Dr. Mary Caracoglia B.Sc. ND
Naturopathic Doctor

New Patient Intake Form

Today's Date: ___________________________

Name: _________________________________ Age: ____ Birth Date: _______ M ☐ F ☐

Address: ____

City: _________________________ Province: _______ Postal Code: _______________

Primary phone #: (____) ______________ Email: _______________________________

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

____

Reason for Seeking Naturopathic Care

Please check off all that apply to you, and specify your relevant health goal if applicable:

☐ General health promotion ____

☐ Skin health ____

☐ Acupuncture ____

☐ Health conditions/concerns

1. ____
2. ____
3. ____

Medical History

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

1. ____ Date: ____________
2. ____ Date: ____________
3. ____ Date: ____________

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 have any environmental allergies? Please specify.

____

Please complete the chart below by listing all medications and natural health products you are currently taking.

Prescription medications	**Over-the-counter medications** (I.e.: Advil, Claritin, TUMS, laxatives).	**Supplements, herbs and homeopathics**
1.	1.	1.
2.	2.	2.
3.	3.	3.

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.

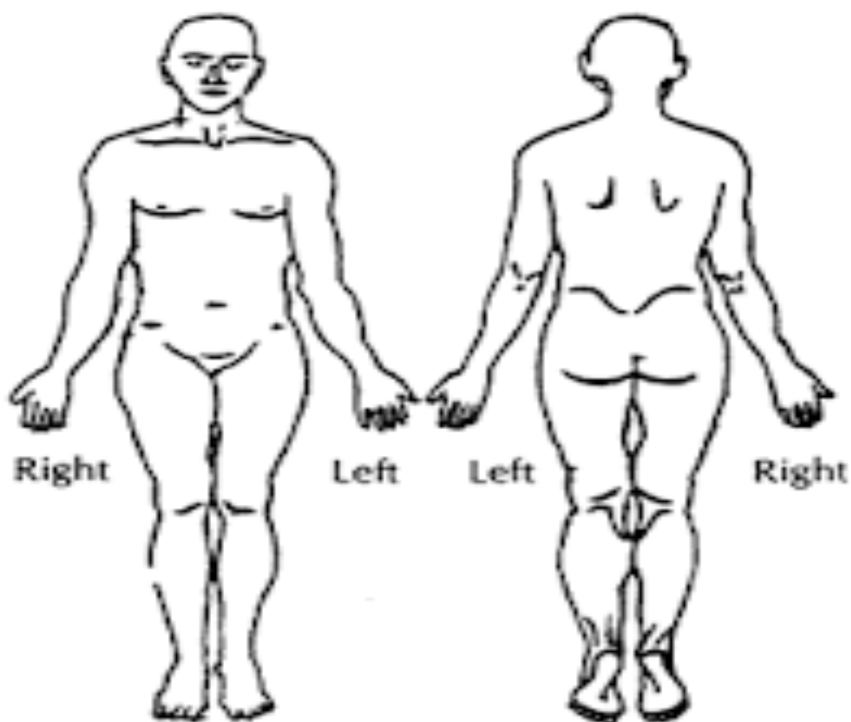
I accept full responsibility of fees incurred during care and treatment.

I, ____have read, understood and acknowledge the above statements.

Date: ___________________ Signature: ______________________________

Name: ____

Age: ___________ **Height:** ___________ **Weight:** __________



Notes:(for office use only)

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Review of Systems:

Please check off all of the symptoms you are CURRENTLY experiencing, and symptoms that have FREQUENTLY RECURRED in the past year.

General

- ☐ Change in appetite
- ☐ Chills
- ☐ Dizziness/vertigo
- ☐ Fatigue
- ☐ Mental fogginess
- ☐ Frequent infections
- ☐ Strong thirst
- ☐ Diabetes
- ☐ Rapid weight gain
- ☐ Rapid weight loss
- ☐ Bleed/bruise easily
- ☐ Night sweats
- ☐ Fever
- ☐ Alcoholism
- ☐ Allergies: ____________

Skin and Hair

- ☐ Acne
- ☐ Changes in moles
- ☐ Dandruff
- ☐ Dryness
- ☐ Eczema
- ☐ Rashes
- ☐ Skin cancer
- ☐ Skin ulcers
- ☐ Other: _____________

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

- ☐ Headaches
- ☐ Blurry vision
- ☐ Cataracts
- ☐ Dry eyes
- ☐ Wear prescription glasses
- ☐ Eye pain
- ☐ Glaucoma
- ☐ Diminished hearing
- ☐ Ringing in the ears
- ☐ Other: _____________
- ☐ Sinus problems
- ☐ Cold sores
- ☐ Recurring sore throat
- ☐ Jaw clicks
- ☐ Neck pain

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Coughing blood
- ☐ Cough
- ☐ Difficulty breathing
- ☐ Excess mucus
- ☐ Pneumonia
- ☐ Other: _____________

Cardiovascular

□ Blood clots	□ swelling of hands/feet	□ High blood pressure
□ Cold hands/feet	□ Chest pain	□ Low blood pressure
□ Leg cramps	□ Irregular heart beat	□ Varicose veins
□ Numbness of hands/feet	□ Palpitations	□ Other: _____________

Gastrointestinal

□ Abdominal pain	□ Vomiting	□ Hemorrhoids
□ Bloating	□ Nausea	□ Blood in stool
□ Excessive burping	□ Constipation	□ Bad taste in mouth
□ Gas	□ Diarrhea	□ Other: _____________

Genito-urinary

□ Blood in urine	□ Frequent urination	□ Frequent UTI infections
□ Decrease in urine flow	□ Pain with urination	□ Kidney stones
□ Difficult urination	□ Inability to hold urine	□ Other: _____________

Gynecology and pregnancy

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

Date of last PAP: __________________ Normal PAP results □ Abnormal cells □

Birth control used Yes □ No □ if yes, what type? ______________

Number of live pregnancies _______ Miscarriages _______ Abortions _______

Menstrual Cycle:

When was the first day of your last period (specify date)? ___________________

How many days does your period generally last? ___________________________

How long is your average cycle (the amount of days between your periods)? ___

Do you skip periods? Yes □ No □

Flow:

How would you describe the flow of your period? (heavy/light) _______________

Do you experience blot clots? Yes □ No □

PMS:

List symptoms that occur prior to your period:

____

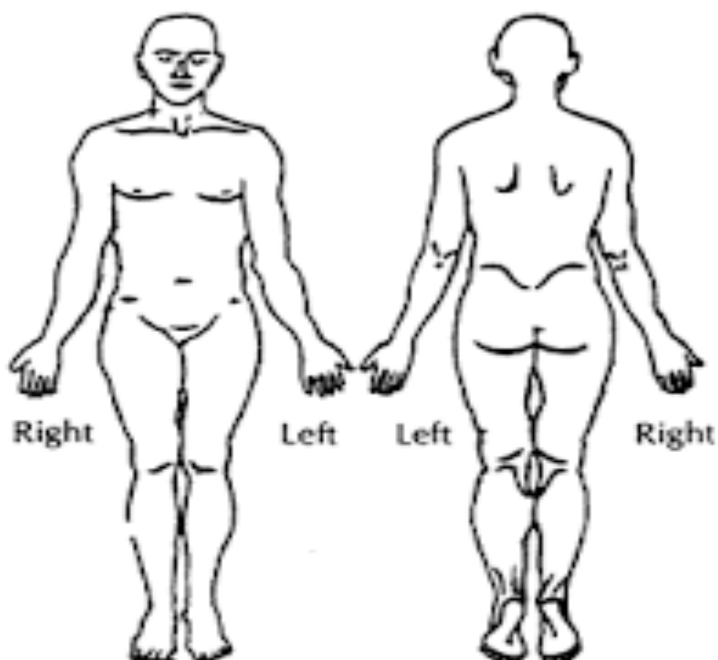
____

Vaginal health:

□ Unpleasant smelling discharge	□ Vaginal dryness	□ Pain with intercourse
□ itchiness	□ Sores/lesions on labia	□ Vaginal bleeding after sexual intercourse
□ Colored discharge	□ Other: ___________	□ Other: ___________
(i.e. grey, pink, red, light blue, or green)		

Musculo-skeletal

Please indicate affected area. Specifyif experiencing pain, weakness, stiffness or swelling:



Notes:____
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Neuro-psychological

- □ Anxiety
- □ Depression
- □ Poor memory
- □ Numbness
- □ Loss of balance
- □ Involuntary movements
- □ Seizures/convulsions
- □ Other: __________

Lifestyle and habits

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 □

Number of bowel movements per day _______

Daily water intake: _______ cups per day OR _______ liters

On average, how many hours of sleep do you get each night? _______

Please complete the following food journal by detailing what you ate yesterday:

Breakfast	
Lunch	
Dinner	
Snack 1	
Snack 2	
Snack 3	

Please indicate which relative has been diagnosed with the following health conditions and diseases below.

Family History

	Mother	**Father**	**Sister(s)**	**Brother(s)**	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
No significant history known								
Alcoholism/Dug abuse								
Alzheimer's								
Asthma								
Bleeding or Clotting Disorder								
Cancer Colon								
Cancer Prostate								
Cancer Other Type: _________________								

Coronary Artery Disease (i.e. heart attack, angi								
High Blood Pressure								
High Cholesterol								
Kidney Disease								
Hypothyroidism								
Diabetes								
Osteoporosis								
Anxiety								
Depression								
Migraine Headaches								
Autoimmune Disease:								
Celiac Disease								
Crohn’s Disease								
Fibromyalgia								
Hashimoto’s Thyroiditis								
Lichen Sclerosis								
Lupus								
Psoriasis								
Rheumatoid Arthritis								
Ulcerative Colitis								
Women’s Health:								
Endometriosis								
Early Onset Menopause								
Fibroids								
Cancer Breast								
Cancer Ovarian								

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