

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: _____

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

Dr. Krista Moyer, Naturopathic Doctor
Broadway Wellness

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 leave blank 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	Y	Thyroid	Y	Chronic	Y	Liver	Y		
disease		disease		bronchitis		disease			
Eating	Y	Auto-	Y	Chronic	Y	Dental	Y		
disorder		immune		fatigue		abscess			
		disease		syndrome					

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	_____	_____	_____	_____	_____	_____

Check all that apply:

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 _____ Appetite _____

Sweeteners _____ 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

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:** _____