Adult Intake Form

GENERAL INFORMATION

Name: _____

Date of Birth: _____ Age: _____ Sex: male/female

Address: _____

E-mail: _____

Home Phone #: _____ Work Phone #: _____

Emergency Contact (Name, Phone Number):

_____

Occupation: _____ Hours worked/week: _____

Marital Status: _____ Current weight: _____

Weight one year ago: _____ Height: _____

Family Physician:_____

Address: _____

Telephone #: _____

What are your main concerns/complaints?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list any prescribed medications and doses you are currently taking:

Name	Dose
_____	_____
_____	_____
_____	_____
_____	_____

Please list any over-the-counter medications, supplements or herbs that you are currently taking:

Name Dose

_____ _____

_____ _____

_____ _____

Do you have any drug, food or environmental allergies? If so, please list:

_____

PAST MEDICAL & HEALTH HISTORY

Please describe your medical history (major illnesses, accidents and/or injuries, surgeries or hospitalizations):

_____

_____

Have you had any of the following tests in the past year?

Test	Yes	No
PAP Test		
Mammogram		
Colonoscopy		
Testicular/Prostate Exam		
Cholesterol check		
Blood Pressure check Blood sugar		

Have any of these tests been abnormal?_____

_____

_____

_____

_____

_____

FAMILY HEALTH HISTORY

Please complete the list below:

Relation	Age	Medical Condition(s)	If deceased, age & cause of death
Mother			
Father			
Brother(s)			
Sister(s)			
Mat. Grandmother			
Mat. Grandfather			
Pat. Grandmother			
Pat. Grandfather			

LIFESTYLE

Do you currently smoke cigarettes? Yes No If yes, for how long? _____
Have you smoked in the past? Yes No If yes, for how long? _____

Do you drink alcohol? Yes No
How many of each per week: _____ Beer _____ Wine _____ Liquor

Do you consider yourself (circle):
_____ Overweight _____ Underweight _____ About right

What is your ideal weight: _____ Has your weight changed recently? Y/N

What factors (if any) make it difficult for you to eat right (please check all that apply)?
___ eating out ___ eating large portions ___ frequent snacking
___ someone else cooks ___ need info on healthy eating

Are you on a special diet or do you have any dietary restrictions? (please describe) _____

Do you consume any/all of these on a regular basis (please check or circle all that apply:

Red meat
Dairy (milk, cheese, etc)
Microwaved foods
White flour pastas, crackers, white rice
Sugary snacks (cakes, pastries, ice cream, etc)
Chocolate

Do you drink caffeinated beverages? Y/N
If yes, please indicate the number of cups per day:
_____ coffee _____ tea _____ cola

On a scale of 1-10 (10 being the best), rate your quality of sleep: _____
How many hours of sleep do you typically have per night? _____
Do you typically awake rested? Yes No

How active are you? _____ Very _____ Moderately _____ Sedentary

Describe typical physical activity and number of times/week:
_____
_____
_____

Rate your current stress level on a scale of 1-10 (10 being the worst):

1 2 3 4 5 6 7 8 9 10

What are your main stressors (work, finances, family, etc.)?
_____
_____
_____

What goals do you have in receiving naturopathic treatment?

1. _____
2. _____
3. _____

Is there any additional information that you would like share?
_____
_____
_____
_____

Thank You.

Declaration and Consent to Naturopathic Treatment

1. This is to acknowledge that I have been informed and I understand that:

    - Any treatment or advice provided to me as a patient of the Sunnybrook Chiropractic clinic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I understand that naturopathic treatment may consist of any or all of the following modalities: Clinical Nutrition, Homeopathy, Physical Medicine, Traditional Asian Medicine and Acupuncture, Lifestyle Counseling, and/or Botanical Medicine.
    - I am at liberty to seek or continue medical care from a medical doctor, chiropractor or any other healthcare provider licensed to practice in Ontario.

2. I am aware that no part of my treatment or testing is covered by OHIP and that I am solely responsible for payment. Payment is to be made at the time of treatment.

3. Cancellation Policy: We require 24 hours notice if you are unable to keep an appointment. Patients who fail to call will be billed for their missed appointment.

For Patients Receiving Acupuncture Treatments:
Acupuncture is generally very safe. Serious side effects are very rare—less than one per 10, 000 treatments.

Does acupuncture have side effects?

- *Drowsiness may occur after treatment in a small number of patients, and, if affected, you are advised not to drive*
- *Minor bleeding or bruising occurs after acupuncture in about 3% of treatments*
- *Pain during treatment occurs in about 1% of treatments*
- *Fainting can occur in certain patients, particularly during/after the first treatment*

In addition, if there are any particular risks that may apply in your case, your practitioner will discuss these with you.

Is there anything your practitioner needs to know?
Apart from general medical information, it is important that you let your practitioner know:

- *If you have a history of fainting spells* *YES* *NO*
- *If you have a pacemaker or any other electrical implants* *YES* *NO*
- *If you have a bleeding disorder* *YES* *NO*
- *If you are taking anti-coagulants (blood thinners)* *YES* *NO*
- *If you are or are planning to become pregnant* *YES* *NO*

Only single-use, sterile & disposable needles are used in this clinic.

I hereby authorize and consent to treatment by the Naturopathic Doctor working in this clinic.

_____ _____ _____

Patient/Guardian Signature Naturopath's Signature Date