Back On Track Naturopathic Intake Form

1-101 First Ave Spruce Grove, AB T7X 2H4 780.962.2423 www.sprucegrovenaturopathic.com

Please complete the following as thoroughly as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

General Information

Name_____
Date of Birth (d/m/y)_____Age____ Sex____
Address_____
City _____ Province_____ Postal Code_____
Primary Phone#_____
Do you consent to messages being left at this number?
(Please Initial) Y_____ N_____
Email_____
Alberta Health Care #:_____
Emergency Contact (Name) _____
Phone # _____ Relationship_____
Medical Doctor (Name) _____
Phone _____
How did you hear about our office? _____
How should we contact you? _____

Current Health Concerns

Please list your current health concerns, in order of importance to you. If possible, specify the date you first noticed the problem.

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

Did something trigger your change in health?
_____

Allergies & Sensitivities

List all allergies to medications/ environment/ food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications *(including pain medication, sleep aids, birth control, etc)*

Name	Dose/Frequency	Start date	Reason for use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Supplements *(including vitamins, minerals, herbal medicines, homeopathics, etc)*

Name	Dose/Frequency	Start date	Reason for use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical History

List any condition that you have been diagnosed with including the date of diagnosis — *Ongoing / Past*

1 _____ Date _____ **O** / **O**
2 _____ Date _____ **O** / **O**
3 _____ Date _____ **O** / **O**

Please list all past hospitalizations, surgeries and injuries — *Any present health issues as a result?* — *Yes / No*

1 _____ Date _____ **O** / **O**
2 _____ Date _____ **O** / **O**
3 _____ Date _____ **O** / **O**

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Symptom Review

*Please check all **current** symptoms*

GENERAL

Height: _____ **O** Fever/chills **O** Heat/Cold Intolerance **O** Fatigue

Weight: _____

Desired weight: _____

Have you ever had an unexplained loss or gain of weight of 10 lbs or more in the past 6 months? **O** Yes **O** No

HEAD, EYES & EARS

O Headache/migraine **O** Ear pain/ear infections **O** Ear buzzing/ringing **O** Changes in hearing

O Dry/itchy/watery eyes **O** Visual disturbances **O** Other: _____

MUSCULOSKELETAL

O Low back pain **O** Foot cramps/pain **O** Joint deformity **O** Joint pain/redness/stiffness

O Muscle pain/cramps **O** Muscle weakness **O** Tendonitis **O** TMJ problems

O Other: _____

SKIN & NAILS

O Acne (face/torso) **O** Athlete's foot/ jock itch **O** Eczema/psoriasis **O** Dry/ itchy skin

O Dark circles under eyes **O** Sweat easily **O** Hives/ rash **O** Hair loss

O Brittle or discolored nails **O** Suspicious moles **O** Changes in pigment

O Excess hair growth (facial hair, etc) **O** Other: _____

GASTROINTESTINAL

O Bloating/ indigestion **O** Constipation **O** Trouble swallowing **O** Blood/ mucus in stool

O Pain during bowel movement **O** Diarrhea **O** Belching/ excess gas **O** Acid reflux

O Hemorrhoids **O** Abdominal pain **O** Nausea/ vomiting **O** Jaundice

O Anal fissures **O** How often do you have a bowel movement? _____ **O** Other: _____

RESPIRATORY

O Breathlessness **O** Exercise intolerance **O** Cough **O** Hoarseness

O Nasal congestion **O** Post nasal drip **O** Wheezing/ asthma **O** Frequent sore throats

O Other: _____

CARDIOVASCULAR

O Chest pain/ angina **O** Heart palpitations **O** Easy bruising **O** Varicose veins

O Swollen ankles/ feet **O** High blood pressure **O** Cold hands and feet **O** Other: _____

URINARY

O Urinary tract infections **O** Incontinence/ dribbling **O** Discomfort w/ urination **O** Frequent urination

O Blood in urine **O** Other: _____

LYMPH / IMMUNE

O Swollen glands/nodes **O** Frequent colds/flu **O** Frequent antibiotic use **O** Slow wound healing

O Canker sores **O** Cold sores/Herpes **O** Shingles **O** Sinus infections

O Other: _____

MIND/ NERVOUS SYSTEM

O Anxiety/ panic attacks **O** Depression **O** Irritability/ impatience **O** Difficulty concentrating

O Poor memory **O** Fearful/ chronic worry **O** Numbness/ tingling **O** Brain fog

O Seizures **O** Tremor/ trembling **O** Dizziness/ vertigo **O** Light headed/ fainting

O Loss of balance **O** Other: _____

EATING/ APPETITE

O Can't gain weight **O** Can't lose weight **O** Frequent dieting **O** Poor appetite

O Frequent thirst/hunger **O** Emotional eater **O** Binge eating **O** Caffeine-dependant

O Cravings **O** Bulimia/ anorexia **O** Other: _____

Specify: _____

Name_____ Date_____

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Family History

Please check all that apply. If deceased, please indicate with "D".	Mother	Father	Siblings	Children	Grandma (maternal)	Grandpa (maternal)	Grandma (paternal)	Grandpa (paternal)
Cancer (*Type?*)								
Genetic disorder								
Heart disease, Stroke or Hypertension								
Diabetes								
Dementia								
Psychiatric/ Mood disorder (anxiety, depression, schizophrenia, bipolar, etc.)								
Food/ Environmental Allergies								
Autoimmune conditions (rheumatoid arthritis, MS, lupus, Crohn's, colitis, etc)								
Seizures								
Asthma/Allergies								
Thyroid Conditions								
Addictions (alcohol/drug abuse)								

Other family members with any of the conditions mentioned above (aunts, uncles, etc.):
_____
_____

Men's Health

Please check all that apply

O Prostate enlargement **O** Hernia **O** Testicular mass / pain **O** Sexual difficulties
O Change in libido **O** Wake to urinate **O** Urinary urgency/ hesitancy/ change in stream/ dribbling
O STI/STD **O** Prostate or urinary infection
O Other: _____ Have you had your PSA checked? If so, date of most recent test:_____

Women's Health

OBSTETRIC HISTORY *Please check applicable boxes and provide number*

O Pregnancy _____ **O** Caesarean _____ **O** Vaginal deliveries _____
O Miscarriage _____ **O** Abortion _____ **O** Living children _____
O Gestational diabetes **O** Postpartum depression **O** Breast fed: How long? _____

DIAGNOSTIC & ROUTINE TESTING *Please check all that apply*

O PAP test: **O** Normal **O** Abnormal **O** Mammogram **O** Normal **O** Abnormal
Date of last PAP exam: _____ Date of last Mammogram: _____

Name_____ Date_____

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Women's Health

MENSTRUAL HISTORY *Please check applicable boxes and provide number*

Age at first period: _____ Length of cycle: _____ days (eg. 28 day cycle) Length of period: _____ days (eg. lasts 5 days)
Date of last period: (d/m/y) _____
Is your cycle? **O** Regular **O** Irregular **O** Often early **O** Often late

Do you experience: **O** Heavy periods **O** Light periods **O** Missed periods **O** Blood clots **O** Menstrual pain
Type of menstrual pain: **O** Stabbing **O** Dull **O** Cramping **O** Heavy feeling **O** Downward pressure **O** Severe
Does anything relieve the pain? (pressure, heat, medications, etc.)_____
Are you pregnant? **O** Yes **O** No Are you breastfeeding? **O** Yes **O** No Are you sexually active? **O** Yes **O** No
Are you trying to conceive? **O** Yes **O** No

FEMALE REPRODUCTIVE SYSTEM *Please check all that apply*

O Endometriosis	**O** Pain with intercourse	**O** Low libido/sexual difficulties	**O** Cervical dysplasia
O PCOS (ovarian cysts)	**O** Bleeding between periods	**O** Fibrocystic breasts	**O** Female Cancer (please specify): _____
O Uterine fibroids	**O** Infertility	**O** STI / STD	**O** Other: _____
O Recurrent yeast infections	**O** Breast changes (skin rash, lump, etc)	**O** Vaginal discharge	

PMS *Please check all that apply*

PMT-A:	**PMT-C**	**PMT-D**	**PMT-H**	**PMT-P**
O Nervous tension	**O** Headache	**O** Depression	**O** Weight gain	**O** Joint pain
O Irritability	**O** Craving sweets	**O** Forgetful	**O** Abdominal bloating	**O** Low back pain
O Mood changes	**O** Increased appetite	**O** Crying	**O** Swelling of extremities	**O** Abdominal pain
O Anxiety	**O** Heart pounding	**O** Confusion	**O** Breast tenderness	**O** Headaches
O Insomnia	**O** Dizziness or faint	**O** Clumsy	**O** Water retention	
O Paranoia	**O** Fatigue	**O** Withdrawn		

MENOPAUSAL SYMPTOMS *Please check all that apply*

O Hot flashes	**O** Vaginal dryness	**O** Night sweats	**O** Mood changes
O Weight gain	**O** Thinning hair	**O** Dry skin	**O** Acne
O Changes in sleep pattern	**O** Brain fog/poor memory	**O** Other: _____	

Date of last menses? (d/m/y) _____

O Use of hormone replacement therapy: Type? _____ For how long? _____

Social History

Living With whom do you live with? _____
Are you exposed to any mold/second hand smoke/ pet dander? Specify: _____
Occupation What do you do for work? _____ **O** Student, studying

Smoking **O** Never smoked **O** Currently smoking for _____ years, _____ cigarettes per day
O Social smoker **O** Used to smoke for _____ years, _____ cigarettes per day
Year quit _____

Alcohol How many alcoholic drinks per week? **O** none **O** 1-3 **O** 4-6 **O** 7-10 **O** >10
Please list any recreational drug use: _____

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Nutrition

Do you adhere to a specific diet (eg. vegetarian, gluten-free)? _____

What foods do you avoid? _____ What changes would you like to make?_____

Known food intolerances:_____

Describe your **typical daily diet**:

Breakfast: _____ Lunch: _____

Dinner: _____ Snacks: _____

Drinks: _____ Water intake per day: _____

Caffeine intake? _____ servings/day **O** Coffee **O** Tea **O** Soda

Exercise

Do you exercise? **O** Yes **O** No

Do you engage in sports/activities? **O** Yes **O** No _____ times/week for _____ minutes

O Stretching/Yoga **O** Cardio **O** Strength **O** Other

Energy levels (please rate average daily level of energy): Low 1 2 3 4 5 6 7 8 9 10 High

Sleep

Hrs/night _____ Do you wake feeling well rested? **O** Yes **O** No

Check all that apply:

O Difficulty falling asleep **O** Difficulty staying asleep Wake_____ times/night **O** Snoring **O** Nightmares/ night terrors **O** Restless legs

Stress (please rate average level of stress): Low 1 2 3 4 5 6 7 8 9 10 High

What are the major stressors in your life? (eg. financial, job related, health, family, spiritual)_____

_____

How do you deal with stress? (eg. exercise, hobbies, prayer, reading, journal, meditation, yoga, etc.) _____

_____

Psychosocial *Please check the one that applies to you*

How satisfied are you with . . .?	Very	Moderately	Not at all	N/A
Work/School	**O**	**O**	**O**	**O**
Financial situation	**O**	**O**	**O**	**O**
Social life / Friends	**O**	**O**	**O**	**O**
Sex	**O**	**O**	**O**	**O**
Spirituality	**O**	**O**	**O**	**O**
Spouse / Boyfriend / Girlfriend	**O**	**O**	**O**	**O**
Family	**O**	**O**	**O**	**O**

Context of Care

1. What do you know about the naturopathic approach to medicine? _____
2. What expectations do you have from your visits here or from me as your doctor? _____

_____

3. What are your short-term goals for your health? _____
4. What are your long-term goals for your health? _____
5. What obstacles do you foresee getting in the way of these goals? (eg. time, money, willpower, lack of support, etc.)

_____

6. What habits/behaviors/thought patterns do you currently have that prevent you from being optimally healthy?

_____

7. What habits/behaviors/thought patterns do you currently have that help you be optimally healthy? _____

_____

Name_____ Date_____

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Naturopathic FEE SCHEDULE & FINANCIAL POLICY

Effective January, 2014

Service	*Patient Fee*
Initial Consultation	
(Adult/Senior)	**$200**
(Child 0-14yrs)	**$147**
Follow Up	
(Adult)	**$84**
(Child 0-14years)	**$73.50**
15 minute Phone Consultation	**$42**
30 minute Phone Consultation	**$84**
Missed Appointment Fee	**50% of the regular fee**
Lab Testing & Injections	**Prices vary**

You are responsible for the balance of the fees at the time of services rendered, unless you are on a prepaid agreement.

Lab testing, supplements, and injections if required, are an additional cost that varies with the specific test or product.

A follow up appointment is required for all lab testing results.

You may carry addition insurance, i.e.: Alberta Blue Cross, Manulife, Sunlife, etc. that may reimburse you for naturopathic care. At this time we are only able to direct bill with Chamber of Commerce, Great West Life, Industrial Alliance, Johnsons Inc. Manulife, Maximum Benefits, Standard Life and Sunlife. For all other insurance companies you will be provided with a receipt to submit for reimbursement.

Alberta Health Care does not cover charges for these items.

I am aware that I will be charged 50% of the regular appointment fee for any missed appointment. (In the event that an appointment is cancelled with any amount of notice this fee will not apply)

I have read and understand the financial schedule & policy for Back on Track Chiropractic and agree to comply as indicated above.

_____ _____

Patient/Parent/Legal Guardian Signature Date

Name_____ Date_____

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Declaration and Informed Consent for Naturopathic Care

1. I understand that the practice of Naturopathic medicine requires taking a **thorough case history,** and may require a **physical exam** and, in some cases, **diagnostic testing** involving collection of blood, urine and/ or saliva.
2. I confirm that the information I have provided to the doctors at Back On Track is **complete and inclusive of all health concerns** including possibility of pregnancy and all current medications, including over-the-counter drugs and supplements.
3. I understand that Naturopathic medicine **carries a risk of complications and that resolution of symptoms is not guaranteed.** Slight health risks of some Naturopathic treatments may include, but are not limited to: temporary aggravation of pre-existing symptoms; allergic reactions and other adverse effects to herbs or supplements; pain, fainting, bruising or injury from venipuncture or acupuncture.
4. I understand that the treatment I receive through the doctors at Back On Track is **not mutually exclusive from any other treatment** or advice I may now, or in the future, be receiving, and I am at liberty to seek, or continue, medical care offered by another qualified health care provider. I confirm that I have the **ability to accept or reject the recommended treatment** of my own free will and choice.
5. I am here as a patient seeking Naturopathic medicine and am **not attending the clinic for any other reason** or misrepresenting myself in any way to the practitioner without making my intention known to the practitioner and/ or staff.
6. I understand that a record of my visits will be kept and that this record will be **kept strictly confidential** and not released to any persons without my consent. However, I acknowledge that the doctors at Back On Track may enhance my care periodically by discussing my case with each other. I will inform my doctor if this is a concern.
7. I have read and understood the fee schedule and I acknowledge that I am **responsible for payment of services in full at each visit.**
8. I acknowledge that I understand and **have been informed of the recommended therapeutic procedures** and have discussed these and any other related information with the practitioner to my satisfaction.
9. I understand that the doctors at Back On Track reserve the right to determine which cases fall outside of their scope of practice, in which case the **appropriate referral** will be recommended.
10. I understand that there is a **cancellation fee** for appointments missed without notice or cancelled with less than **24 hours notice.** The charge will be **50% of the fee** of the appointment missed.
11. I acknowledge that if I have not seen the doctor in **2 years or longer,** I will need to fill in new patient intake forms and be scheduled for a 1 hour visit in order to fully address my health concerns.
12. I understand there may be times when I may be required to wait as the doctor is provided needed attention to a current patient.

Patient's Name (please print): _____

Patient's Signature: _____

Date: _____

ND: _____

_____ (initials) From time to time the clinic may email you updates, newsletters, information about upcoming events, or similar communications. Please initial if you agree to be contacted at the email provided. You may opt out of such emails at any time.

Name_____ Date_____