

CONFIDENTIAL ADULT INTAKE FORM Nadia Tymoshenko ND, Naturopathic Doctor

Name _____ Sex: M F How did you hear about me? _____

If Internet, how specifically did you find me (certain search terms, Glenboure website, Nadia-ND website, Facebook) _____

Address _____ Apt/unit # _____ City _____ Postal Code _____

Home Phone _____ Cell # _____ Work # _____ Email(for appointment reminders) _____

What is the best way to contact you &/or leave messages? (indicate all that apply) Home # _____ Cell # _____ Work # _____

Date of Birth _____ Age _____ Emergency contact name & phone _____

Relationship/marital status _____ # of children _____ Occupation _____

PLEASE LIST YOUR HEALTH CONCERNS IN ORDER OF IMPORTANCE TO YOU:

HEALTH CONCERN:	SINCE WHEN?

Please list all allergies _____ Have an EpiPen? _____

Are you currently under the care of other health care providers? Please indicate names & titles (i.e., M.D., physio, counsellor):

Please list all prescription and over the counter medications you are taking (include the name, dose & reason for taking each):

Natural Supplements (please list brand name, ingredients, strength and daily dose for each one - use extra paper if needed):

Please list all surgeries, medical procedures and hospitalizations you've had (list types & approximate dates): _____

Please list all accidents, injuries , traumas (list types & approximate dates): _____

Please list medical tests you've had (i.e., blood work, colonoscopy, MRI, bone density, biopsies): bring copies if you have them

FAMILY HISTORY Indicate which of the following ailments, and any other ailments that have affected your relatives:

- | | | | | | |
|------------|--------------------|------------|-----------|------------------|--------------|
| Alcoholism | Asthma | Depression | Epilepsy | Heart disease | Skin disease |
| Allergies | Autoimmune disease | Diabetes | Gout | High cholesterol | Stroke |
| Arthritis | Cancer | Eczema | Hay fever | Mental illness | Tuberculosis |

RELATIVE	AGE	AGE AT DEATH	MAJOR HEALTH ISSUES
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Blood Type (circle if known): A B O AB +/- Are you sensitive to perfumes, cosmetics, fumes? _____

Are you or have you ever been regularly exposed to toxins or other hazards? What kinds? _____

Approximately how many times have you been treated with antibiotics in your life? _____

What vaccinations have you had? (for travel, hepatitis, flu, etc.) _____

Rate your typical stress level (please circle): None Minimal Average High Very high Unbearable

What are your main stresses? _____

Do you take time for relaxation? _____ Time for leisure? _____ Vacation/holiday time? _____

Do you take time for exercise/movement? _____ Type and frequency: _____

Any other things you do to support your health? _____

Please rate the following on a satisfaction scale of 0-10, with 10 being the most satisfied: Energy _____ Sleep _____

Mood _____ Work/daily occupation _____ Relationships (friends, family, partner, etc.) _____

Do you consider yourself: Underweight___ Overweight___ Just right___ Any difficulty maintaining a healthy weight?_____

Do you smoke?_____ # Years smoked:_____ EX-Smoker?_____ # Years smoked:_____ Cigars?_____

Alcohol?_____ Quantity/frequency:_____ 'Recreational' drugs?_____ Frequency:_____

Please describe a typical day's diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

On average, how many cups per day do you drink of the following: Water_____ Milk_____ (type:_____)

Juice_____ Coffee _____ Black tea_____ Other teas_____ "Diet" drinks_____ Pop_____ Energy drinks_____

Please list any dietary restrictions (ie, religious, vegetarian/vegan, food sensitivities)_____

What are your short-term health goals (3 months)?_____

What are your long-term health goals (1 year or more)?_____

Are there any obstacles or challenges you foresee with reaching your health goals?_____

How ready do you feel, on a scale of 1 to 10, to make changes in order to reach your health goals?

1 2 3 4 5 6 7 8 9 10
(not very) (depends how hard it is) (I'll do what it takes!)

Check "√" any of the following you are **Currently** experiencing.
Write "P" for any of the following you have experienced in the **Past**.

Digestion & Elimination

- | | | | |
|-------------------------------|-----------------------|-------------------------|----------------------------|
| Irritable bowel_____ | Burping_____ | Hiatus hernia_____ | Parasites_____ |
| Frequent diarrhea _____ | Abdominal pain _____ | Heartburn_____ | Skip meals regularly_____ |
| Difficult to pass stool_____ | Hemorrhoids _____ | Reflux_____ | Tendency to overeat_____ |
| Hard/dry/small stools _____ | Diverticulitis_____ | Ulcer_____ | Eating disorder _____ |
| Mucus in stool_____ | Recurrent nausea_____ | Antacid use _____ | |
| Undigested food in stool_____ | Gallstones_____ | Laxative use_____ | Your birth history: |
| Abdominal bloating_____ | Fatty liver_____ | Sleepy after meals_____ | Born by C-section? yes no |
| Gas/flatulence_____ | Hepatitis_____ | Low blood sugar_____ | Were you breastfed? yes no |

How often do you have a bowel movement? _____

Check “√” any you are **Currently** experiencing. **Write “P”** for any you have experienced in the **Past**:

Sleep, Energy

Trouble falling asleep _____
Trouble staying asleep _____
Sleep not restful _____

Fatigue _____
Anemia, low iron _____
Need caffeine to get going _____

Thyroid problems _____
Hyperactivity _____
Restlessness _____

Mind, Emotions

Easily stressed _____
Depression _____
Anxiety _____
Nervousness _____
Panic attacks _____

Irritable _____
Mood swings _____
Anger easily _____
Worrier _____
Overwhelm easily _____

Declining memory _____
Poor focus _____
Psychological counselling _____
Psychiatric care _____

Skin, Hair & Nails

Acne _____
Psoriasis _____
Skin fungus _____
Rashes _____
Eczema/dermatitis _____
Boils, cysts _____

Dry skin _____
Itchy skin _____
Sensitive skin _____
Rosacea _____
Changes in moles _____
Hives _____

Excess hair loss _____
Dandruff _____
Nails split or break easily _____
White spots on nails _____
Nail fungus _____
Skin slow to heal _____

Head/Neck

Migraines _____
Headaches _____
Dizziness _____

Loss of balance _____
Concussion _____
Head injury _____

Jaw clicking, TMJ _____
Grind/clench teeth _____

Eyes

Watery eyes _____
Dry eyes _____
Discharge from eyes _____

Eye infections _____
Dark under eyes _____
Puffy under eyes _____

Sensitive to light _____
Impaired vision _____
Outer eyebrow thinning _____

Ears

Ear infections _____
Itchy ears _____

Excess wax _____
Drainage from ear _____

Earaches _____
Impaired hearing _____

Nose/Sinuses

Chronic stuffy nose _____
Chronic runny nose _____

Sinus pain _____
Sinus infections _____

Loss of smell _____
Recurrent nosebleeds _____

Mouth/Throat

Swollen glands _____
Frequent need to clear throat _____
Post-nasal drip _____
Frequent throat infections _____
Hoarseness _____

Loss of taste _____
Cracks at corners of lips _____
Cold sores/Herpes _____
Canker sores _____
Problems with gums _____

Dentures _____
Dental abscess _____
Root canals _____ (how many _____)
Cavities _____ (how many _____)
Mercury fillings _____ (how many _____)

Circulation/Heart

Irregular or skipped heartbeat _____
Palpitations, fluttering _____
Chest discomfort or pain _____
High cholesterol _____

High blood pressure _____
Low blood pressure _____
Varicose veins _____
Easy bruising _____

Cold hands _____
Cold feet _____
Swollen feet/ankles _____
Excessive sweating _____

Lungs/Respiratory

Frequent colds _____
Infections settle in lungs _____
Wheezing _____
Shortness of breath _____

Chronic cough _____
Cough up phlegm _____
Bronchitis _____
Asthma _____

Difficult to take deep breath _____
Pain with deep breath _____
Pneumonia _____
Chest X-rays _____

Urinary

Excessive urination _____
Inability to hold urine _____
Urinary urgency _____

Painful urination _____
Reduced urine flow _____
Change in strength of flow _____

Increased thirst _____
Bladder/kidney infection _____
Kidney stones _____

Female Reproductive

Age when periods began_____	Irregular periods (early or late)_____	Yeast infections _____
Date of last period _____	Missed periods _____	Vaginal dryness _____
Usual number of days of flow _____	Spotting between periods _____	Painful intercourse _____
Usual length of cycle _____ days	PMS _____	Low sex drive _____
Number of pregnancies _____	Painful periods _____	Sexual abuse/trauma _____
Number of live births _____	Headache with periods _____	
Number of miscarriages _____	Heavy flow _____	Menopause__ since what age _____
Fertility challenges _____	Brown/black blood _____	Hot flashes _____
Painful ovulation _____	Clots/clumps _____	Night Sweats _____
Ovarian cysts _____	Abnormal PAP _____	Hysterectomy _____
Fibroids _____	Cervical dysplasia _____	
Endometriosis _____	Genital warts or herpes _____	

Total length of time on **hormone contraceptives** (i.e., pill, patch, IUD) _____

Are you on or ever been on **hormone replacement therapy** _____ For how long _____

Are you currently pregnant? _____ Trying to get pregnant? _____ Are you currently breastfeeding? _____

Breast

Lumps, cysts _____	Do you perform breast self exams _____
Pain, tenderness _____	When was your last breast exam by health professional _____
Nipple discharge _____	Total number of months spent breastfeeding _____

Male Reproductive

Hernia _____	Sperm/fertility problems _____	Genital warts _____
Groin rash, Jock itch _____	Erectile difficulties _____	Genital herpes _____
Testicular lump _____	Sexual difficulties _____	Prostatitis, prostate swelling _____
Testicular pain _____	Sexual abuse/trauma _____	Prostate cancer _____

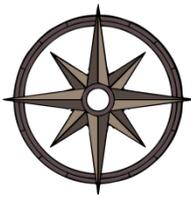
Musculoskeletal

Joint pain _____	Extremity numbness _____	Muscle cramps _____
Joint swelling _____	Carpal tunnel syndrome _____	Muscle aches _____
Joint stiffness _____	Tendonitis _____	Osteopenia _____
Arthritis _____	Restless legs _____	Osteoporosis _____

Are there any illnesses, traumas or stresses after which you have never been totally well again, or which have been more severe than usual? Which ones?

Please provide any other health or personal information that you feel is important:

Thank you
All your information will be kept confidential
I look forward to helping you any way I can



dr.nadia.nd

Nadia Tymoshenko | Naturopathic Doctor
Nadia-ND.com

Consent Form (Please read and sign this page)

Naturopathic medicine is the treatment and prevention of disease by natural means. Gentle, non-invasive techniques are used in order to support and stimulate the body's inherent healing capacity. Naturopathic therapies include: diet and nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, naturopathic bodywork, and lifestyle counselling. Your Naturopathic Doctor will take a thorough case history, perform a physical examination as is pertinent to your case, and make recommendations based on the history, findings and assessment.

Statement of Acknowledgement & Consent to Treatment

I understand that Nadia Tymoshenko ND provides naturopathic care based on the practices mentioned in the previous paragraph. I understand that it is my responsibility to provide complete information of all health concerns including but not limited to: any illness/diagnosis, pregnancy, breast-feeding, and all prescription & over the counter medications I am taking. I understand that results cannot be guaranteed. As with any form of medicine, there is a potential for aggravation of symptoms or allergic reactions (i.e., to herbs or supplements). I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I understand that any questions I have will be answered by Nadia to the best of her ability.

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 directed by me in writing or unless required by law. I understand that I am at liberty to seek or continue care from a medical doctor or other health care provider.

With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above. I intend this consent to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures any time.

Signature _____ Date _____

If a guardian has signed, please print guardian's name and relation _____

Payment Policy

All payments are due in full at the time of each appointment. Our clinic accepts payment by cash, cheque and credit card. First visit is \$160 (students & seniors age 65+ first visit is \$140), follow-up visits are \$85.

Please provide at least 24 hours notice to change or cancel appointments. The full appointment fee will be billed if you do not give sufficient notice of cancellation or change. This fee also applies to missed appointments. Exceptions can be made for extenuating circumstances.

Many people have extended health care benefits through their own plan or another family member's plan that covers naturopathic consultations. At each appointment, we provide you with an official receipt that you can submit for reimbursement.

I agree to pay for my appointments in full at each appointment. I understand the cancellation policy and agree to pay the appointment fee if I fail to give at least 24 hours notice of cancellation or change.

Signature _____ Date _____