CONFIDENTIAL ADULT INTAKE FORM **Nadia Tymoshenko ND, Naturopathic Doctor**

Name____________________________Gender__________How did you hear about me?___________________

If Internet, how specifically did you find me (Glenboune website, Nadia-ND website, NSAND site, 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			

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

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

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?___________________________

Rate your typical stress level (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)?____

____

What 3 expectations do you have from this first visit with me?____

____

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 lifestyle 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________	Fatigue_______	Thyroid problems______
Trouble staying asleep________	Anemia, low iron_____	Hyperactivity______
Sleep not restful_______	Need caffeine to get going_____	Restlessness______

Mind, Emotions

Easily stressed_____	Irritable _______	Declining memory________
Depression_______	Mood swings_____	Poor focus______
Anxiety_______	Anger easily_______	Psychological counselling______
Nervousness______	Worrier______	Psychiatric care______
Panic attacks_______	Overwhelm easily_____	

Skin, Hair & Nails

Acne______	Dry skin______	Excess hair loss______
Psoriasis______	Itchy skin______	Dandruff______
Skin fungus______	Sensitive skin______	Nails split or break easily______
Rashes ______	Rosacea ______	White spots on nails______
Eczema/dermatitis_______	Changes in moles______	Nail fungus ______
Boils, cysts______	Hives______	Skin slow to heal_____

Head/Neck

Migraines ______	Loss of balance _____	
Headaches ______	Concussion______	Jaw clicking, TMJ______
Dizziness______	Head injury______	Grind/clench teeth______

Eyes

Watery eyes______	Eye infections______	Sensitive to light______
Dry eyes______	Dark under eyes______	Impaired vision_____
Discharge from eyes____	Puffy under eyes ______	Outer eyebrow thinning___

Ears

Ear infections______	Excess wax______	Earaches_____
Itchy ears______	Drainage from ear______	Impaired hearing______

Nose/Sinuses

Chronic stuffy nose______	Sinus pain_____	Loss of smell _______
Chronic runny nose______	Sinus infections_______	Recurrent nosebleeds______

Mouth/Throat

Swollen glands_______	Loss of taste _____	Dentures______
Frequent need to clear throat______	Cracks at corners of lips_____	Dental abscess ______
Post-nasal drip_______	Cold sores/Herpes______	Root canals_____(how many_____)
Frequent throat infections_____	Canker sores______	Cavities_____(how many_____)
Hoarseness______	Problems with gums ____	Mercury fillings____(how many____)

Circulation/Heart

Irregular or skipped heartbeat______	High blood pressure______	Cold hands______
Palpitations, fluttering______	Low blood pressure______	Cold feet______
Chest discomfort or pain______	Varicose veins ______	Swollen feet/ankles______
High cholesterol ________	Easy bruising______	Excessive sweating______

Lungs/Respiratory

Frequent colds_____	Chronic cough_____	Difficult to take deep breath_____
Infections settle in lungs_____	Cough up phlegm_____	Pain with deep breath_____
Wheezing_____	Bronchitis_____	Pneumonia_____
Shortness of breath_____	Asthma_____	Chest X-rays_____

Urinary

Excessive urination______	Painful urination ______	Increased thirst______
Inability to hold urine ______	Reduced urine flow______	Bladder/kidney infection______
Urinary urgency______	Change in strength of flow_____	Kidney stones______

Female Reproductive

Age when periods began_______
Date of last period_____________
Usual number of days of flow_____
Usual length of cycle _________days
Number of pregnancies_______
Number of live births_______
Number of miscarriages_______
Fertility challenges___________
Painful ovulation_______
Ovarian cysts_______
Fibroids______
Endometriosis______

Irregular periods (early or late)_____
Missed periods______
Spotting between periods______
PMS_______
Painful periods_______
Headache with periods______
Heavy flow______
Brown/black blood______
Clots/clumps______
Abnormal PAP_______
Cervical dysplasia_______
Genital warts or herpes_____

Yeast infections ______
Vaginal dryness______
Painful intercourse______
Low sex drive______
Sexual abuse/trauma ______

Menopause__ since what age____
Hot flashes_____
Night Sweats_____
Hysterectomy_____

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______
Pain, tenderness______
Nipple discharge______

Do you perform breast self exams________
When was your last breast exam by health professional_________
Total number of months spent breastfeeding________

Male Reproductive

Hernia______
Groin rash, Jock itch ____
Testicular lump______
Testicular pain______

Sperm/fertility problems______
Erectile difficulties ______
Sexual difficulties _____
Sexual abuse/trauma ______

Genital warts _____
Genital herpes _______
Prostatitis, prostate swelling______
Prostate cancer______

Musculoskeletal

Joint pain_______
Joint swelling________
Joint stiffness________
Arthritis ________

Extremity numbness______
Carpal tunnel syndrome____
Tendonitis_____
Restless legs_______

Muscle cramps______
Muscle aches_______
Osteopenia______
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, debit 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__________________________________