Naturalaura HEALTH

Naturopathic Adult Intake Form (14+ older) ~ Laura M. Brown, ND

Please allow yourself about 30 minutes to complete the form to the best of your knowledge. If you have any questions we can review it together in our session.

Name:_____ Sex:_____ Age:_____ Birth date(dd/mm/yy):_____
Address:_____City:_____Postal Code:_____
Phone (home): _____ (work):_____extn.: ____cell:_____
Leave a message? Y/N Which number? _____ Email:_____
Emergency contact: _____Relationship: _____Phone:_____
Occupation:_____Employer:_____
How did you find Naturalaura Health? _____
Family Doctor:_____ Phone:_____ Fax: _____
Address:_____ Date of last visit:_____
Blood work? _____ Imaging? _____
Date of last Annual Physical Exam? _____
Findings of concern:_____
Diagnosed conditions_____ Date of onset?_____
Diagnosed conditions_____ Date of onset?_____
Diagnosed conditions_____ Date of onset?_____
Other Current (C) or Past (P) healthcare providers? C/P Chiropractor C/P Dentist C/P Massage Therapist C/P Physiotherapist C/P Counselor C/P Therapist C/P Energy healer C/P Spiritual director C/P Optometrist
C/P Other (list):_____
Reason for coming in today? _____ Date of onset? _____
Other health concerns: _____ Date of onset? _____
Other health concerns: _____ Date of onset? _____
Other health concerns: _____ Date of onset? _____
Any condition or event you feel you have been never well since? _____
_____
Current weight:_____ Height_____
Current Energy (worst ever) 1----2----3----4----5----6----7----8----9----10 (best ever)
Allergies: _____
Sensitivities: _____
Adverse reactions to vaccinations? _____
Past hospitalizations, surgeries, major injuries (date): _____
_____
Current medications (& dose): _____
_____
Current Supplements (& dose): _____
_____

Information for direct billing to insurance companies:

Are you interested in having your practitioner pursue direct billing on your behalf? Y/N
Please note you are responsible for payment in the event that direct billing is unavailable.
Please inform receptionist at time of booking that you are a direct billing client.
I authorize Balance Integrated Health Solutions /Laura M. Brown ND, to conduct direct billing on my behalf:_____(Signature)
Insurance company:_____Policy #_____
Member ID#_____ Card # _____

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Where are you in birth order? □ First □Last □ Middle □ Only

Family Medical History: i.e. Allergies, Asthma, Heart Disease, High Blood Pressure, Cancer, Diabetes, Depression, Mental Illness, Drug or Alcohol Abuse, Other

Relation	Alive Y/N	Present health or date and cause of death
Father		
Mother		
Spouse		
Children		
Sibling		

Hobbies : _____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____

_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N
Are you frequently exposed to animals (work, pets, etc.)? Y / N

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

_____

_____

How would you describe the emotional climate of your home?

_____

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

_____

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

_____

_____

Please review and check where appropriate

Substance use (how much/often):	**Sleep**
☐ Alcohol _____	☐ Night shift _____
☐ Tobacco _____	☐ 7-8 hours per night? _____

☐ Pain Killers _____ ☐ Recreational Drugs _____ ☐Coffee _____☐ Tea _____ ☐Cortisone /Steroids _____ ☐ Sedatives _____ ☐ Laxatives _____ ☐ Antacids _____	☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Wake refreshed ☐ Partner/pet wakes you(noise/moves) ☐ TV/screen use before bed ☐ Bedroom dark & quiet ☐ Teeth clench/grind
Overall: ☐ Shortness of breath ☐ Difficulty keeping eyes open in daytime ☐ General weakness ☐Easily catch colds ☐ Low energy ☐ Feel worse after exercise ☐ Dark urine or blood in urine ☐ Offensive breath ☐ Foul odour stool	**Over all Temperature** : ☐ Cold hands ☐ Cold feet ☐ Sweaty hands ☐ Sweaty feet ☐ Hot body temperature (sensation) ☐ Cold body temperature (sensation) ☐ Afternoon flushes ☐ Night sweats ☐ Heat in the hands, feet, chest ☐ Hot flushes any time of day ☐ Thirsty ☐ Perspire easily ☐ Lack of perspiration ☐ Take water to bed
DAMP ☐ General sensation of heaviness in the body ☐ Mental heaviness ☐ Mental sluggishness ☐ Mental fogginess ☐ Convulsions ☐ Lump in throat ☐ neck tension ☐ Limited range of motion in neck ☐ Shoulder tension ☐ Limited range of motion in shoulder ☐Drink alcohol ☐ Recreational drugs? Which_____ How much per week? _____ ☐High pitch ringing in the ears ☐ Gallstones (history or current) ☐Sexually transmitted disease (which)? _____ ☐ Thirst, no desire to drink	**LU** ☐ Nasal discharge (colour) _____ ☐ Cough ☐ Nose bleeds ☐ Sinus congestion ☐Dry mouth ☐ Dry throat ☐Dry nose ☐ Dry skin ☐ Allergies (to what)_____ ☐ Alternating fever and chills ☐ Sneezing ☐Headache? (location) _____ ☐ Swollen hands ☐ Swollen feet ☐ Swollen joints ☐ Chest congestion ☐ Nausea ☐ Snoring ☐ Overall achy feeling in the body

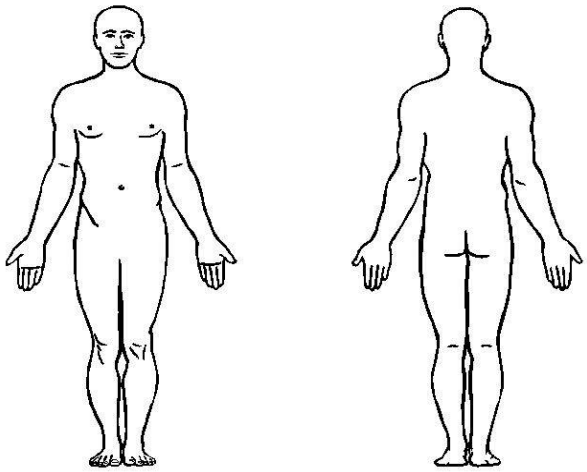
	☐ Stiff neck ☐ Stiff shoulders ☐Sore throat ☐ Difficulty breathing ☐ Smoke cigarettes (# per day)_____ ☐ Sadness ☐ Melancholy
SP ☐ Low appetite ☐ Abrupt weight gain ☐Abrupt weight loss ☐ Abdominal bloating ☐Abdominal gas ☐ Gurgling noise in stomach ☐ Fatigue after eating ☐ Prolapsed organs (previously diagnosed) which? _____ ☐ Easily bruised ☐ hemorrhoids ☐ Pensive ☐ Overthinking ☐ Worry	**SP/SI/LI** ☐ Loose stool ☐ Constipation ☐ Incomplete ☐ Duck like droppings ☐ Diarrhea ☐ Blood in stool ☐ Mucus in stool ☐ Undigested food in stool **Blood (LV/SP/HT)** ☐Dizziness ☐ See floating back spots ☐Pale and brittle nails
ST ☐ Burning sensation after eating ☐ Large appetite ☐ Bad breath ☐ Mouth (canker) sores ☐ Bleeding, swollen or painful gums ☐ Heartburn ☐ Acid regurgitation ☐ Ulcer (diagnosed) ☐Belching ☐ Hiccoughs ☐ Stomach pain ☐ Vomiting looks like_____	**HT** ☐ Palpitations ☐Anxiety ☐Sores on tip of tongue ☐ Restlessness ☐ Mental confusion ☐ Chest pain travelling to shoulder ☐Frequent dreams ☐ Insomnia ☐ Wake un-refreshed ☐Drink coffee (3 cups per week)____ ☐ uncontrolled laughter, crying ☐ Hot body with cold hands and feet ☐ Feeling of oppression or constriction in chest
LV/GB ☐ Alternating diarrhea and constipation ☐ Chest pain	**KD/UB** ☐ Frequent cavities ☐Easily broken bones ☐ Sore knees

☐ Tightness in chest ☐ Feeling of lump in throat ☐ Bitter taste in mouth (when?)_____ ☐ Anger easily ☐Frustration ☐ Irritable ☐ Frequently unable to adapt to stress What causes the stress? _____ ☐ Skin rashes ☐ Headache at top of head ☐ Tingling sensation ☐ Numbness ☐ Muscle spasms ☐Muscle cramping ☐ Seizures ☐ Lack of bladder control ☐ Fear ☐ Easily startled **Eyes**: ☐Itchy ☐ Bloodshot ☐Hot ☐ Dry ☐ Watery ☐ Gritty ☐ Blurry ☐ Pain and or distension in eyes ☐Decreased night vision ☐ Near sightedness ☐ Far sighted	☐Weak knees ☐ Cold sensation in knees ☐ Low back pain ☐ Memory problems ☐ Excessive hair loss ☐ Low-pitched ringing in ears ☐ Kidney stones ☐ Bladder infections ☐ Wake during night twice or more to urinate ☐ Discharge ☐ Difficult urination ☐ Painful urination ☐ Urgent urination ☐ Frequent urination ☐ Dribbling after urination ☐ Coffee or energy drinks # day_____ ☐ Swelling of the face ☐ Swelling of hands and or feet **Libido** ☐ Normal ☐ High ☐ Low

Patient Profile: Please clearly mark any areas of pain Ⓟ or scars ✗

Describe the pain:
☐ Sharp
☐ Shooting
☐ Cramping
☐ Fixed
☐ Burning
☐ Dull
☐ Aching
☐ Moving

Pain is better/ worse with: (B/W = circle)
B / W cold
B / W heat
B / W pressure
B / W exercise



♀ Female

Regular menstrual cycle? ☐ Yes ☐ No Date of Last Menstrual Period: DD/MM/YY_____
Pregnant? ☐ Yes ☐ No
Number of Children _____ Number of Pregnancies _____
Number of miscarriages _____ Number of abortions _____

Age of first menstruation:_____ Age of menopause (if applicable): _____
Average number of days of flow: _____ Average days of cycle: _____
Nature of flow:_____ Colour of flow: _____Clots:_____
Vaginal discharge: _____
Bleeding between periods: _____

PMS symptoms:
☐nausea ☐vomiting ☐ migraines ☐ headaches ☐ anxiety ☐depression
☐ irritability ☐ bloating ☐breast tenderness ☐ breast swelling ☐food cravings
☐ pain of what nature? _____where? _____
Other: _____

For fertility patients please also attach your chart for Basal Body Temperature.

Last PAP:_____ Any abnormal PAP?_____
Sexually Active: ☐ Yes ☐Past ☐Never
Form of birth control: _____
Form of personal protection: _____
History of Sexually Transmitted Infection (STI)? _____
Date of last test for STI: _____

Self Breast exams ☐Yes ☐ No
Over 50: Last mammogram: _____
It is recommended that women aged 50 to 74 have a screening mammogram, generally every two years. Evidence shows that women aged 50–74 benefit most from regular mammograms. Women who have been confirmed to be at high risk for breast cancer should have a screening mammogram and breast MRI every year.

Other Comments: _____

_____

Male

☐ Swollen Testes
☐ Testicular Pain
☐ Impotence
☐ Premature Ejaculation
☐ Feeling of coldness or numbness in external genitalia

Sexually Active: ☐ Yes ☐Past ☐Never
Form of birth control / personal protection: _____
History of Sexually Transmitted Infection (STI)? _____
Date of last test for STI: _____

Ages 17-35: Self testicular exam? ☐Yes ☐ No
Ages > 50: Last Prostate exam: _____ PSA value:____
Any urinary concerns? _____

☐ Other: _____

Other Comments: _____

_____

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Informed Consent

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. Your Naturopathic Doctor will take a thorough case history; perform a physical examination, including a breast exam, and take blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

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.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

The staff is trained to handle emergencies should the need arise.

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.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parental therapy.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa.
- Muscle strains and sprains or disc injuries from spinal manipulation.
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened by the Naturopathic Doctor prior to manipulating the neck.

I understand:

- The clinic does not guarantee treatment results.
- That my Naturopathic 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 treatment at any time.

Patient Name (please print): _____

Signature of Patient or Guardian: _____Date: _____

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

Privacy of your personal information is an important part of Naturalaura Health, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what Naturalaura Health is doing to ensure that

- ✓ Only necessary information is collected about you;
- ✓ We only share 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.

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

Naturalaura Health 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 send you newsletters and other information mailings
- ✓ To remind you of upcoming appointments
- ✓ To communicate with other treating health-care providers
- ✓ To allow us to efficiently follow-up for treatment, care and billing
- ✓ To complete claims for insurance purposes
- ✓ To invoice for goods and services
- ✓ To process credit card payments
- ✓ To collect unpaid accounts
- ✓ To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others
- ✓ To use for educational and research purposes at Naturalaura Health (this includes case summaries, photographs, lab results and other pertinent medical information). Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

PATIENT CONSENT

I have reviewed the above information that explains how Naturalaura Health will use my personal information, and the steps that Naturalaura Health is taking to protect my information. I agree that Naturalaura Health can collect, use and disclose personal information about (Patient Name)_____ as set out above in the information about Naturalaura Health's privacy policies.

Signature Print name Date