HEAD TO TOE HEALTH CENTRE

Adult Intake Form - Naturopathy

This confidential information of your medical record and health history will be kept in the Head to Toe Health Centre and will not be released to any individual except when you have authorized this release in writing or when required by law. Please complete this form as thoroughly as possible to optimize your health care outcomes.

Contact Information:

Name: _____ Age: _____ Date of Birth: _____ Gender: : ☐ M ☐ F

Address:_____Email: _____

Phone (H): _____ (W): _____ (C): _____

Emergency contact: _____ Relationship: _____ Phone: _____

Medical doctor: _____ Phone: _____

Address:_____

How did you become aware of the Head to Toe Health Centre: _____

Email/ E-newsletter:

Would you like to receive our e-newsletter* to this email? ☐ Yes ☐ No

*Periodically Head to Toe sends out an e-newsletter updating patients on clinic news and events providing helpful holistic health care information. Your email address will not be shared.

Health Goals/Concerns:

What main health goal/concern brought you to the clinic today? _____

_____

How long have you had it? _____

Describe any factors you suspect may have played a role in the onset and perpetuation of your condition:

_____

Previous practitioners consulted for this condition: ☐ MD ☐ ND ☐ Other _____

Please explain their diagnosis, therapy and results where applicable: _____

_____

What types of therapy have you tried for this problem?

☐ Diet modification ☐ Vitamin/mineral supplements ☐ Herbs ☐ Homeopathy ☐ Chiropractor

☐ Acupuncture ☐ Conventional drugs ☐ Osteopathy ☐ Other _____

What makes it better? _____ What makes it worse? _____

Please list any other health concerns or goals in order of importance: _____

_____

Personal Information/ Lifestyle:

Do you identify as: ☐ Straight ☐ Homosexual ☐ Bi-sexual ☐ Trans-gendered ☐ Other _____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ With partner Number of dependants _____

Occupation: _____ Shift work? ☐ Y ☐ N Do you enjoy your work? ☐ Y ☐ N ☐ Sometimes

Is your job associated with potentially harmful chemicals (e.g. pesticides, solvents, radioactivity) or health and/or life threatening activities (e.g. firefighting, mining, etc.)? Please specify: _____

Hours/day you spend: Working: _____ Driving: _____ Watching TV: _____ In front of computer/screen: _____

Circle the level of stress you are presently experiencing in your life (10=highest): 1 2 3 4 5 6 7 8 9 10

Please list the major causes of stress for you (work, finances, relationship, health, etc.) _____

_____

Have you experienced any major trauma, loss, or life changing significant events? _____

_____

Have you worked with a counsellor, psychologist, or psychiatrist? ☐ No ☐ Currently ☐ In the past

Medical History:

How would you describe your general state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you wear a medical alert bracelet/tag? ☐ Y ☐ N For what condition? _____ What is your blood type? _____

Do you wear: ☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical devices/prosthetics/implants

For the following tables, please use the back of this page if more room is required:

Medical Conditions: Please indicate any hospitalizations, surgeries and injuries you have experienced:

Hospitalization /Surgery/Injury	Date	Symptoms	Condition Resolved?

X-rays, CT Scans, EKGs, ECGs, MRIs, or other imaging scans you've had in the past:

Scan/Screen/Test	Date	Reason	Result

Allergies and/or food sensitivities:

Allergy/Sensitivity	Symptoms	Treatment/Avoidance?

Current medications/supplements: Please list ALL medications or supplements you take on a regular basis:

Medication/Supplement	Dose (if known)	Length of Use	Prescribing Practitioner	Are You Taking Presently?

Screening Tests: Please indicate when you had the following screening tests (if known):

Screen/Test*	Year	Screen/Test*	Year
PAP (Females)		DEXA Scan	
Digital Rectal Exam (Males)		Complete Blood Count (CBC)	
PSA Test (Males)		Cholesterol	
Breast Exam (Both)		Blood Glucose	
Mammogram		Other: _____	

** Please bring a copy of any test results you have to your first visit.*

Date of last complete physical exam: _____

Have you taken antibiotics within the last 5 years? ☐ Y ☐ N If yes, how many times? _____

Were you frequently given antibiotics as a child? ☐ Y ☐ N How often? _____

Diet and Health Habits:

General energy level out of 10 (1=lowest, 10=highest): _____ What time of day is it highest? _____ Lowest? _____

What time of day do you eat the following: Breakfast _____ Lunch: _____ Dinner: _____

Do you consume: ☐ Canned foods ☐ Pop ☐ Aspartame (e.g. diet pop, gum) ☐ Deli meats ☐ Margarine ☐ Juice

Are you on a special diet? ☐ Y ☐ N Explain: _____

Do you crave: ☐ Sugar ☐ Chocolate ☐ Salt ☐ Protein ☐ Fats ☐ Other: _____

How many glasses of water do you drink on an average day? _____ Do you drink purified water/filtered water? ☐ Y ☐ N

Diet and Health Habits (continued):

Please provide examples of things you typically consume at the following meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you have digestive difficulty with any specific foods? Please specify: _____

Do you smoke? ☐ Y ☐ N How long ago did you start? _____ Number of cigarettes per day: _____

Did you smoke in the past? ☐ Y ☐ N For how long? _____ Number of cigarettes per day: _____

Do you drink alcohol? ☐ Y ☐ N What type? _____ How frequently?_____

Do you take recreational drugs? ☐ Y ☐ N What type? _____ How frequently?_____

Do you drink coffee? ☐ Y ☐ N How many cups per day? _____

How often do you exercise? ☐ 5-7 days/week ☐ 3-4 days/week ☐ 1-2 days/week How long do you spend? _____

What do you do for exercise/movement? _____

How many hours of sleep do you get each night? _____ Do you wake feeling rested? Y ☐ N ☐ Do you nap? Y ☐ N ☐

Do you wake in the night? Y ☐ N ☐ For any particular reason? _____ At any particular time? _____

Have you ever been diagnosed with any of the following?

☐ Alcoholism	☐ Colitis	☐ Genetic Disorder	☐ Mono
☐ Alzeimer's Disease	☐ Crohn's Disease	☐ Glaucoma	☐ Osteoarthritis
☐ Anemia	☐ Depression	☐ Gastric/Duodenal Ulcer	☐ Osteoporosis
☐ Asthma	☐ Diabetes	☐ Head Injury	☐ Pancreatitis
☐ Autoimmune Disease	☐ Drug Addiction	☐ Hepatitis	☐ Pneumonia
☐ Benign Prostatic Hypertrophy	☐ Eating Disorder	☐ High Blood Pressure	☐ Psoriasis
☐ Bronchitis	☐ Eczema	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Cancer	☐ Emphysema	☐ HIV	☐ Skin Condition
☐ Cardiovascular Disease	☐ Endometriosis	☐ Intestinal Parasites	☐ STD
☐ Celiac Disease	☐ Epilepsy	☐ Mental Illness	☐ Stroke
☐ Chronic Fatigue Syndrome	☐ Fibromyalgia	☐ Migraine Headaches	☐ Thyroid Condition
☐ Other:_____			

Childhood History:

Were you breastfed? Y ☐ N ☐ If yes, for how long? _____

Were you immunized? Y ☐ N ☐ If yes, any reactions? _____

Which “childhood” illnesses did you have?

☐ ADD/ADHD	☐ Eczema	☐ German Measles	☐ Mumps
☐ Frequent Ear Infections	☐ Meningitis	☐ Red Measles	☐ Rheumatic Fever
☐ Chicken Pox	☐ Whooping Cough	☐ Thrush/Candida	☐ Autism/Asperger’s

Family History:

Has anyone in your family been diagnosed with any of the following conditions?

☐ Alcoholism	☐ Diabetes	☐ Heart Disease	☐ Multiple Sclerosis
☐ Alzeimer's Disease	☐ Drug Abuse	☐ High Blood Cholesterol	☐ Osteoporosis
☐ Asthma	☐ Eczema	☐ High Blood Pressure	☐ Osteoarthritis
☐ Cancer	☐ Epilepsy	☐ Kidney Disease	☐ Psoriasis
☐ Depression	☐ Fibromyalgia	☐ Mental Illness	☐ Thyroid Disorder

Please list any other illnesses of your relatives, such as: parents, siblings, grandparents, aunts and uncles:

_____

_____

_____

_____

_____

_____

_____

Is there anything else that you feel is important that hasn’t been addressed on this form? _____

_____

_____

_____

_____

_____

_____

Review of Systems:

Weight: _____ Weight one year ago: _____ Height: _____

Do you consider yourself: ☐ Underweight ☐ Slightly Underweight ☐ Slightly Overweight ☐ Overweight ☐ Just Right

Please mark symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank

Systemic			**Comments**
Chills	C ☐	P ☐	
Chronic Generalized Pain	C ☐	P ☐	
Dizziness/Vertigo	C ☐	P ☐	
Dizziness upon rising	C ☐	P ☐	
Fainting	C ☐	P ☐	
Fatigue	C ☐	P ☐	
Frequent Colds	C ☐	P ☐	
Lightheadedness	C ☐	P ☐	
Low Grade Fever	C ☐	P ☐	
Night Sweats	C ☐	P ☐	
Strong Body Odour	C ☐	P ☐	
Skin			**Comments**
Acne	C ☐	P ☐	
Boils	C ☐	P ☐	
Changes in Mole(s)	C ☐	P ☐	
Colour Change	C ☐	P ☐	
Dry Skin	C ☐	P ☐	
Eczema/Dermatitis	C ☐	P ☐	
Hives	C ☐	P ☐	
Itching	C ☐	P ☐	
Lumps	C ☐	P ☐	
Nail Changes	C ☐	P ☐	
Rashes	C ☐	P ☐	
Skin Cancer	C ☐	P ☐	
Eyes			**Comments**
Far Sighted	C ☐	P ☐	
Near Sighted	C ☐	P ☐	
Blind Spot(s)	C ☐	P ☐	
Sensitive to Sun	C ☐	P ☐	
Cataract(s)	C ☐	P ☐	
Stigmatism	C ☐	P ☐	
Blurred Vision	C ☐	P ☐	
Discharge	C ☐	P ☐	
Dry Eyes	C ☐	P ☐	
Eye Pain	C ☐	P ☐	
Glaucoma	C ☐	P ☐	
Itching	C ☐	P ☐	
Redness	C ☐	P ☐	
Tearing	C ☐	P ☐	
Ears			**Comments**
Discharge	C ☐	P ☐	
Earache	C ☐	P ☐	
Feeling of Fullness	C ☐	P ☐	
Frequent Infections	C ☐	P ☐	

Review of Systems:

Please mark symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank.

Ears (cont.)			Comments
Impaired Hearing	C	P	
Ringing	C	P	
Sensitive Hearing	C	P	
Wax Build-Up	C	P	
Nose and Sinuses			**Comments**
Allergies	C	P	
Frequent Nose Bleeds	C	P	
Nasal Discharge	C	P	
Sinusitis/Sinus Problems	C	P	
Stuffiness	C	P	
Mouth & Throat			**Comments**
Bleeding of Gums/Tongue	C	P	
Canker Sores	C	P	
Cold Sores	C	P	
Dentures	C	P	
Gum Problems	C	P	
Frequent Sore Throat	C	P	
Hoarseness	C	P	
Loss of Taste	C	P	
Metal Fillings	C	P	
Phlegm	C	P	
Root Canal(s)	C	P	
Sore Tooth/Teeth	C	P	
Tonsilitis	C	P	
Head & Neck			**Comments**
Dandruff	C	P	
Goiter (Enlarged Thyroid)	C	P	
Headaches	C	P	
Hair Loss, Excessive	C	P	
Hair Growth/Hirsutism	C	P	
Migraines	C	P	
Pain/Stiffness of Neck	C	P	
Swollen Glands	C	P	
Thinning Eyebrows	C	P	
Respiratory			**Comments**
Difficulty Breathing	C	P	
Hyperventilation	C	P	
Pain on Breathing	C	P	
Persistent Cough	C	P	
Persistent Respiratory Infection	C	P	
Shortness of Breath	C	P	
Shortness of Breath on Exertion	C	P	
Shortness of Breath While Lying Down	C	P	
Sitting Up Blood	C	P	
Sputum	C	P	
Wheezing	C	P	

Review of Systems:

Please mark symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank.

Cardiovascular			Comments
Angina	C	P	
Abnormal Heart Tests	C	P	
Chest Pain(s)	C	P	
Cholesterol, Elevated	C	P	
Heart Murmur(s)	C	P	
Heart Palpitations	C	P	
High Blood Pressure	C	P	
Low Blood Pressure	C	P	
Peripheral Vascular			**Comments**
Bruise Easily	C	P	
Bleed Easily	C	P	
Cold Hands/Feet	C	P	
Cyanosis (Skin Appears Blue)	C	P	
Deep Leg Pain	C	P	
Extremity Numbness	C	P	
Extremity Swelling	C	P	
Extremity Ulcers	C	P	
Hemorrhoids	C	P	
Leg Cramps	C	P	
Leg Pain Worse with Exercise	C	P	
Lymph Node Swelling	C	P	
Numbness or Tingling	C	P	
Past Transfusions	C	P	
Raynode's Syndrome	C	P	
Varicose Veins	C	P	
Wounds Heal Slowly	C	P	
Urinary			**Comments**
Blood in Urine	C	P	
Cloudy Urine	C	P	
Dribbling of Urine	C	P	
Frequent Infections	C	P	
Increased Frequency	C	P	
Increased Urgency	C	P	
Inability to Hold Urine	C	P	
Hesitancy	C	P	
Kidney Stones	C	P	
Pain on Urination	C	P	
Strong Urine Odour	C	P	
Unusual Change in Colour of Urine	C	P	
Urination at Night	C	P	
Gastrointestinal			**Comments**
Abdominal Pain	C	P	
Anal Fissures	C	P	
Anal Prolapse	C	P	
Belching, Excessive	C	P	
Bloating	C	P	
Constipation	C	P	
Diarrhea	C	P	

Review of Systems:

Please mark symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank.

Gastrointestinal (cont.)			Comments
Fecal Incontinence	C	P	
Gallstones	C	P	
Heartburn	C	P	
Indigestion	C	P	
Nausea	C	P	
Painful Bowel Movement	C	P	
Pain on Swallowing	C	P	
Passing Gas, Excessive	C	P	
Rectal Bleeding	C	P	
Vomitting	C	P	
Worse with Fatty Foods	C	P	
Number of Bowel Movements Each Week: _____			

Stool			Comments
Blood in Stool	C	P	
Black/Tarry Stool	C	P	
Greenish Stool	C	P	
Hard Stool	C	P	
Loose Stool	C	P	
Mucus in Stool	C	P	
Stool Floats	C	P	
Undigested Food in Stool	C	P	
Yellow/Pale Stool	C	P	

Musculoskeletal			Comments
Backache	C	P	
Bone Pain	C	P	
Broken Bones	C	P	
Heel Spurs	C	P	
Joint Pain	C	P	
Joint Stiffness	C	P	
Joint Swelling	C	P	
Limited Joint Motion	C	P	
Muscle Cramps	C	P	
Muscle Spasms	C	P	
Muscle Weakness	C	P	
Muscle Wasting	C	P	
Sprain Joints Easily	C	P	

Endocrine			Comments
Change in Thirst	C	P	
Change in Appetite	C	P	
Cold Intolerance	C	P	
Excessive Sweating	C	P	
Heat Intolerance	C	P	
High Blood Sugar	C	P	
Low Blood Sugar	C	P	
Recent Weight Gain	C	P	
Recent Weight Loss	C	P	
Seasonal Depression	C	P	
Thyroid Problems	C	P	

Review of Systems:

Please mark symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank.

Neurological			Comments
Learning Challenges	C	P	
Loss of Balance	C	P	
Loss of Coordination	C	P	
Loss of Memory	C	P	
Paralysis	C	P	
Seizures/Convulsions	C	P	
Speech Difficulties	C	P	
Tremor(s)	C	P	
Unusual Sensations	C	P	
Emotional			**Comments**
Anger, Excessive	C	P	
Anxiety/Nervousness	C	P	
Depression	C	P	
Irritability, Excessive	C	P	
Insomnia	C	P	
Mood Swings	C	P	
Panic Attacks	C	P	
Fears/Phobias	C	P	
Worry, Excessive	C	P	
Female Reproductive			**Comments**
Age menses began: _____			
Average number of days of menstruation at present: _____			
Average number of days between periods at present: _____			
Are you pre-menopausal, menopausal or post-menopausal? _____			
Are you sexually active? _____			
Could you be pregnant? _____			
Birth Control: What type(s), when and for how long? _____			
Number of pregnancies: _____			
Number of miscarriages: _____			
Number of abortions: _____			
Bleeding Between Periods	C	P	
Blood Clots	C	P	
Breast Lumps	C	P	
Breast Tenderness	C	P	
Breast Discharge	C	P	
Cervical Dysplasia	C	P	
Cervical Cancer	C	P	
Decreased Sex Drive	C	P	
Difficulty Conceiving	C	P	
Endometriosis	C	P	
Excessive Flow	C	P	

Review of Systems:

Please mark symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank.

Female Reproductive (cont.)			Comments
Fibroids	C	P	
Hot Flashes	C	P	
Hysterectomy	C	P	
Increased Sex Drive	C	P	
Irregular Cycles	C	P	
Night Sweats	C	P	
Ovarian Cancer	C	P	
Ovarian Cysts	C	P	
Painful Menses	C	P	
Pain on Intercourse	C	P	
Scanty Flow	C	P	
Sexually Transmitted Disease: What kind and when: _____ _____	C	P	
Sexual Difficulties	C	P	
Uterine Cancer	C	P	
Vaginal Discharge	C	P	
Vaginal Dryness	C	P	
Vaginal Itching	C	P	
Yeast Infections	C	P	
Are there any other symptoms not described on the above list? _____ _____			

Male Reproductive			Comments
Are you sexually active? _____			
Date of last prostrate exam: _____			
Discharge of Sores	C	P	
Decreased Sex Drive	C	P	
Itchiness	C	P	
Prostate Problems	C	P	
Prostate Cancer	C	P	
Rashes in Genital Area	C	P	
Sexually Transmitted Disease: What kind and when: _____ _____	C	P	
Testicular Hernia	C	P	
Testicular Masses	C	P	
Testicular Pain	C	P	

HEAD TO TOE HEALTH CENTRE

Patient Agreement Form
Naturopathic Medicine

Your signature below acknowledges the following:

1. *I understand that Naturopathic medicine is not covered by the provincial gouvernment (OHIP), though may be covered by private and extended insurance plans. Naturopathic medicine may also be tax deductible.*
2. *The fees and services have been clarified in advance. Payment is due at the end of each visit as the Head to Toe Health Centre does not bill insurance companies directly. Cash, Cheque, Interac, Visa, and Mastercard are acceptable methods of payment.*
3. *Twenty-four hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 50% of the missed appointment fee.*
4. *Items purchased are non-refundable, whether or not they have been opened.*
5. *I understand that naturopathic care is a joint responsibility between me (the patient) and my practitioner. Improving my lifestyle can be as important as the remedies and treatments.*
6. *I recognize that Naturopathic medicine is not an isolated system and that Naturopathic Doctors welcome teamwork with MDs, DCs, RMTs, and other health practitioners.*

Informed Consent:

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional, spiritual and environmental factors, all of which play a role in an individuals' health. Gentle, non-invasive modalities of treatment are employed to stimulate the body's inherent healing capacity. These modalities include, but are not limited to; diet and nutritional supplements, botanical medicine, homeopathy, Traditional Chinese Medicine and acupuncture, hydrotherapy, massage, physical medicine, as well as psychotherapeutic and lifestyle counselling.

As a patient of the Head to Toe Health Centre, I hereby acknowledge that I am willing to provide an ND with the information necessary for them to fully understand my medical history, presenting symptoms, and health goals I wish to achieve in our work together. I thereby consent to a thorough case history and relevant physical examination.

I understand that the Head to Toe Health Centre will keep a record of my personal health information and of the services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless required by law. I understand that the Head to Toe Health Centre will act as the Health Information Custodian for my personal and health information. If I am seeing more than one practitioner at the Head to Toe Health Centre, I imply consent for them to share and discuss my file as deemed necessary by the practitioners, to ensure that I receive care most appropriate for my condition.

I understand that naturopathic medicine can be employed in conjunction with other forms of therapy and need not be considered exclusively beneficial. I acknowledge that one method of treatment need not be chosen over others and that various methods often work best in conjunction with one another.

I recognize that even the gentlest forms of treatment potentially have their risks and complications. The risks associated with Naturopathic medicine include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, interactions with prescription medications, or pain, bruising, fainting or injury from acupuncture.

As with all forms of therapy, I understand that naturopathic treatment also has its limitations and thus I understand that the results are not guaranteed. Nor do I expect the naturopathic doctor at the Head to Toe Health Centre to be able to anticipate and explain all risks and complications prior to treatment.

With this knowledge, I voluntarily consent to Naturopathic care and I intend for this consent form to cover my entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient name (Please print): _____

Signature of Patient or Guardian: _____ Date: _____