WOODBRIDGE AVENUE CHIROPRACTIC AND WELLNESS CENTRE
53 WOODBRIDGE AVENUE, UNIT 4
WOODBRIDGE, ON, L4L 9K9
P: 905-264-8107 F: 905-264-8542

Adult Intake Form

Name: _____ Date: _____

Address: _____City:_____

Postal Code: _____ E-mail: _____

Date of birth : _____Sex:_____Age: _____ Weight: _____ Height: _____

Pregnant: Y/N, How many weeks: _____ Breast feeding: _____

Phone (primary): _____ other: _____

May we leave phone messages relating to your visits? Y/N

Occupation: _____

Marital Status: _____ Number of Children: _____

Medical Doctor: _____ Phone: _____

Have you received naturopathic care previously? _____

How did you hear about us: _____

Emergency Contact Name: _____

Phone: _____ Relation: _____

What are your main health concerns in order of importance to you?

1. _____ 2. _____

3. _____ 4. _____

Do you have any known allergies or sensitivities ?

_____

Please list all the vitamin, mineral, herbal supplement you are currently taking and for how long? (include the brands)

_____ _____

_____ _____

_____ _____

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Please list all the medications that you are taking and for how long? *Please bring all the medications or photo to first visit*

_____ _____

_____ _____

_____ _____

Please list any injuries, major surgeries, major diseases or illnesses that you have had and when they occurred?

_____

_____

_____

How many times have you been treated with antibiotics ? _____

Do you have any dietary restrictions: (vegetarian, vegan, religious)

_____

Do you drink alcohol: _____ how many drinks per week ?_____

Do you smoke: _____ how many cigarettes per day?_____

Do you use recreational drugs:_____

Please check any condition that may have occurred in close relative (parent, child, sibling):	Please check any conditions you have, or have had in the past:
☐ Allergies ☐ Asthma ☐ Diabetes ☐ High blood pressure ☐ Cardiovascular disease ☐ Cancer ☐ Mental Health Conditions ☐ Other: _____	☐ Anemia ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ HIV ☐ Hepatitis ☐ Mental Health Conditions: _____

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

_____

_____

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Review of systems

Please check any Symptoms you have or had in the past:

General:
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Change in thirst
- ☐ Night sweats
- ☐ Heat or cold intolerance

Skin:
- ☐ Poor Wound Healing
- ☐ Easy Bruising
- ☐ Rashes/ Itching/hives
- ☐ Eczema/Psoriasis
- ☐ Excess Dryness or moistness
- ☐ Frequent Skin Infections
- ☐ Skin ulcer/skin cancer
- ☐ Nail changes
- ☐ Hair changes

Eyes, Ears, Nose, Throat, Respiratory:
- ☐ Floaters/blind spot
- ☐ Eye pain
- ☐ Ringing in the ears
- ☐ Loss of hearing
- ☐ Frequent colds
- ☐ Sinus issues
- ☐ Swollen glands
- ☐ Sore Throat

Cardiovascular:
- ☐ Chest pain
- ☐ Palpitation/fluttering
- ☐ Cold hands and feet

Lungs:
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Chronic cough
- ☐ Emphysema

Gastrointestinal:
- ☐ Heartburn
- ☐ Gas or bloating
- ☐ Difficulty swallowing
- ☐ Nausea /Vomiting
- ☐ Blood or mucus in the stool
- ☐ Diarrhea or constipation

Musculoskeletal:
- ☐ Joint pain /stiffness
- ☐ Muscle cramps
- ☐ Muscle weakness

Neurological:
- ☐ Fainting or loss of consciousness
- ☐ Loss of sensation
- ☐ Numbness or tingling
- ☐ Memory problems
- ☐ Seizures

Urinary:
- ☐ Blood in the urine
- ☐ Pain during urination
- ☐ Urinary tract infections
- ☐ Urgency
- ☐ Inability to hold urine

Men's Health:
- ☐ Erectile Difficulties
- ☐ Prostate Difficulties
- ☐ Discharge from the Penis

Women's Health:
- ☐ Bleeding between Periods
- ☐ Clots in Menstrual blood
- ☐ Heavy or Excessive Menstrual Flow
- ☐ Scanty or Light Menstrual Flow
- ☐ Irregular Cycles
- ☐ Difficulties Becoming Pregnant
- ☐ Difficulty Maintaining a Pregnancy or History of Miscarriages
- ☐ Menopausal Symptoms

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Thank you for filling the forms out

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

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. I will conduct a thorough case history and perform any necessary physical examinations, including more specific examinations such as breast, gynecological, rectal, prostate or genital exams with your consent. Specific blood and/or urine laboratory samples may be used as part of your treatment work-up.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Allergic reactions to certain supplements and herbs. Please advise your Naturopath of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture.
- Fainting or puncturing of an organ with acupuncture needles .

Supplements, remedies, botanicals, laboratory tests and other services are charged separately and are not included in the visit fee. There will be no refunds or exchanges on visit fees, supplements, remedies, botanicals, laboratory tests and other services.

My health records will be kept confidential and will only be released to comply with legal and regulatory requirements. It may also be used to complete claims for insurance purposes. If needed, my Naturopathic doctor may communicate with other health-care providers. I may look at my medical record at anytime and can request a copy of it by paying $0.10 per page.

I understand:

- The clinic does not guarantee treatment results.
- I am free to withdraw my consent and to discontinue treatment at any time.
- I give my informed consent to provide naturopathic medical consultation, assessment and/or treatment to me.
- I intend this informed consent to apply to all my present and future naturopathic care.
- I do not expect the doctors to be able to anticipate and explain all risks and complication
- I understand that some therapies or treatments have the potential for complications
- I accept full responsibly for any fees incurred during care and treatment

Patient's Name (please print):_____

Signature of patient or guardian:_____Date: _____

ND:_____