

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 (Glenboure 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 _____

Your 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 exposed to toxins, mould 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 hopes and 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 _____
 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 _____
 Brain fog _____
 Psychological counselling _____
 Psychiatric care _____

Skin, Hair & Nails

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

Dry skin _____
 Itchy skin _____
 Sensitive skin _____
 Rosacea _____
 Changes in moles _____
 Skin slow to heal _____

Excess hair loss _____
 Dandruff _____
 Nails split or break easily _____
 White spots on nails _____
 Tick bite ___ Rash from tick bite ___
 Feel flu-like after insect bite _____

Head/Neck

Migraines _____
 Headaches _____
 Dizziness _____

Whiplash _____
 Concussion _____
 Head injury/trauma _____

Grind teeth _____
 Clench teeth _____

Eyes

Watery eyes _____
 Dry eyes _____
 Discharge from eyes _____

Eye infections _____
 Dark under eyes _____
 Puffy under eyes _____

Sensitive to light _____
 Changes with 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 _____
 Pneumonia _____
 Shortness of breath _____

Chronic cough _____
 Cough up phlegm _____
 Bronchitis _____
 Asthma _____

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

Urinary

Frequent 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 _____ 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 (including during childhood) 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 both sections of 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 Information & Cancellation Policy

Our clinic accepts payment by cash, cheque & credit card. Payment is due at each appointment. First visit fee is \$180 (\$145 for child 17 years old or younger & seniors age 65+), follow-up visits are \$90.

Naturopathic fees are not covered by provincial health care/MSI. Most extended health insurance plans offer coverage. We provide an official receipt that you can submit for reimbursement.

Please be advised that you are responsible for appointment times you have reserved. Appointments are in high demand, and your early cancellation/rescheduling will give another person the possibility to access that time. Therefore, we require at least **2 business days notice** to change or cancel your naturopathic appointment. If you miss or cancel an appointment without 2 business days notice, you will be responsible to pay a \$50 fee. Exceptions to this policy can be considered in emergency situations.

I agree to pay for my appointments in full at each appointment. I understand that I will be billed \$50 for missed appointments or with less than 2 business days notice of cancellation or change.

Signature _____ Date _____