nourish
INTEGRATIVE HEALTH

20 Eglinton Ave E Toronto ON M4P 1A9
ph. 416 960 9001 fax. 647 342 9050

CONFIDENTIAL ADULT INTAKE FORM

Name:		Date:
Date of Birth:	Age:	Gender:
Address:	City:	Postal Code:
Phone:	Email:	
Emergency Contact:	Phone:	

How did you hear about the clinic?

Have you ever been treated by a Naturopathic Doctor? ☐ Yes ☐ No If Yes, when?

Medical Doctor:	Phone:	Fax:

Other Healthcare Providers:

1.	Phone:	Specialty:
2.	Phone:	Specialty:

What are your current health concerns (in order of importance to you)?	**On a scale of 1-10 (10 being highest) please rate the following:**	
1.		
2.	Overall Health:	/10
3.	Energy Level:	/10
4.	Stress Level:	/10

Please list all known **allergies** (food or drug) or "**MEDIC ALERT**" conditions:

Please list all medications and natural health products you are currently taking:

Product	Dosage	Taken since…	Finding benefit?

If more, please list them here:

Personal Health:

Height: Weight: Weight 1 year ago: Max weight: When?

Tobacco use: ☐Yes ☐No Amount per day: Year stopped Years smoked:

Recreational drug ☐Yes ☐No Frequency: Type:

Alcohol use: ☐Yes ☐No Frequency: Type:

Caffeine use: ☐Yes ☐No Frequency: Type:

WOMEN: Are you currently pregnant? ☐Yes ☐No ☐Unsure Date of last menstrual cycle:

Birth control use: ☐Yes ☐No Type Years of use:

Age of 1st menses Cycle length Regular cycle? ☐Yes ☐No

Are you still menstruating? ☐Yes ☐No Age of Menopause:

Current and Past Illnesses, accidents, hospitalizations, and surgeries:

Year:

Year:

Year:

If more, please list them here:

Painkiller use? ☐Yes ☐No Frequency: Type:

Antibiotic use? ☐Yes ☐No Frequency: Type:

Are your vaccinations up to date? ☐Yes ☐No Recent vaccinations:

How was your health until age 12?

What do you feel is your weakest organ system(s)? Why?

Personal Medical History: Please highlight the areas of concern that pertain to **you** personally.

☐Allergies	☐Cardiovascular / Heart	☐Fatigue	☐Headaches / migraines
☐Anemia	☐Cancer	☐Fever / Hot flushes	☐Hypertension
☐Anxiety	☐Depression	☐Frequent cold/flu	☐Kidneys
☐Arthritis / Joint pain	☐Diabetes	☐Gallbladder/ Liver	☐Skin
☐Asthma	☐Digestion	☐Gum/ Taste/ Teeth	☐Thyroid
☐Bladder/ Urinary	☐Edema	☐Gynecological	☐Weight management

Others not mentioned above:

Family Medical History: Please list all conditions suffered by family members.
If deceased, please include cause and age at death.

Father	Paternal Grandfather
	Paternal Grandmother
Mother	Maternal Grandfather
	Maternal Grandmother
Sibling (s)	

Lifestyle & Balance:

Describe home environment:

Occupation: Enjoyment level of work: /10 (10 = high)

Hobbies:

Are there any food groups you eat a lot of? Cravings?

Amount of water consumed each day: Other beverage consumption

Hours sleep per night: Do you wake feeling rested? ☐Yes ☐No

Do you regularly exercise? ☐Yes ☐No Type, Duration & Frequency:

How do you manage your stress?

Do you feel you have at least 1 supportive friend or family member? ☐Yes ☐No

Treatment Goals: What do you hope to achieve during your treatment?

1.
2.
3.

Thank you for taking the time to fill in this form. Please sign the consent form on the next page.

Nourish Integrative Health
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INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. A visit may consist of a thorough case history, screening physical examination, including breast exam, and may require blood or urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams. Treatments recommended include botanical medicine, Traditional Chinese Medicine and acupuncture, homeopathy, clinical nutrition, Parenteral (IV) therapy, hydrotherapy and physical therapy such as spinal adjustments, exercises and massage.

It is important that your Naturopathic Doctor be informed of any diseases that you are suffering from and if you are on any medication or over the counter drugs, supplement or herbal products. If you are pregnant, suspect pregnancy, become pregnant or are breast-feeding, please inform your Naturopathic doctor immediately.

As a patient, you will receive information about the nature of the naturopathic treatment, the benefits and risks associated with the treatment as well as any medical alternatives. The health risks associated with naturopathic medical treatment may include but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, bruising or injury from acupuncture; fainting due to needle use. Results are not guaranteed and not all risks and complications can be anticipated and explained.

I understand:

- The clinic does not guarantee treatment results and naturopathic therapies may take time to improve my condition.
- That my Naturopathic Doctor(s) at Nourish Integrative Health will explain to me the nature of any treatment provided, the risks of treatment, alternatives to undergoing treatment and the risks of not undergoing treatment and will answer any questions I may have to the best of her ability.
- Any treatment or advice provided to me at Nourish Integrative Health is not mutually exclusive from any treatment or advice that I may be receiving now or in the future from another licensed health care provide.
- I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario. No employee, agent, or anyone else under the clinic's direction or control is suggesting or recommending to me to refrain from seeking or following the advice of another licensed health care provider.
- 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 without my consent, unless required by law. I may look at my medical record at any time and request a copy by paying the appropriate fee.
- That I am responsible for the fees incurred during care and treatments.
- That I am free to withdraw my consent and to discontinue treatment at any time.

By signing, I agree to the above terms and consent to treatment at Nourish Integrative Health.
I intend this consent to apply to all present and future naturopathic care.

Patient Name (please print): _____

Signature of Patient or Guardian: _____ Date: _____