



**ADULT NATUROPATHIC INTAKE FORM**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical History:**

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations (along with approximate dates).

Do you have any allergies (to foods, medicines, environmental, etc.)? Please explain:

**Please list all current medications:**

Prescription Drugs	Over-The-Counter Drugs	Supplements (vitamins, etc)	Herbal medicines	Homeopathic medicines

Please list past prescription medications:

How many times have you taken antibiotics? \_\_\_\_\_ In the past year? \_\_\_\_\_

Do you frequently use any of the following? (Please Circle)

Aspirin      Laxatives      Antacids      Diet pills      Birth control pill / injection

Alcohol (how much/day or week ) \_\_\_\_\_ Tobacco (form and amount/day) \_\_\_\_\_

Caffeine (form and amount/day) \_\_\_\_\_ Recreational drugs  
 (what and how often) \_\_\_\_\_

Please indicate with an (X) what immunizations you have had:

DPT (diphtheria, pertussis, tetanus)		Tetanus booster (when?): _____	
MMR (measles, mumps, rubella)		"Flu"	
Hepatitis A		Haemophilus influenza B	
Hepatitis B		Polio	
Smallpox		other: _____	

Any adverse reactions to immunizations? Y N

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) Y N

**Diet:**

Do you have any food allergies or intolerances? Please list.

Do you have any dietary restrictions (religious, vegetarian/vegan, etc)?

Describe a typical day's diet:

Breakfast	Lunch	Dinner	Snacks

How frequently do you consume a serving of the following food groups? (Indicate if per day or per week)

Meats (beef, pork, chicken)		Wheat (pasta, bread, pastries, etc.)	
Dairy (Milk, cheese, ice cream, cottage cheese, yoghurt)		Other grains (rice, oats, barley, millet, rye)	
Eggs		Raw/Uncooked Vegetables (salads, carrots, etc.)	
Fruits		Cooked vegetables (frozen vegetables, potatoes, etc.)	
Juices: What types?		Nuts (peanuts, almonds, cashews, walnuts, etc.)	

**Family medical history:**

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

Condition	Who?	Condition	Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug/alcohol abuse	
High blood pressure		Kidney disease	
Cancer		Diabetes	
Autoimmune disease		Other	

**Environment:**

List your hobbies:

What do you do for exercise and how often?

Are you exposed to significant tobacco smoke (work, home, socially)? 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.)? Y N  
Please describe.

How would you describe the emotional climate of your home?

Please rate the level of stress at your work, or in other aspects of your life (scale: 1-10): \_\_\_\_\_

Please describe the nature of your stress:

How well do you handle these stresses?

If applicable, indicate any painful or distressed areas with a *number* and *describe the numbered area* in the space provided (ex. Type of pain/sensation, temperature, rashes, growths, scars, infections, etc.)

1. \_\_\_\_\_  
 \_\_\_\_\_  
 2. \_\_\_\_\_  
 \_\_\_\_\_  
 3. \_\_\_\_\_  
 \_\_\_\_\_  
 4. \_\_\_\_\_  
 \_\_\_\_\_  
 5. \_\_\_\_\_  
 \_\_\_\_\_  
 6. \_\_\_\_\_  
 \_\_\_\_\_

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



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

The Naturopathic Doctor, as named above, understands the importance of protecting your personal information and is committed to collecting, using, and disclosing your personal information responsibly. The Doctor will try to be as open and transparent as possible about the way your personal information is handled.

The privacy policy adheres to the Personal Health and Information Protection Act 2004 (PHIPA), and outlines what the Doctor is doing to ensure that:

- Only necessary information is collected about you;
- She only shares your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

The Naturopathic Doctor 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 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 treatment, care and billing
- To assist your insurance company and completing claims
- To comply with the legal and regulatory requirements of your regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the *Drugless Practitioners Act*
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply generally with the law
- To allow potential purchasers, practice brokers, or advisors to conduct an audit in preparation for a practice sale

I have reviewed the above information and I agree that Dr. Christine Dychangco N.D. can collect use and/or disclose personal information about \_\_\_\_\_ as set out above in the information regarding the privacy policy. (Patient Name)

\_\_\_\_\_  
Patient or Guardian Name

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

