Adult Intake Form

Full Name: _____ Date: _____
(First) (Middle) (Last) (dd/mm/yy)

Age: _____ Birth date: _____ Sex: _____ Gender: _____
(dd/mm/yy)

Contact Information

Address: _____ City:_____ Postal: _____
(Street No.) (Street Name) (Apt. No.)

Home Phone: _____ Work Phone: _____ Other: _____

E-mail Address: _____ Occupation: _____

May we leave messages relating to your visits? □ Y □ N. Which Phone Number: _____

Emergency Contact Information

Emergency Contact Name:_____

Phone:_____ Relationship to you: _____

Other Health-care Providers

Names and types of other Healthcare providers:

1. _____ Phone: _____

2. _____ Phone: _____

3. _____ Phone: _____

Date of last medical visit:_____ Date of last physical exam:_____
(dd/mm/yy) *(dd/mm/yy)*

How did you hear about this clinic? _____

If referred, please state by whom? _____

Have you been treated by Naturopathic Doctor before? □ Y □ N

If yes, by whom? _____ Date of last ND visit? _____
(dd/mm/yy)

Health Assessment Questionnaire

Chief Concerns (please list in order of importance):

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

Medications/Supplements/ Drugs

Please list all the current prescription medications:

Name of medication	Dose	Frequency	Duration	Side effects (any)

List all past medications: _____
_____

Please list all the current supplements, vitamins, herbs, homeopathic, over-the-counter, non-prescription medications:

Name of medication	Dose	Frequency	Duration	Side effects (any)

Medical History

How would you describe your general state of health? □ Excellent □ Good □ Fair □ Poor

Please list any major trauma, accident, illness, injuries, surgeries, and hospitalizations:

Incident/Procedure	Date	Long term effect/results

Please indicate what immunizations you have had:

□ DPT (diptheria, pertussis, tetanus) □ Haemophilus Influenza B □ Hepatitis A
□ Tetanus booster; when? □ "Flu" □ Hepatitis B
□ MMR (measles, mumps, rubella) □ Polio □ Smallpox
□ Other:_____

Please indicate if any caused adverse reactions:_____

_____

Current Weight: _____ Height: _____ Weight 1 year ago: _____

Date of last dental check up: _____ Any mercury fillings? □ Y □ N If yes, how many? ____

Do you have any known allergies? □ Y □ N If yes, please list the allergies:_____

_____

Do you have any food allergies or sensitivities? Please list: _____

_____

Diet and Lifestyle

Energy level (1-10, 10 being the best): _____ How many hours do you sleep in a night? _____

Do you wake up feeling refreshed? □ Y □ N Do you wake up during the night? □ Y □ N

Do you frequently use any of the following? □ Aspirin □ Tylenol □ Laxatives □ Antacids □ Diet pills

Do you drink coffee? □ Y □ N #cups/day: _____Do you drink alcohol? □ Y □ N #drinks/week: _____

Do you smoke? □ Y □ N #cigarettes/day: _____How long have you smoked? _____

Do you use recreational drugs? □ Y □ N What and how often _____

Do you drink pop? □ Y □ N #drinks/week: _____ Do you use artificial sweeteners? □ Y □ N

# of times you've used antibiotics in last 5 years_____ Most recent course _____

Describe your weekly exercise:_____

Are you on a restricted diet? □ Y □ N Have you ever been on a restricted diet? □ Y □ N

Please describe: _____

_____

Describe your typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluid intake: _____

Please check any of the following that you have experienced in the PAST (P) or CURRENT (C)

General

	P	C		P	C		P	C
Chills			Poor sleep			Fatigue		
Night sweats			Weight gain/loss			Sweat easily		

Skin and Hair

	P	C		P	C		P	C
Rashes			Eczema, hives			Itching		
Acne, boils			Loss of hair			Dandruff		
Dryness			Ulcerations			Skin cancer		
Recent moles			Change in hair/skin texture			Color change		
Lumps			Dryness/moistness			Temperature		
Nail changes			Other					

Head, Eyes, Ears, Nose and Throat (HEENT)

	P	C		P	C		P	C
Headaches			Eyes bothered by sun			Stuffiness		
Head injury			Itching in eyes			Hay fever		
Dizziness			Redness in eyes			Sinus problems		
Impaired vision			Discharge from eyes			Frequent sore throat		
Glasses/contacts			Tearing/dryness in eyes			Sore tongue/mouth		
Eye pain			Impaired hearing			Gum problems		
Blind spot			Earache			Hoarseness		
Double vision			Discharge from ears			Dental cavities		
Glaucoma			Ear infections			Loss of taste		
Cataracts			Frequent colds			Other		
Blurring			Nose bleeds					

Neck

	P	C		P	C		P	C
Lumps			Swollen glands			Goiter		
Pain			Stiffness			Other		

Respiratory

	P	C		P	C		P	C
Difficulty breathing			Pain with a deep breath			Pneumonia		
Cough			Production of mucus			Asthma		
Bronchitis			Coughing blood			Pleurisy		
Emphysema			Shortness of breath			Last chest x-ray		
Tuberculosis			Shortness of breath at night			Other		
Tuberculin test			Shortness of breath lying down					

Cardiovascular

	P	C		P	C		P	C
Fainting			High blood pressure			Cold hands or feet		
Chest pain			Low blood pressure			Irregular heartbeat		
Angina			Swelling of ankles/feet/hands			Varicose veins		
Murmurs			Blood clots			Heart disease		
Rheumatic fever			Palpitations, fluttering			Cyanosis		
Past ECG								

Gastrointestinal

	P	C		P	C		P	C
Trouble swallowing			Change in bowel movements			Indigestion		
Heartburn			Blood in stool			Diarrhea		
Change in thirst			Belching/passing gas			Rectal bleeding		
Change in appetite			Jaundice			Hemorrhoids		
Nausea			Liver disease			Black, tarry stool		
Vomiting			Gall bladder disease			Abdominal pain		
Vomiting blood			Ulcer			Food allergy		
Hernia			Other					

Urinary

	P	C		P	C		P	C
Frequent urination			Unable to hold urine			Blood in urine		
Kidney stones			Frequency at night			Frequent UTIs		
Decrease in flow			Urgency to urinate			Hesitancy		
Pain on urination			Increased frequency			Other		

Male reproductive

	P	C		P	C		P	C
Hernias			Are you sexually active			Heterosexual		
Testicular masses			Sexual difficulties			Bisexual		
Testicular pain			Venereal disease			Homosexual		
Discharge/sores			Other					

Gynecology and Pregnancy

Are you pregnant? Y □ N □ What was the first day of your last period? _____
Age of first period: _____ Average # of days _____ Length of cycle_____
Date of last PAP _____ Normal cells □ Abnormal cells □
(dd/mm/yy)

□ Pregnancies # _____ □ Live births # _____ □ Miscarriage # _____ □ Abortion # _____
□ Birth control use; type _____ # of years on birth control pill: _____

	P	C		P	C		P	C
Regular period			Bleeding between periods			Pain during intercourse		
Painful periods			Excessive flow			Are you sexually active		
Birth control			Difficult conceiving			Heterosexual		
Sexual difficulties			Venereal disease			Bisexual		
Vaginal discharge			Vaginal itching			Homosexual		
PMS			Other					

Breasts

	P	C		P	C		P	C
Breast self exams			Lumps			Pain		
Nipple discharge			Other					

Musculoskeletal

	P	C		P	C		P	C
Joint pain/stiffness			Arthritis			Broken bones		
Weakness			Muscle spasms/cramps			Joint swelling		
Backache			Other					

Peripheral vascular

	P	C		P	C		P	C
Deep leg pain			Cold hands/feet			Varicose veins		
Thrombophlebitis			Leg cramps			Extremity numbness		
Extremity coldness			Extremity swelling			Extremity ulcers		

Neurologic

	P	C		P	C		P	C
Fainting			Seizures/convulsions			Paralysis		
Muscle weakness			Numbness/tingling			Loss of memory		
Loss of balance			Involuntary movement			Speech problems		

Endocrine

	P	C		P	C		P	C
Thyroid trouble			Heat/cold tolerance			Excessive thirst		
Excessive hunger			Excessive urination			Excessive sweating		
Diabetes			Hypoglycemia			Hormone therapy		

Blood/lymphatic

	P	C		P	C		P	C
Anemia			Past transfusions			Lymph node swelling		
Easy bleeding			Easy bruising					

Emotional

	P	C		P	C		P	C
Depression			Mood swings			Anxiety/nervousness		
Tension			Phobias			Alcohol/drug abuse		
Insomnia								

Family Medical History

Indicate which close relative (parent, child, sibling, grandparent) has any of the following:

□ Cancer _____
□ Asthma _____
□ Diabetes _____
□ Allergies _____
□ Seizures _____
□ Alcoholism _____
□ Arthritis _____
□ High Blood Pressure _____
□ Depression _____
□ Heart Disease _____
□ Thyroid Disease _____
□ Stroke _____
□ Kidney Disease _____
□ Other _____

Environment

Are you exposed to significant tobacco smoke (work, home, etc.)? □ Y □ N

Are you frequently exposed to animals (work, pets, etc.) □ Y □ N

How is your home heated? _____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?_____

_____

How would you describe the emotional climate of your home? _____

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

_____

Is there anything that you feel is important that has not been covered? _____

_____

Arashdeep Khaira, ND

Patient Consent Form

Please note that this form must be signed before your first appointment.

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors use the principles and practices of Naturopathic Medicine to assist the body in using its own healing properties to reach your health goals. Nutrition, botanical medicine, traditional Chinese medicine, homeopathy, physical medicine, hydrotherapy and lifestyle counselling are main modalities of Naturopathic Medicine. Naturopathic Doctors consider the physical, emotional, mental and spiritual aspects of each individual. As part of your care, the Naturopathic Doctor will take a thorough case history and perform any necessary physical examination. Specific laboratory tests maybe used as part of your treatment work-up.

It is important to inform your Naturopathic Doctors of any diseases processes you are suffering from and any medications/ over the counter drugs you are currently taking. Please advice the Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant and if you are breast-feeding.

Declaration of Informed Consent to treatment

I, the undersigned, do hereby acknowledge that I have been informed and understand that:

- The medical care is based on Naturopathic principles and may be treated using any of the modalities of Naturopathic Medicine;
- My Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have to the best of their ability;
- However rare, there are potential for complications. These include but are not limited to: aggravation of pre-existing symptoms with homeopathic remedies, reaction to supplements or herbs, fainting/ puncturing of organs from acupuncture, accidental burning of skin from moxa, pain/ fainting/ bruising or injury from venipuncture and acupuncture, muscle sprains/ strains, disc injuries from spinal manipulations;
- I understand that my Naturopathic Doctor does not guarantee treatment results;
- I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Alberta;
- I have provided complete and accurate information about my health on my intake form to assist my practitioner in treating me;
- I am not an agent of any private, county provincial or federal agency attempting to gather information without so stating;
- I accept responsibility of all fees for services and supplements that are payable at the time of the appointment. As well, notice of 24 hours is required for appointment cancellation, otherwise, I will be charged half of the appointment fee;
- I accept or reject this care of my own free will;
- I acknowledge that I can withdraw my consent and discontinue treatment at any time.

By signing below, I acknowledge that I have reviewed, understand, asked any questions and agree to the above and give my informed consent to receive Naturopathic Care including Naturopathic medical consultation, assessment, diagnostics and treatment from Arashdeep Khaira, ND. I intend this informed consent to apply to all my present and future Naturopathic care.

_____ _____

(Print Name) (Signature of Patient or Parent/Guardian)

_____ _____

(Arashdeep Khaira, ND Signature) (Date)

Arashdeep Khaira, ND

Patient Consent Form for Collection, Use and Disclosure of Personal Information

Privacy of your information is an important part of our office, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what we will do to ensure that:

- Only necessary information is collected about you;
- We only share information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;

How we Collect, Use and Disclose Patients' Personal information

We understand the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how we will be using and disclosing your information.

We will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of the treatment options
- To establish and maintain contact with you
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advice authorities of child abuse and reporting diseases and individuals who may be an imminent threat to harm themselves or others
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for practice sale.

By signing this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above

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Patient Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I agree that the office can collect, use and disclose personal information about _____
as set out above in the information about the office's privacy policy. (Print Name)

_____ _____

(Print Name) (Signature)

_____ _____

(Date) (Signature of Witness)

Arashdeep Khaira, ND

Informed consent for Acupuncture

I hereby by request and consent to the administration of medical acupuncture and other supplementary techniques as deemed appropriate by my Naturopathic Doctor.

Acupuncture had been explained to me as a therapeutic treatment performed by the insertion of single use, sterile, disposable needles.

The needles are inserted through the skin into the underlying tissues at specific point on the body for the purpose of balancing energy, alleviating pain, improving mobility and re-establishing normal function.

I understand that there is the possibility of temporary complications that may result from an acupuncture treatment, which include, but are not limited to fainting, minor bleeding, bruising, minor pain or soreness, nausea, weakness, fatigue, fainting, or aggravation of existing symptoms for a short time. I understand that if there are any particular risks that apply to my case the Naturopathic Doctor will discuss these with me.

I further state that the following conditions do not exist in my current state of health and that I will immediately notify my practitioner of any changes regarding the following:

- Pregnancy
- Local infections
- Seizure disorder (epilepsy)
- Pacemaker
- Elevated risk of infections
- Bleeding disorders

Alternatives to acupuncture have been discussed. I have read the above consent form. I have had an opportunity to ask questions about its content, and by signing below I agree to the above-mentioned acupuncture procedures. I intend this consent form to apply to my entire course of treatment, for present and future conditions for which I seek treatment. I understand I can refuse treatment at any time.

_____ _____

(Print Name) (Signature of Patient or Parent/Guardian)

_____ _____

(Witness) (Date)