ADULT HISTORY & INFORMATION

This intake form is a *confidential* health assessment tool designed to gain insight into your personal health status. When embarking on an individualized health plan it is important to begin with a thorough understanding of where you are currently, your personal and family history, as well as your habits, concerns, and thoughts with respect to your health. Please take the time to answer the questions on this form as genuinely and as accurately as possible.

PATIENT CONTACT INFORMATION

Patient Name: _____ **Date of Visit:** _____

Birthday: _____ **Age:** _____ MALE / FEMALE **Height:** _____ Weight:_____ Frame **S /M/ L**

Address: _____
Street Name Apt/Suite # City Postal Code

Home Tel #: (_____) _____ Mobile #: (_____) _____ **Work Tel #:** (_____) _____

Email address: _____@_____ **Best way to reach you:** _____

Status: SINGLE / MARRIED/ PARTNERED # of Children: _____ **Occupation:** _____

Referred by: _____

IN CASE OF EMERGENCY

Name: _____ **Relationship:** _____ **Tel #:** _____

CURRENT HEALTH CONCERNS Please list in order of importance to you.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

MEDICAL HISTORY

Current /past illnesses, hospitalizations, surgeries, etc. Include dates.

_____

_____

_____

_____

Date of last Annual Physical exam /Blood test: _____

Do you have any internal pins/wires, artificial limbs, special equipment?
Y/N _____

Are you fully vaccinated? **YES / NO** Reactions/Notes? _____

Allergies/Sensitivities (foods, drugs, pets, seasonal, etc.):

_____

_____

LIST OF MEDICATIONS & NUTRITIONAL SUPPLEMENTS

(Please list conditions it treats)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Family Physician: _____ **Specialty:** _____ **Phone number:** (_____) _____

Address: _____ **Fax number:** (_____) _____

Thank you for taking the time to fill out your form before your visit. Please remember to bring any lab work, medications, or supplements with you.

FAMILY MEDICAL HISTORY

Please indicate pertinent health information regarding your parents and grandparents (including hospitalizations, diagnoses, etc.).

- What is your birth order, how many siblings do you have? (First and only, 2nd child, 3rd child, etc.) _____

FATHER'S FAMILY HEALTH		MOTHER'S FAMILY HEALTH	
YOUR FATHER		YOUR MOTHER	
F. MOTHER		M. MOTHER	
F. FATHER		M. FATHER	

DIET & LIFESTYLE

Do you eat or use any of the following? ✓ Please check all that apply.

	Aluminum pans		Microwave		Margarine
	Candy		Fried foods		Refined/processed foods
	Luncheon meats		Plastic Tupperware		Artificial sweetener
	Fast foods		Air Fresheners		Scented body products

How would you describe your eating habits, any dietary restrictions: ✓ Please check one.

	A meat eater		Vegetarian		Vegan – No animal foods of any type		Other _____

How do you eat your meals: With family around the table _____ In front of the T.V. ____ On the run ____ Alone ____

Restaurant _____ how often (weekly) Fast food _____ how often (weekly)

Please describe what you typically eat in one day:

Breakfast _____ Time:_____

Lunch _____ Time:_____

Dinner _____ Time: _____

Snacks _____ Times:_____

Water _____ cups/day

Milk _____ cups/day

Coffee _____ cups/day

Tea _____ cups/day

Alcohol _____ drinks/wk

Other _____

Do you have a bowel movement every day? YES / NO **Do you Strain?** YES / NO

Food Likes/Cravings: _____

Smoking _____ cigarettes/d How long have you been smoking? _____

Exercise _____ times/wk What type? _____

Describe your current stress level: LOW / MODERATE / HIGH **What are your outlets for stress?** _____

How many hours do you sleep daily? (include naps) _____ **Do you wake feeling rested?** YES NO SOMETIMES

FEMALE REPRODUCTIVE SYSTEM

Circle what describes you best: REGULAR / IRREGULAR / NO PERIODS / PERI-MENOPAUSAL / MENOPAUSAL

Date of last normal period: _____ **PMS Symptoms:** _____

(♀) Are you currently pregnant: **YES / NO Due Date:** _____ Delivering Hospital/Midwife: _____

Please use this space to describe any information that has not been discussed above _____

_____

_____

_____

ADULT HISTORY & INFORMATION

DOCTORS NATURAE™ PRIVACY & CANCELLATION POLICIES

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

The office will collect, use and disclose only necessary information about you for the following purposes:

- To collect information for naturopathic assessments.
- To collect information for nutritional and dietary assessments.
- To collect consultation or cancellation fees, and fees for supplements, food, and seminars.

As our valued patient we trust that you will appreciate a friendly reminder call/email and a monthly newsletter via email in order to continue our relationship together during your personal health journey. ☐ ***If you wish to opt out of this program please check this box.***

Your information will be disclosed as follows:

- To all health professionals and staff employed by Doctors Naturae.
- To an emergency service personnel if one's life could be endangered.
- To an appropriate association, organization or other if one of our health professionals feels it's necessary.

We will only share your information with your consent, with the exception of the above. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols set out by the Board of Drugless Therapies Naturopathy (BDDTN), the International Organization of Nutritional Consultants (IONC) and Ontario's Personal Health Information Protection Act (PHIPA).

At Doctors Naturae, we value the time we get to spend with you and strive to offer the best customer service possible, even if that is to schedule you a last minute appointment. Thus, in order to serve you better we enforce a strict 24 hour cancellation policy. If something comes up and you cannot make your appointment, please call us right away. If we do not receive a phone call or voice message, a cancellation fee of $50 will apply. We hope you will appreciate this service as your time here at Doctors Naturae is valuable.

I have reviewed the above information that explains how Doctors Naturae will be the custodian of my personal medical records, and the steps that will be taken to protect my personal information. I agree that Doctors Naturae can collect, use, and disclose my personal information as set out above in the information about the clinic's privacy policies and charge a cancellation fee if I do not provide 24 hours of notice for a missed appointment.

_____ _____ _____

Signature Print Name Date

CONSENT TO DIAGNOSTIC/THERAPEUTIC PROCEDURES:

ACUPUNCTURE | BOWEN THERAPY | ENERGY THERAPY | HOMEOPATHY | HYPNOSIS | MASSAGE THERAPY | NATUROPATHY | NUTRITION | BIE

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic/therapeutic procedure(s) described by the attending practitioner, and have discussed to my satisfaction this and any requests for related information with the attending practitioner and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the procedure(s) with respect to the nature of the procedure, expected benefits, potential risks, side effects and financial cost; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. I understand that I can withdraw my consent at any time.

Attending Practitioner(s): _____

Signature of Patient: _____ Date: _____

For Office Purposes Only

☐ Verbal consent acquired and witnessed. Patient understands and acknowledges risks and benefits to treatment explained.

Thank you for taking the time to fill out your form before your visit. Please remember to bring any lab work, medications, or supplements with you.

Doctors PRACTICE Naturae DISPENSARY

Dr. Kristin Wootton, ND • Dr. Olinca Trejo, ND • Dr. Tracy Pan, ND • Dr. Alexa Kristy, ND

AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE PROFESSIONAL TO DOCTORS NATURAE

(Please send a copy of this form back with records)

Fax: (905) 336 – 9622 or (905) 662 -3239

SECTION 1:

(Patient to complete Section 1 and 3 of this form)

Practitioner: _____ **Patient:** _____

Fax #: _____ **Date of Birth:** _____

City: _____ **Address:** _____

Practitioner: _____ _____

Fax #: _____ **Tel #:** _____

City: _____

SECTION 2:

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Laboratory Results _____*Most recent blood work._____

Other _____

SECTION 3:

I _____ give permission for Doctors Naturae to receive/send the above listed reports on my and or my child's behalf. I understand that this is a cooperative effort by the practitioners involved to share information that will lead to a better understanding of my health care needs and will facilitate more comprehensive patient care.

I release from you all legal responsibility or liability that may arise from this authorization.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

SIGNATURE OF REQUESTING PRACTITIONER: _____ **DATE:** _____

Thank you for taking the time to fill out your form before your visit. Please remember to bring any lab work, medications, or supplements with you.