Mélanie Jacobson, ND
Doctor of Naturopathic Medicine
Mjacobson.nd@gmail.com

Dear friends,

Thank you for taking the time to fill out this intake form.

We ask that you bring the completed form with you to your first visit. You may also bring any recent or past blood work, or other laboratory results and findings to your appointment so that they can be reviewed. These results may be helpful in your treatment plan.

I am looking forward to meeting with you.

Melanie Jacobson, ND

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?

☐**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?

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

MEN'S HEALTH

- ☐ Discharge or sores
- ☐ Testicular pain
- ☐ Sexual difficulty
- ☐ Hernias

MUSCULOSKELETAL SYSTEM

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

NERVOUS SYSTEM

- ☐ Light headedness and fainting
- ☐ Ringing/Buzzing in ears
- ☐ Trembling hands
- ☐ Loss of feeling in hands/feet
- ☐ Unsteady/Loss of balance
- ☐ Weak Grip
- ☐ Nervous/Anxiety
- ☐ Convulsions
- ☐ Confused/forgetful
- ☐ Slowed or slurred speech
- ☐ Blurred vision
- ☐ Eyelids Droop

STRESS

- ☐ Need coffee/tea/Tobacco/Sugar/ Stimulant
- ☐ Feel tense
- ☐ Irritable/Oversensitive
- ☐ Loss of clear thoughts

Dr. Melanie Jacobson, N.D
Doctor of Naturopathic Medicine

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

Adult Fee Schedule[**]

Initial consult (up to 90 minutes)	**$265.00**
Subsequent visit (45 minutes)	**$100.00**
Subsequent visit (30 minutes)	**$85.00**

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

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 our 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.

Patient Signature: _____ **Date:** _____

Patient Informed Consent

I, Melanie Jacobson, ND utilize the principles and practices of Naturopathic Medicine and other supportive therapies including lactation support to assist the body's own ability to heal and to improve the quality of life and health through natural means.

I will always conduct a thorough case history. A physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. The majority of treatments used by a Naturopathic Doctors fall under one or more of the following categories: clinical nutrition and diet modification, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy, physical medicine and counseling.

Statement of Acknowledgement

Printed name _____

As a patient of this clinic I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions, in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; as well as all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain or bruising from acupuncture.

I also confirm that I have the ability to accept or reject this care of my own free will and choice. I accept full responsibility for any fees incurred during care and treatment.

_____ _____ _____

SIGNATURE DATE Naturopathic Doctor Signature