
| <input type="checkbox"/> fainting/blackouts | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> weakness | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> numbness/loss of sensation | <input type="checkbox"/> tingling/pins and needles |
| <input type="checkbox"/> tremors/involuntary motion | <input type="checkbox"/> speech problems |
| <input type="checkbox"/> nervousness | <input type="checkbox"/> tension |
| <input type="checkbox"/> depression | <input type="checkbox"/> memory changes/loss |
| <input type="checkbox"/> difficulties concentrating | <input type="checkbox"/> irritability |
| <input type="checkbox"/> convulsions/seizures | <input type="checkbox"/> loss of sleep |

Hematological

- | | |
|--|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> any past transfusions |
| <input type="checkbox"/> easy bleeding | <input type="checkbox"/> 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 body's 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:** _____