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_____
Frequent diarrhea _____
Difficult to pass stool_____
Hard/dry/small stools ____
Mucus in stool_____
Undigested food in stool____
Abdominal bloating_____
Gas/flatulence_____

Burping_____
Abdominal pain _____
Hemorrhoids _____
Diverticulitis_____
Recurrent nausea_____
Gallstones_____
Fatty liver_____
Hepatitis_____

Hiatus hernia_____
Heartburn_____
Reflux_____
Ulcer_____
Antacid use _____
Laxative use_____
Sleepy after meals____
Low blood sugar_____

Parasites_____
Skip meals regularly_____
Tendency to overeat_____
Eating disorder _____

Your birth history:
Born by C-section? yes no
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_____
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 credit card, eTransfer, cheque. First visit is $195 (children & seniors age 65+ first visit is $160), follow-up visits are $95.

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/reschedule 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 cancellation fee. Exceptions to this policy can be made in emergency situations.

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

Signature_____ Date_____