NATUROPATHIC INTAKE FORM

I am aware of the time it takes to fill out such a lengthy intake form, however, your cooperation in completing it is essential to providing the highest standard of care. To complete this form before the visit is highly encouraged because I will spend my own time to preview your case and we can spend more time on treatment during the visit. All information is strictly confidential**.** **PLEASE PRINT**.

Personal information

Name: _____ Date: _____
(First) (Middle) (Last) dd / mm / yy

Date of Birth: ___ /___ / ___ Age: _____ Gender: ☐ F ☐ M
dd/ mm / yy

Address: _____

City: _____ Province: _____ Postal Code: _____

Home ( ) _____ Cell: ( ) _____

Email: _____

Occupation(s) _____

Hobbies _____

May we leave messages on your home phone relating to your visits? ☐ Y ☐ N ☐ only on my cell

Emergency contact:

Name: _____ Phone:( )_____ Relationship: _____

Family Doctor: _____ Phone:( )_____ Fax: ( ) _____

Other Doctor: _____ Phone:( )_____ Fax: ( ) _____

Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

How did you find out about our Naturopathic Services?

Do you have extended medical coverage for Naturopathic Doctor visit? ☐Yes, ☐No
if yes, what services are covered?

HEALTH CONDITION

What are your health concerns/problems brought you to this office?

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? Please list with approximate dates:

Post/Current Medical History

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? Please list with approximate dates:

Do you have any allergies (medicines, environmental, foods)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics), with dosage:

Medications:

Supplements:

Please list any past prescription medications if have:

Have you been treated by Antibiotics? ☐ yes, ☐No; What is the condition and when? Approximately how many times since childhood if you remember.

Please select the following conditions/sign & symptoms you have had. ☑P=past; ☑C=current

SKIN

Past	Current	
☐	☐	Rashes
☐	☐	Eczema
☐	☐	Psoiasis
☐	☐	Vitiligo
☐	☐	Dryness
☐	☐	Hives
☐	☐	Boils
☐	☐	Acne
☐	☐	Contact dermatitis
☐	☐	Warts
☐	☐	Fungal infection

EYES

☐	☐	Dry eyes
☐	☐	Double vision
☐	☐	Spots/floaters
☐	☐	Flashing lights
☐	☐	Glaucoma
☐	☐	Cataract
☐	☐	Discharge/infection

EARS

☐	☐	Infection
☐	☐	Ringing
☐	☐	Hearing loss

NOSE & SINUSES

☐	☐	Nasal congestion
☐	☐	loss of smell
☐	☐	Nose bleeding
☐	☐	sinus infection

MOUTH & THROAT

☐	☐	Mucus ulcer
☐	☐	Gingivitis
☐	☐	Sore throat

RESPIRATORY

☐	☐	cough
☐	☐	asthma
☐	☐	bronchitis
☐	☐	Pneumonia
☐	☐	Emphysema
☐	☐	Coughing blood
☐	☐	Tuberculosis
☐	☐	Chest pain
☐	☐	Difficult breathing

CIRCULATION SYSTEM

☐	☐	irregular heart beat
☐	☐	Hypertension
☐	☐	Chest pain
☐	☐	palpitations
☐	☐	Rheumatic heart disease
☐	☐	Thrombophlebitis
☐	☐	lower limbs edema
☐	☐	cold hands/feet

GASTROINTESTINAL

☐	☐	Trouble swallowing
☐	☐	Nausea/vomiting
☐	☐	heartburn/acid reflux
☐	☐	Indigestion
☐	☐	Bloating/gassy
☐	☐	abdominal pain
☐	☐	stomach ulcer
☐	☐	diverticulosis
☐	☐	Bloody stool
☐	☐	Diarrhea
☐	☐	Hemorrhoids

LIVER/GALBLADDER

☐	☐	Jaundice
☐	☐	Hepatitis
☐	☐	Gallbladder stone

GENITOURINARY

☐	☐	Urgency/Frequent
☐	☐	Dribbling/leaking
☐	☐	Burning pain
☐	☐	incontinence
☐	☐	Kidney stones
☐	☐	Kidney infection
☐	☐	Urinary tract infection
☐	☐	STD (HPV, etc)

MENTAL

☐	☐	Depression
☐	☐	Bipolar disorder
☐	☐	Anxiety
☐	☐	Irritation
☐	☐	Insomnia
☐	☐	Eating disorder

FEMALE

☐	☐	PMS
☐	☐	Menopause
☐	☐	low libido
☐	☐	yeast/candida
☐	☐	Painful periods
☐	☐	Vaginal dryness
☐	☐	Irregular menstrual cycle
☐	☐	Miscarriage(s)
☐	☐	abortion(s)
☐	☐	endometriosis
☐	☐	Uterine fibroids
☐	☐	Cervical dysplasia
☐	☐	Fibrocystic breasts
☐	☐	breast cancer

MALE

☐	☐	Enlarged prostate
☐	☐	prostatitis
☐	☐	Urethra discharge
☐	☐	Low libido
☐	☐	Erectile dysfunction

HEMATOLOGICAL

☐	☐	Anemia
☐	☐	Easy bleed/bruising
☐	☐	Varicose
☐	☐	HIV

MUSCULOSKELETAL

☐	☐	pain everywhere
☐	☐	joint pain
☐	☐	osteoarthritis
☐	☐	back pain
☐	☐	muscle cramps
☐	☐	Gout
☐	☐	flat feet

NEUROLOGICAL

☐	☐	Numbness/tingling
☐	☐	Vertigo/dizziness
☐	☐	Tremors
☐	☐	Memory loss

GENERAL

☐	☐	Abnormal weight gain/loss
☐	☐	Night sweating
☐	☐	Weakness/fatigue
☐	☐	Diabetes

OTHER MEDICAL HISTORY

☐	☐	_____
☐	☐	_____
☐	☐	_____

LIFESTYLE:

☑	Frequent/week	amount/time or day	Type/schedule
☐ Caffeine			
☐ Alcohol			
☐ Recreational drugs			
☐ Cigarette			
☐ Night shift			
☐ Exercise			

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

Blood test ☐ Y* ☐ N *If yes, Please bring your recent test result with your visit.

Pap ☐ Y ☐ N

If yes, what is the result of your most recent test?

Others:

DIET

Do you have food allergies or intolerance's? Please list:

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

Family Health History

(Please indicate ☑M: any family members with this condition in your Mother side; ☑F:any family members with this condition in your father side; describe the relationship with you on underline part):

Diabetes	☐M	☐F _____	Cancer	☐M	☐F _____
Heart disease	☐M	☐F _____	Asthma	☐M	☐F _____
Bleeding disorder	☐M	☐F _____	Epilepsy	☐M	☐F _____
Thyroid disorder	☐M	☐F _____	Gout	☐M	☐F _____
Kidney disease	☐M	☐F _____	Mental illness	☐M	☐F _____
Tuberculosis	☐M	☐F _____	Auto-immune	☐M	☐F _____
Inborn defect	☐M	☐F _____	Hyperlipidemia	☐M	☐F _____

Others :

ENVIRONMENT

Are you regularly exposed to toxins or other hazards (pesticides, toxic elements, organic solvens @work, home, hobbies, etc.)? Please describe:

How would you describe the emotional climate of your home or your relationship?

Is there anything that you feel that is important that hasn't been covered in this intake form?

For Women only

Do you have menstrual cycle: ☐No ☐Yes

If No, when you stop the menstrual cycle?

If Yes, is the period regular (plus/minus 5days)? ☐No ☐Yes

Date of last menstrual period: (approx.)

Do you have abnormal vaginal bleeding?

Frequency of period (average): days

Age of first menstrual period: years old

Number of pregnancies:

Number of children:

Are you trying to become pregnant? ☐No ☐Yes

Having trouble getting pregnant? ☐No ☐Yes

Are you sexually active? ☐No ☐Yes

What type of contraception are you using? Now: Past:

Last pap smear (approx. date):

All normal in the past? ☐No ☐Yes

If No, please details:

INFORMED CONSENT TO TREATMENT

1. I understand that Dr. Christine L.F. Chen, is a Naturopathic Physician, and will use naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and improve the quality of life and health through natural means.

2. I understand that any advice given to me as a patient from Dr. Christine Chen, is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.

3. Dr. Christine Chen will 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. Dr. Christine Chen will have access to your history to minimize repetition while maintaining complete confidentiality.

4. I understand that the services offered here are not covered by MSP, and that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests.

5. I understand that 24 hours notice is required for appointment cancellation, otherwise I will be responsible for the cancellation fee.

6. I understand that any therapies recommended will be explained to me in full by the naturopathic physician, and that I will give consent to treatment based on informed consent.

Statement of acknowledgement

Patient's name: _____

As a patient of Dr. Christine Chen, I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. As this clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or 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; and all medications, including over the counter drugs and supplements. The slight health risks of some naturopathic treatment include, but not limited to aggravation of pre-existing symptoms, allergic reaction to supplement or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.

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, country, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment. I understand the refund policy of this clinic is limited to unopened supplement purchased within 7 days.

Please be advised that by signing you are agreeing to Dr. Christine LF Chen treat your healthcare in an integrated way using the knowledge of the associates within her practice.

I _____ have read, understood and agree to the above statements.

Signature_____ Date_____

Thank you for taking the time to complete this intake form. We look forward to working with you in your Naturopathic care.