



Adult Intake Form

Today's Date: _____

Name: _____ Age: _____ Birth Date: _____ M F

Address: _____

City: _____ Province: _____ Postal Code: _____

Home phone #: (____) _____

Alternative # (Cell or Work):(____) _____

Email: _____

Primary contact which you prefer to use: Home Work Cell phone Email

May the clinic leave voice mail messages relating to appointments? Yes No

Emergency Contact Name, phone #, and relationship to you:

Other Health Care Providers :

1. _____ Phone #: (____) _____

2. _____ Phone #: (____) _____

How did you hear about the clinic?

If you were referred, please indicate the name of the person who referred you:

Health Concerns

What are your health concerns, in order of importance:

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

Previous treatments and results? _____

Your Medical History

How would you describe your general state of health?

- Excellent Good Fair Poor

Please check the following that apply to you:

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Other: _____ | | |

Past Medical History

Please indicate any serious health conditions, illnesses and hospitalizations you have had in the past:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Family Medical History

Please indicate any significant conditions in your family, and specify which member of the family you are referring to.

Environment, Diet and Lifestyle

Occupation: _____

Do you have any food allergies or intolerances? Please specify

Do you have any dietary restrictions (religious, vegetarian/vegan, celiac, etc)? Please specify.

Do you exercise regularly? Yes No
If Yes, what type of exercise and how often?

Do you drink coffee? Yes No Cups per day: _____

Do you smoke? Yes No Cigarettes per day: _____

Do you drink alcohol? Yes No Drinks per week: _____

Do you use recreational drugs? Yes No

List all current prescription medications

How many times have you been treated with antibiotics in the past 5 years? _____

List all over-the-counter medications that you take regularly. (Examples- Advil, Tylenol, TUMS, diet pills, laxatives).

List all supplements, herbs, and homeopathics currently taking

Do you have any known allergies? Yes No , if yes what are they?

Do you have regular screening tests done by another doctor? Yes No
(Blood tests, Pap smear, Prostate exam etc.)

When was your last physical exam? _____

Review of Systems:

Check of any of the following symptoms if they are CURRENT or RECURRING symptoms.

General

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Rapid weight gain | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Rapid weight loss | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Bleed or bruise easily | |

Skin and Hair

- | | | |
|---------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Skin ulcers | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Changes in moles | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Other |

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Jaw clicks |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Wear glasses | <input type="checkbox"/> Diminished hearing | <input type="checkbox"/> Recurring sore throat |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Nose bleeds | |

Respiratory

- | | |
|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Excess mucus production |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Other |

Cardiovascular

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Numbness of hands/feet | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of hands/feet | |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Varicose veins | |

Gastrointestinal

- | | | |
|--|---|---|
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Gas or belching | <input type="checkbox"/> Nausea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diarrhea | | |

Genito-urinary

- | | | |
|---|---|--|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Sore on genitals |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Decrease in urine flow | <input type="checkbox"/> Frequent urinary tract infections |
| <input type="checkbox"/> Difficult urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Other |
| <input type="checkbox"/> Urgency, inability to Hold urine | <input type="checkbox"/> Impotency | |

Gynecology and pregnancy

If you are female, are you pregnant? Yes No Trying to get pregnant

What is the first day of your last period? _____

Age of first period: _____ How long does your period last? _____

Date of last PAP: _____ Normal PAP results Abnormal cells

- Regular periods
- Irregular periods
- Painful periods
- Clots
- PMS, list symptoms _____
- Birth control used Yes No if yes, what type? _____
- Number of live pregnancies _____
- Number of miscarriages _____
- Number of abortions _____
- Heavy flow
- Light flow
- Vaginal discharge
- Vaginal sores

Musculoskeletal

- Back pain
- Shoulder pain
- Hand/wrist pain
- Knee pain
- Foot/ankle pain
- Hip pain
- Bones break easily
- Swollen joints
- Stiff joints
- Muscle pain
- Muscle weakness
- Other

Neuro-psychological

- Loss of balance
- Poor memory
- Anxiety
- Depression
- Numbness
- Tingling
- Seizures/convulsions
- Involuntary movements/tics



Informed Consent

Naturopathic medicine is the treatment and prevention of diseases by natural means. The focus of a Naturopathic Doctor is to assess the whole person, taking into consideration each person's unique physical, mental, emotional and spiritual characteristics that contribute to their current state of health. A thorough case history will be conducted. A physical exam and specific blood or urine laboratory reports may be used as assessment tools.

Treatments consist of non-invasive methods and techniques, that will be explained to you in detail prior to treatment. It is important that you inform the Doctor of any health conditions or injuries that you are suffering from, as well as, any medications, over-the counter drugs or supplements you are taking.

Statement of acknowledgement:

I have read and understood that I will be assessed by Dr. Mary Caracoglia, ND, and treated by means of Naturopathic therapies. I recognize that even the gentlest of therapies may have complications such as in certain physiological conditions, young children, or people on multiple medications.

The information I have provided is complete and inclusive of all health concerns including risk of pregnancy and breastfeeding. The rare health risks associated with some Naturopathic treatments include but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, bruising, fainting or injury from venipuncture or acupuncture.

I understand that my Doctor will explain to me the exact nature of any treatment provided, and will answer any questions I may have. I am free to withdraw my consent and to discontinue participation in therapy, and I must inform my Doctor of my decision.

I accept full responsibility of fees incurred during care and treatment.

I, _____ have read, understood and acknowledge the above statements.

Date: _____ Signature: _____

Witness: _____



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

Privacy of your personal information is an important part of providing you with quality naturopathic care. At Centre for Women's Health, we understand the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly.

The privacy policy outlines what the centre is doing to ensure that:

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

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

- To assess your health concerns
- To advise you of treatment options
- To establish and maintain communication with you
- To remind you of upcoming appointments
- To communicate with all other health care providers in your health care team
- To allow us to efficiently follow up for treatment, care, and billing
- To comply with legal and regulatory requirements of our regulatory body, and The Board of Directors of Drugless Therapy-Naturopathy
- To comply with the law.

By signing this form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed.

PATIENT CONSENT

I have reviewed the above information that explains how Dr. Mary Caracoglia, ND and the staff of Centre for Women's Health will use my personal information. I understand the policy and how it protects my personal information.

I consent to Dr. Mary Caracoglia, ND collecting, using and disclosing my personal information as set out above in the information about the office's privacy policies.

Signature: _____ Print Name: _____

Date: _____ Witness: _____

