



Naturopathic Adult Intake Form

PERSONAL & CONTACT INFORMATION

NAME: _____ ADDRESS: _____
 GENDER: _____ ASSIGNED SEX: _____
 DATE OF BIRTH (YY/MM/DD): _____ PHONE: _____
 AGE: _____ HEIGHT: _____ WEIGHT: _____ EMAIL: _____
 EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT ME?

WORD OF MOUTH FACEBOOK SIGNAGE IN CLINIC REFERRAL FROM COMPLETE HEALTH PRACTITIONER
 OTHER _____

WOULD YOU LIKE TO BE SUBSCRIBED TO RECEIVE DR. ANNIE'S BLOG POSTS AND NEWSLETTER? YES NO

If yes, please be sure to include your email address above

OTHER HEALTH CARE PROVIDERS – Please put a * beside the name of your primary health care provider

NAME: _____ SPECIALTY: _____ PHONE: _____
 NAME: _____ SPECIALTY: _____ PHONE: _____

HOW WOULD YOU DESCRIBE YOUR GENERAL STATE OF HEALTH?

EXCELLENT GOOD FAIR POOR

WHAT ARE YOUR TOP CONCERNS ABOUT YOUR HEALTH?

1) _____ 2) _____ 3) _____

MAJOR TRAUMAS / SURGERIES / INJURIES / ILLNESSES – Spiritual, mental, emotional, or physical

EVENT	DATE	OUTCOME

ALLERGIES AND SENSITIVITIES – List any known or suspected allergies, sensitivities and/or intolerances

SUBSTANCE (FOOD, DRUG, ENVIRONMENTAL / CHEMICAL)	REACTION

CURRENT MEDICATIONS & SUPPLEMENTS – Please include all prescription drugs, over the counter drugs (aspirin, antacids, laxatives, ...), birth control pills, herbs, vitamins, minerals, homeopathics, etc.

NAME	DOSE	REASON FOR TAKING	DATE STARTED	SIDE EFFECTS

OTHER SUBSTANCES – Which of the following have you used / do you currently use?

	PAST OR CURRENT	AMOUNT	DATE STARTED	SIDE EFFECTS
ALCOHOL				
CAFFEINE				
RECREATIONAL DRUGS				
TOBACCO				

FAMILY HISTORY – Please list if anyone in your biological family (parents, siblings, grandparents, aunts/uncles) has or has had any of the following. If you do not have information about your biological family's medical history, please skip.

	FAMILY MEMBER		FAMILY MEMBER
ALCOHOLISM/DRUG ABUSE		DIGESTIVE CONDITION	
ALLERGIES/HAY FEVER		HEART DISEASE	
ARTHRITIS		MENTAL HEALTH CONDITION	
ASTHMA/EMPHYSEMA		OVERWEIGHT/OBESITY	
AUTO-IMMUNE CONDITION		SKIN DISEASE	
CANCER		THYROID DISEASE	
DIABETES		OTHER: _____	

SOCIAL HISTORY

SEXUALITY: _____ RELATIONSHIP(S): _____
HAPPY WITH YOUR SEX LIFE? _____
HOW WOULD YOU DESCRIBE THE EMOTIONAL CLIMATE OF YOUR HOME? _____
OCCUPATION: _____ DO YOU ENJOY YOUR WORK? _____
DIETARY RESTRICTIONS (E.G. RELIGIOUS, VEGETARIAN)? _____
DO YOU EXERCISE? IF YES, WHAT FORMS? _____ HOW OFTEN? _____
DIFFICULTY FALLING/STAYING ASLEEP? YES NO WAKE RESTED? YES NO

LIFESTYLE

WHAT ARE THE MAJOR SOURCES OF STRESS IN YOUR LIFE AND HOW DO YOU COPE WITH THEM?

WHAT BEHAVIOURS OR LIFESTYLE HABITS DO YOU CURRENTLY ENGAGE IN THAT YOU BELIEVE SUPPORT YOUR HEALTH?

WHAT BEHAVIOURS OR LIFESTYLE HABITS DO YOU CURRENTLY ENGAGE IN THAT YOU BELIEVE ARE SELF-HARMING?

WHAT POTENTIAL OBSTACLES DO YOU FORESEE IN ADDRESSING THE CAUSE(S) OF YOUR HEALTH CONCERNS AND RESTORING YOUR HEALTH?

REVIEW OF SYSTEMS

Check the conditions that you are currently experiencing, or have experienced often in the past.

		current	previous			current	previous			current	previous	
<u>General Symptoms</u>					<u>Cardiovascular</u>					<u>Infections / Illnesses</u>		
Loss of consciousness		↑	↑	High blood pressure		↑	↑	Herpes		↑	↑	
Numbness / tingling		↑	↑	Low blood pressure		↑	↑	Hepatitis		↑	↑	
Fever		↑	↑	Bleeding disorders		↑	↑	Plantar warts		↑	↑	
Sweats		↑	↑	Chest pain		↑	↑	TB		↑	↑	
Fainting		↑	↑	Stroke		↑	↑	HIV / AIDs		↑	↑	
Dizziness		↑	↑	Artery hardening		↑	↑	Cancer		↑	↑	
Loss of sleep/insomnia		↑	↑	Varicose veins		↑	↑	Allergies		↑	↑	
Frequent colds / flus		↑	↑	Swelling of the ankles		↑	↑	<u>Muscles and Joints</u>				
Loss of weight		↑	↑	Poor circulation		↑	↑	Stiff neck		↑	↑	
<u>Head / Neck</u>				Angina		↑	↑	Backache		↑	↑	
Headaches		↑	↑	Heart disease		↑	↑	Swollen joints		↑	↑	
Type _____				<u>Genitourinary</u>								
Vision problems		↑	↑	Trouble urinating		↑	↑	Painful tail bone		↑	↑	
TMJ concerns		↑	↑	Blood in the urine		↑	↑	Foot trouble L / R		↑	↑	
Earaches		↑	↑	Kidney infections		↑	↑	Shoulder pain L / R		↑	↑	
Decreased hearing		↑	↑	Bed wetting		↑	↑	Elbow pain L / R		↑	↑	
Sinus problems		↑	↑	Prostate trouble		↑	↑	Wrist pain L / R		↑	↑	
Difficulty swallowing		↑	↑	<u>Gastrointestinal</u>								
<u>Skin</u>				Poor digestion		↑	↑	Hip pain L / R		↑	↑	
Rashes / Eczema		↑	↑	Indigestion		↑	↑	Knee pain L / R		↑	↑	
Itching		↑	↑	Excessive hunger		↑	↑	Arthritis		↑	↑	
Bruise easily		↑	↑	Belching or gas		↑	↑	Weakness / lost strength		↑		
Dryness		↑	↑	Nausea / Vomiting		↑	↑					
Boils / Hives		↑	↑	Abdominal pain		↑	↑	<u>Women's Health</u>				
Contagious skin disease		↑	↑	Constipation		↑	↑	Painful menstruation		↑	↑	
<u>Respiratory</u>				Diarrhea		↑	↑	Excessive flow		↑	↑	
Chronic cough		↑	↑	Hemorrhoids		↑	↑	Irregular cycle		↑	↑	
Shortness of breath		↑	↑	Liver concerns		↑	↑	Hot flushes		↑	↑	
Smoking		↑	↑	Gall bladder trouble		↑	↑	Cramps or backache		↑	↑	
Breathing problems		↑	↑	Bladder concerns		↑	↑	Vaginal discharge		↑	↑	
Asthma / Bronchitis		↑	↑	Ulcer		↑	↑	Swollen breasts		↑	↑	
				Diabetes		↑	↑	Lumps in the breast		↑	↑	
								Are you pregnant	Yes	↑	No	↑
								On birth control	Yes	↑	No	↑
								Breastfeeding	Yes	↑	No	↑
								# of pregnancies	_____			
								# of children	_____			
								Age of first period	_____			

Informed Consent for Naturopathic Medicine

I, _____, hereby request and consent to examination and treatment with Naturopathic Medicine by Dr. Annie Cannon, ND.

I understand that as a Naturopathic Doctor, Dr. Cannon may include, but is not limited to, the following examination or treatment methods:

- Physical examination (including vitals, EENT, heart and lung, abdominal, musculoskeletal, orthopedic and neurological assessments).
- Common diagnostic procedures (including laboratory evaluation of blood, urine, stool and saliva)
- Botanical/herbal medicine (prescription of therapeutic plant substances which may be given in the form of, pills, creams, tinctures [which usually contain alcohol], suppositories, pastes, plasters, or other forms)
- Clinical nutrition (including food selection, diet plans, nutritional supplements)
- Counselling (including but not limited to visualization, self-empowerment techniques, mind-body medicine and stress reduction techniques)
- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the body surface)

In addition to the procedures mentioned above, I also consent to the following advanced therapies (please initial the following):

_____ **Consent to Injections:** I consent to all injection procedures (including, but not limited to, vitamins, procaine, or other solutions) rendered by Dr. Cannon.

I understand that:

1. The procedure involves inserting a needle into various areas of the body and injecting of substances.
2. Risks of injection therapies include but are not limited to:
 - a. Occasionally to commonly:
 - i. Discomfort, severe pain, bruising, inflammation, injury and numbness at the site of injection.
 - ii. Fatigue, dizziness, or light-headedness after the injections.
 - iii. Fainting or loss of consciousness during the procedure.
 - b. Extremely Rarely:
 - i. Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

I am aware that other unforeseeable complications could occur. I do not expect Dr. Cannon to anticipate and/or explain all risk and possible complications.

_____ **Consent to Intravenous Therapy:** I consent to all intravenous therapy procedures (including, but not limited to micronutrient intravenous therapies) rendered by Dr. Cannon.

I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
3. Risks of intravenous therapy include but are not limited to:
 - a. Occasionally to commonly:
 - i. Discomfort, bruising and pain at the site of injection.
 - b. Rarely:
 - i. Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
 - c. Extremely Rarely:
 - i. Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.
4. Benefits of intravenous therapy include:
 - i. Injectables are not affected by stomach, or intestinal absorption problems.
 - ii. Total amount of infusion is available to the tissues.
 - iii. Nutrients are forced into cells by means of a high concentration gradient.
 - iv. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

I am aware that other unforeseeable complications could occur. I do not expect Dr. Cannon to anticipate and/or explain all risk and possible complications.

I understand that it is my responsibility to inform Dr. Cannon immediately of the following and failure to do so could result in unnecessary avoidable complications for which I take full responsibility:

- Notify of all current disease conditions and any changes to my current disease state
- Notify of any medication, over the counter drugs or supplements and any changes to any of these (including new additions)
- Notify of any known allergies to drugs or other substances or any past reactions to anaesthetics
- Notify of pregnancy, suspicion of pregnancy, or breastfeeding

I understand that it is my responsibility to request that Dr. Cannon explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services has been made to me concerning the intended results of any treatment provided to me.

Privacy Policy

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 anytime 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.

My signature below confirms that:

1. I have been provided ample opportunity to read this form or that it has been read to me.
2. I understand the information provided on this form and the procedures have been adequately explained to me and thus give my oral and written consent to evaluation and treatment.
3. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment from Dr. Cannon
4. I release Dr. Cannon from any and all liability associated with, but not limited to, the procedures mentioned herein.
5. I authorize and consent to the performance of the procedures listed herein.
6. I understand that I may withdraw my consent, in writing, at any time.

Printed name of Patient

Printed name of Guardian

Signed name of Patient

Signed name of Guardian

Date

Date