

**Adult Intake Form
Naturopathic Medicine**

(Please print clearly)

Name _____ Date _____

Date of birth _____ (D/M/Y) Sex M F

Address: _____

EmailAddress: _____

Telephone: Home: _____ Work: _____ Cell: _____

May we leave messages relating to your visits? Y / N

Emergency contact information:

Name: _____ Relation: _____

Telephone number: _____

How did you hear about Naturopathic Medicine at Bloor Avenue Chiropractic?

Brochure Information Session Website Naturopathic Association

Referred By whom (as we would like to thank them): _____

Other: _____

Other health care providers you are seeing:

1.	2.	3.
_____	_____	_____
_____	_____	_____

What are your health concerns, in order of importance to you:

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

If you are female are you currently pregnant? Yes No (Please circle one)

Medical history

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

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

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

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

Please list 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—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often _____

Please indicate what immunizations you have had

"Flu"

Haemophilus influenza B

Hepatitis A

Tetanus booster; when?

Polio

Hepatitis B

MMR (measles, mumps, rubella)

Smallpox

DPT (diphtheria, pertussis, tetanus)

Other _____

Please indicate if immunization caused adverse reactions: _____

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

Family Health History

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

Other information on family history

I don't know my family medical history

DIET:

Any known food allergies/intolerances: _____

Foods that Aggravate: _____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? _____

Describe a typical day's diet:

Breakfast _____
 Lunch _____
 Dinner _____
 Snacks _____
 Beverages _____
 Water Intake _____

Please indicate if any of these symptoms apply to you:

SKIN

- Rashes/Eczema
- Itching
- Acne
- Lumps
- Dryness/Moistness
- Nail changes
- Change in moles
- Hair changes

HEAD AND NECK

- Headache
- Dizziness
- Impaired vision
- Eye pain
- Eye dryness or tearing
- Eye discharge
- Eye redness
- Eye itching
- Impaired hearing
- Earache
- Ear discharge
- Ear infection
- Nose bleeds
- Stuffy nose
- Sinus problems
- Sore tongue/mouth
- Dental cavities
- Loss of taste
- Gum problems
- Hoarseness
- Sore throat
- Swollen glands
- Painful or stiff neck
- Goiter

DIGESTION

- Reflux
- Belch/Burp
- Bad Breath
- Foul Taste
- Lack Taste
- Bitter Taste
- Change of Appetite
- Swallowing difficulty
- Use of antacids
- Difficult Digesting fats
- Feeling of Fullness
- Bloating
- Nausea
- Cramping/Aching/Pain
- Constipation
- Diarrhea
- Alternating Constipation/Diarrhea
- Flatulence/Wind
- Anal Itching

ENDOCRINE SYSTEM

- Intolerance to heat/cold
- Dry/oily skin, brittle/thick nails
- Puffy face/hands/feet
- Swollen/bulging eyes
- Slow mental function
- Loss of outer 1/3 of eyebrow
- Swelling of neck/throat
- Difficult gaining/losing weight
- Debility/exhaustion from activity
- Dizzy on standing
- Depression/mood swings
- Dark circles under eyes
- White blotchy skin
- Craving salty food
- Gradual loss of body hair
- Tingling in hands with hunger
- Palpitations/Jittery with hunger
- Sudden anxiety with hunger
- Perspiration/clammy with hunger
- Nightmares/Restless sleep
- Headache, dizzy, irritable with hunger
- Increase urination
- Increased appetite/thirst
- Breath smells sweet
- Excess weight gain

IMMUNE SYSTEM

- Catch colds/flu easily
- Frequent Infections
- ENT congestion/discharges
- Sore throats
- Cough with mucus
- Cold sores/mouth ulcers
- Unexplained weight loss
- Slow wound healing
- Sneezing

CARDIOVASCULAR SYSTEM

- Overly tired
- Coldness in hands and feet
- Palpitations
- Dizziness and headache
- Ringing in ears
- Black Stools
- Pale nail beds/gums/eyes
- Spooned nails
- Sore corners of mouth
- Morning headaches/Dizziness
- Unexplained Nose bleeds
- Tingling of hands
- Ringing ears/blurred vision
- Jittery
- Heartburn extending to left arm/jaw
- Cold extremities
- Chest Pain
- Wheezing/dry cough
- Palpitations
- Prominent Neck Veins
- Fluid retention
- Muscle cramps in legs
- Varicose veins
- Discoloured extremities
- Open sores on hands/feet

RESPIRATORY SYSTEM

- Chest discomfort/pain
- Sudden chest pain
- Shortness of breath
- Shallow breathing
- Rattling with breathing
- Cough
- Blue nails/lips
- Smelly/bloody/thick sputum
- Wheezing
- Snoring
- Infection settles in lungs
- Flu symptoms longer than 5 days

URINARY SYSTEM

- Mild low back pain
- Urge to urinate with small amounts
- Interrupted stream
- Excessive urination
- Changing frequency/urgency
- Burning with urination
- Dripping after urination
- Cloudy/bloody/dark urine

WOMEN'S HEALTH

Do you experience any of the following with your monthly cycle?

- | | | |
|---|---|---|
| <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Cravings | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Fluid retention | <input type="checkbox"/> Bleeding between periods |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Heavy blood flow | <input type="checkbox"/> Irregular period |
| <input type="checkbox"/> Sweating/flushed | <input type="checkbox"/> Clots | <input type="checkbox"/> Heavy Blood flow |
| <input type="checkbox"/> Depressed/Irritability | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Lumps/ulcers on vagina |
| <input type="checkbox"/> Easily angered/overwhelm | <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Abnormal vaginal discharge |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Low/excessive libido | <input type="checkbox"/> Burning/itching |
| <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Acne/Oily Skin | <input type="checkbox"/> Pelvic cramps |
| <input type="checkbox"/> Headaches premenstrual | <input type="checkbox"/> Absent/Irregular periods | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Unable to fall pregnant | |

MEN'S HEALTH

- | | |
|---|--|
| <input type="checkbox"/> Discharge or sores | <input type="checkbox"/> Sexual difficulty |
| <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Hernias |

MUSCULOSKELETAL SYSTEM

- | | | |
|--|--|--|
| <input type="checkbox"/> Bone pain | <input type="checkbox"/> Tooth cavities/pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Shin pain during exercise | <input type="checkbox"/> Limited Range of Motion | <input type="checkbox"/> Restless legs |
| <input type="checkbox"/> Back/hip/Neck pain | <input type="checkbox"/> Frequent/recurrent bone fractures | <input type="checkbox"/> Excessive joint mobility |
| <input type="checkbox"/> Difficulty sitting | <input type="checkbox"/> Shooting/Aching/Tingling pain | <input type="checkbox"/> Loss of muscle strength |
| <input type="checkbox"/> Walking difficulties/limp | <input type="checkbox"/> Excessive Joint Mobility | <input type="checkbox"/> Involuntary Movement/Spasms |
| <input type="checkbox"/> Crunching sounds from joints | <input type="checkbox"/> Muscle aches/pains | <input type="checkbox"/> Frequent strains/sprains/Injuries |
| <input type="checkbox"/> Numbness of hands/feet | <input type="checkbox"/> Muscle Tension/Twitches/Cramps | |
| <input type="checkbox"/> Stiffness/Pain/Swelling/Redness | <input type="checkbox"/> Sore spots when pressed | |

NERVOUS SYSTEM

- | | | |
|--|---|---|
| <input type="checkbox"/> Light headedness and fainting | <input type="checkbox"/> Unsteady/Loss of balance | <input type="checkbox"/> Confused/forgetful |
| <input type="checkbox"/> Ringing/Buzzing in ears | <input type="checkbox"/> Weak Grip | <input type="checkbox"/> Slowed or slurred speech |
| <input type="checkbox"/> Trembling hands | <input type="checkbox"/> Nervous/Anxiety | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Loss of feeling in hands/feet | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Eyelids Droop |

STRESS

- | | | |
|--|--|---|
| <input type="checkbox"/> Need coffee/tea/Tobacco/Sugar/
Stimulant | <input type="checkbox"/> Feel tense | <input type="checkbox"/> Loss of clear thoughts |
| | <input type="checkbox"/> Irritable/Oversensitive | |

**Dr. Melanie Jacobson, N.D
Doctor of Naturopathic Medicine
208 Bloor St West
Toronto, Ontario
M5S 3B4**

Please take a few moments to read over the office policy for Naturopathic Medicine.

Adult Fee Schedule*

Initial consult (60-90 minutes)	\$186.00
First follow-up, review of findings and initiation of treatment (45 minutes)	\$92.00
Subsequent visit and subsequent phone consultation (30 minutes)	\$76.00
Acute visit and acute phone consultation (20 minutes)	\$49.00
Initial Acupuncture	\$92.00
Subsequent Acupuncture	\$65.00

***All prices are subject to change.**

****Should you be unable to attend a subsequent visit, a phone consult may be scheduled instead with the above fee schedule.**

Missed appointments

At least 24 hours notice is required when canceling or rescheduling any appointments. Patients may be responsible for the full fee of any missed appointments without 24 hour notice.

Insurance

Many benefit plans cover some or all of our services. While the naturopathic services do not deal directly with insurance companies, we do issue official receipts that may be submitted for reimbursement.

Privacy Policy

The personal information collected is for limited and confidential use by the clinic. The information will not be released to others unless so directed by the patient themselves or unless the law requires it. We reserve the right to contact you on occasion for the following purposes: confirming appointments, clarifying your prescriptions and protocols, clarifying your account and clinic updates/promotions.

Patient Signature: _____ Date: _____

Patient Informed Consent

General Diagnostic and Therapeutic Procedures

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Naturopathic Doctors are highly trained in clinical diagnosis. Diagnostic procedures include taking a complete medical, social, and environmental history of the individual, physical examination, traditional Chinese tongue and pulse evaluation, laboratory testing and possible referral to another practitioner.

Once a clinical diagnosis has been reached, there are a number of different possible treatment approaches that may be used, and a unique treatment plan will be developed for each individual. The majority of treatments used by Naturopathic Doctors fall under one or more of the following categories: clinical nutrition and diet modification, botanical medicine, homeopathy, traditional Chinese medicine, hydrotherapy, physical medicine and counseling. Although naturopathic treatments are considered gentle and safe when administered correctly, they are not without risks and/or side effects in specific health conditions or if used incorrectly. Your Naturopathic Doctor will discuss any specific risk factors of your treatment with you.

Clinical Nutrition: Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes and promote health. Some benefits include increased energy, increased gastrointestinal function, improved immunity and general well being.

Homeopathy: An effective form of medicine based on the Laws of Similars, ie. the use of tiny doses of the very substance that causes symptoms in healthy people can be used to treat specific illness symptom pictures. These minute doses of plant, animal or mineral origins are used to rebalance the human systems and stimulate the body's ability to heal itself.

Botanical Medicine: Plant-based medicine using herbal teas, tinctures, capsules and other forms of herbal preparations to assist in the recovery from injury and disease. These compounds are also used to boost the body's immune system and prevent disease.

Traditional Chinese Medicine: A form of medicine that uses acupuncture, botanical formulas and dietary changes to eliminate disease and balance body functions based on traditional Chinese medical theory.

Hydrotherapy: The use of water as an effective form of stimulating healing. It promotes blood flow thereby encouraging circulation, detoxification and healing.

Lifestyle counseling: Providing recommendations based on the link between health concerns, lifestyle, events, thoughts and emotions.

If you are on any medications, pregnant, suspect you are pregnant or you are breast-feeding, please advise your Naturopathic Doctor immediately.

Patient Informed Consent

I, _____, do hereby acknowledge that I have been informed of and understand the recommended diagnostic and therapeutic procedures/plan and have discussed, to my satisfaction, this and any requests for related information from Melanie Jacobson, ND, Doctor of Naturopathic Medicine. I further acknowledge and confirm that I have been informed of and understand the therapeutic procedures/plan with respect to the financial costs, expected benefits, potential risks and side effects of specific treatments, the likely consequences of not having/following the procedures/plan, and what alternative course (s) of action are available to me.

As a result, I do hereby voluntarily CONSENT for the recommended diagnostic and therapeutic procedures/plan as specified by my Naturopathic Doctor. I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

Signature of Patient or Lawful Representative

Date signed

Signature of Attending Naturopathic Doctor

Date Signed
