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 (Nadia-ND website, NSAND website, Glenbourne Chiro, 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_____ Your relationship/marital status_____ # of children_____

Occupation _____ Emergency contact name & phone #_____

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. MD, physio, counsellor):

_____

Please list all prescription and over the counter medications you are taking (*list the name, dose & what time of day taken):

_____

_____

_____

List all natural supplements you are taking (brand name, ingredients, and daily dose for each one - use extra paper if needed):

_____

_____

_____

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

_____

List all accidents, injuries, body scars (& approximate dates):_____

_____

List medical tests you've had (blood work, colonoscopy, MRI, bone density, biopsy, ultrasound): bring copies if you have them_____

_____

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?

_____

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

Alcoholism	Asthma	Anxiety	Epilepsy	Heart disease	Skin disease
Allergies	Autoimmune disease	Depression	Eczema	High cholesterol	Stroke
Arthritis	Alzheimer's, Dementia	Diabetes	Cancer (what type)	Mental illness	Tuberculosis

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

Any other significant family health history or family trauma?_____

Are you sensitive to scents/fumes? _____ Have you ever been exposed to chemicals, mould or other toxins?_____

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

What are your main stresses? _____

Do you have, or have you had, any major mental/emotional life-stresses (i.e., loss of a loved one, separation/divorce, career change, job loss, etc):

_____

Do you take time for relaxation_____ Time for leisure, fun?_____ 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 very satisfied: Energy _____ Sleep _____

Moods_____ Mindset/self-talk_____ Work/daily occupation_____ Relationships (friends, family, partner)_____

Do you consider your weight: Just right☐ Underweight☐ Overweight☐ Any difficulty maintaining a healthy weight?_____
Any current or past eating disorders? Current☐ Past☐
Approximately how many times have you been treated with antibiotics in your life? _____
How often do you have a bowel movement? _____
Do you have, or have you had: Fatty liver☐ Gallstones☐ Hepatitis☐ Diverticulitis☐ Kidney stones☐

Your birth history: Were you born by C-section? yes☐ no☐ Were you breastfed? no☐ yes☐

Have you ever had head injury or concussion? _____ Ever had a tick bite? ____Ever felt flu-like after an insect bite? ____

Do you smoke?_____# Years smoked:_____Ex-Smoker?_____# Years smoked:_____ Recreational drugs?_____

Menstrual/Uterine/Hormone Health

Age when periods began_____
Date of last period_____
Cycle length (day 1 to the next day 1)___
Menopause☐ since what age____
Hysterectomy☐
Breast lumps☐ Breast pain☐
Currently Breastfeeding?☐

Fertility challenges☐
Number of pregnancies_____
Number of live births_____
Number of miscarriages_____
Are you currently pregnant?☐
Trying to get pregnant?☐
C-Section☐ Episiotomy/tearing☐

Current or past yeast infections☐
Current or past abnormal PAP☐
Pelvic pain☐
Sexual difficulties☐
Current or past sexual trauma☐
Fibroids☐ Endometriosis☐
Ovarian cysts☐ Other_____

Please describe a typical day's diet:

Breakfast:_____

Lunch:_____

Dinner: _____

Snacks:_____

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

Coffee _____Black tea_____ Other teas_____ "Diet" drinks_____ Energy drinks_____ Alcohol (quantity/frequency)_____

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 do you have for your first appointment with me?_____

_____

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

_____

How ready and motivated 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!)

Please provide any other health or personal information that you feel is important:
(note: a review of body symptoms is on the next page)

MSQ – MEDICAL SYMPTOM QUESTIONNAIRE - **PLEASE PRINT AND FILL OUT**

Name: _____ Date: _____

The Medical Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/Stomach pain

Total _____

EARS

___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Total _____

EMOTIONS

___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability or aggressiveness
___ Depression

Total _____

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

Total _____

EYES

___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near or far-sightedness)

Total _____

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total _____

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

Total _____

JOINTS/MUSCLES

___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness

Total _____

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing

Total _____

MIND

___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

Total _____

MOUTH/THROAT

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

Total _____

NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

Total _____

SKIN

___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

Total _____

WEIGHT

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

Total _____

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

Total _____

GRAND TOTAL _____

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

INFORMED CONSENT & PATIENT AGREEMENT Dr Nadia Tymoshenko BSc, ND

Naturopathic medicine is the treatment and prevention of disease by natural means. Gentle, non-invasive techniques are used to support the body's inherent self-healing process. Naturopathic therapies include: diet and nutritional supplements, botanical medicine, homeopathy, acupuncture, naturopathic bodywork, and lifestyle counselling. Your Naturopathic Doctor will take a thorough case history and perform a physical examination as is pertinent to your case to help identify underlying causes of illness and develop personalized treatment plans to address them.

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 naturopathic health care is a joint responsibility between myself (the patient) and the practitioner. Improving my lifestyle can be as important as the therapies and treatments provided by the clinic. I am willing to be an active participant in my wellness.

I understand it is important to inform my ND immediately of any known or suspected allergies, medications I am taking (prescribed, over-the-counter, and birth control), and any diagnoses I have received from other licensed health care providers. I am also to inform my ND if I am pregnant, trying to get pregnant, or breast-feeding.

As with all medical therapies, naturopathic medicine has its limitations and may not be effective for all conditions. My ND will answer any questions I may have to the best of her ability and explain procedures, probable outcomes and potential risks of treatment whenever possible; however, due to individual responses, ND's cannot anticipate all possible outcomes or guarantee results. Minor health risks that may be associated with Naturopathic treatments include but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, bruising, injury and/or fainting from needle acupuncture. I am free to withdraw my consent and discontinue treatment at any time.

I understand that I am at liberty to seek or continue care from a medical doctor or other licensed health care provider and I do not need to choose one method of healthcare over the other. Nadia Tymoshenko N.D. does not suggest to refrain from seeking or following conventional medical treatments.

I understand that a record will be kept of the health services provided to me. All personal and health information is confidential and will be treated in accordance with the Personal Information Protection and Electronic Documents Act and will not be released to others unless directed by me in writing or if required by law.

I always have the right to discuss and ask questions about any therapy that is proposed and I am able to withdraw my consent for specific therapies or treatments if I am not comfortable. With this knowledge, I voluntarily consent to naturopathic care and 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.

Name of patient (printed)_____ Date_____

Signature_____ If signed by guardian, print guardian's name and relation_____

Payment Information & Cancellation Policy

Payment is due at each appointment. The clinic accepts payment by cash, debit & credit card. We provide an official receipt that you can submit for reimbursement if you have an extended health insurance plan or for income tax purposes if applicable. Naturopathic fees are not covered by provincial health care/MSI.

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 full business days' notice** to change or cancel your naturopathic appointment. If you miss or cancel an appointment without 2 business days' notice, a $50 cancellation fee will be applied to your account. Exceptions to this policy can be considered in emergency situations.

I have read and agree to the above Payment and Cancellation Policy:

Signature_____ Date_____