Better health begins with nature

Ezentials
NATURAL HEALTH CENTRE & SPA

ADULT INTAKE FORM

(Please print clearly and fill out both sides of the pages)

Name _____ Today's Date_____

Date of Birth (Month/Day/Year) _____ Age _____

Gender: Female / Male

Address _____

City_____ Province_____ Postal Code_____

Phone (home) _____ (work &/or cell) _____

Email _____ Employer_____

Occupation _____ Hours per week _____

Names and ages of children, if applicable_____

Marital status? ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership

Live with? ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

Emergency Contact

Name & Relation _____ Phone _____
Address _____

Other Health Care Providers

Type of Provider: Family Doctor
Name: _____
Phone: _____

Type of Provider: _____
Name: _____
Phone: _____

Type of Provider: _____
Name: _____
Phone: _____

List your health concerns, in order of importance:

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

How did you hear about our clinic? _____
Has any other family member been a client at this clinic? _____
Have you received naturopathic treatment in the past?_____

5074 Highway 69 North, Hanmer, Ontario P3P 1B9
Tel. **705.969.0043** • Fax. 705.969.9681

MEDICATIONS

List any prescription or over-the-counter medications that you are presently taking.

Name of Medication	Daily Dosage	How Long?	Reason for Taking	OFFICE USE ONLY: Drug category
1.				
2.				
3.				
4.				
5.				

List any supplements that you are presently taking.

Name of Supplement	Brand	Daily Dosage	How long?	Reason for Taking
1.				
2.				
3.				
4.				
5.				

ALLERGIES

Are you allergic or sensitive to…
Any drugs/medications? _____
Any foods? _____
Any environmentals?_____
Any chemicals? _____
Any supplements? _____

MEDICAL HISTORY

Have you been vaccinated? Yes No Have you experienced any adverse reactions? _____
_____

Have you had the flu shot? Yes No Have you experienced any adverse reactions?_____
_____

Have you experienced any of the following?

□ Scarlet fever	□ Diphtheria	□ Rheumatic fever
□ Mumps	□ Measles	□ German measles
□ Chicken pox	□ Shingles	□ Tuberculosis

List all surgeries that you have had.

Type of Surgery	Year	Reason for Surgery	Complications

List any major illnesses or injuries that you have had (include approximate dates)_____
_____
_____
_____

List the five most significant stressful events in your life.

Stressful Event	Date
1.	
2.	
3.	
4.	
5.	

How would you describe your current state of health? □ Excellent □ Very Good □ Fair □ Poor

Do you have any known contagious diseases at this time? Yes No If yes, what? _____
_____

FAMILY MEDICAL HISTORY

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health (G=Good; P=Poor)						
Age at death (if deceased)						
Cause of death						
Check (√) those applicable						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Drug abuse/alcoholism						
Depression						
Other Mental Illness						
Asthma						
Allergies/Hayfever						
Kidney Disease						
Other						

DIET

Describe your typical daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks (type and quantity): _____

Do you have any dietary restrictions (vegetarian, vegan, religious, allergies, etc.)? _____
_____
_____

LIFESTYLE

Do you exercise? Yes No If yes, what kind and how often? _____
_____
_____

Main interests and hobbies _____
_____

What do you enjoy most in your life? _____
_____

What do you worry about most in your life? _____
_____

For the following, circle "Y" for yes, "N" for no, or "P" for in the past

Average 6-8hrs sleep per night?	Y N	Do you have a religious or spiritual practice? ⊗If yes, what?	Y N
Awake feeling well rested?	Y N		
Have a supportive relationship?	Y N		
Have a history of abuse?	Y N	Do you watch television? ⊗How many hours per week?	Y N
Do you use recreational drugs?	Y N P		
Treated for drug dependence?	Y N P	Do you read? ⊗How many hours per week?	Y N
Do you eat three meals a day?	Y N		
Do you eat out often?	Y N	Do you drink alcohol? ⊗What type? ⊗How many drinks per week?	Y N P
Do you drink coffee?	Y N P		
Do you drink black tea?	Y N P		
Do you drink cola/other sodas?	Y N P	Treated for alcoholism?	Y N P
Do you eat refined sugar?	Y N P	Do you smoke tobacco? ⊗How many packs per day? ⊗How many years?	Y N P
Do you add salt to your food?	Y N P		
Do you enjoy your work?	Y N		
Do you take vacations?	Y N	Exposed to significant tobacco smoke (i.e., 2nd hand smoke)?	Y N P
Do you spend time outdoors?	Y N		

REVIEW OF SYSTEMS

Gastrointestinal

Nausea?	Y N P	Gas and/or bloating?	Y N P
Vomiting?	Y N P	Indigestion?	Y N P
Vomiting blood?	Y N P	Heartburn?	Y N P
Blood in stool?	Y N P	Constipation?	Y N P
Abdominal pain or cramps?	Y N P	Diarrhea?	Y N P
Belching or passing gas?	Y N P	Gall bladder disease/gall stones?	Y N P
Black, tarry stools?	Y N P	Ulcer?	Y N P
Jaundice (i.e., yellow skin)?	Y N P	Hemorrhoids/fissures?	Y N P
Liver disease (hepatitis)?	Y N P	Hernia?	Y N P
Bowel movements – how often?		Change in bowel movements?	Y N P

Male Reproduction

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate enlargement or disease?	Y N P
Venereal disease?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N P	Chlamydia?	Y N P
Impotence?	Y N P	Gonorrhea?	Y N P
Premature ejaculation?	Y N P	Condyloma (i.e., genital warts)?	Y N P
Do you use birth control?	Y N P	Herpes?	Y N P
⊗What type?		Syphilis?	Y N P

Female Reproduction

Age at first menses?		Difficulty conceiving?	Y N P
Age at last menses? (if menopausal)		Cervical dysplasia?	Y N P
Typical length of cycle?	days	Sexual difficulties?	Y N P
Typical duration of menses?	days	Pain during intercourse?	Y N P
PMS?	Y N P	Number of pregnancies?	
Painful menses?	Y N P	Number of live births?	
Heavy or excessive flow?	Y N P	Number of miscarriages?	
Bleeding between periods?	Y N P	Number of abortions?	
Are cycles regular?	Y N P	Menopausal symptoms?	Y N P
Clotting during menses?	Y N P	Venereal disease?	Y N P
Vaginal discharge?	Y N P	Gonorrhea?	Y N P
Vaginal itching?	Y N P	Herpes?	Y N P
Yeast infections?	Y N P	Chlamydia?	Y N P
Are you sexually active?	Y N P	Condyloma (i.e., genital warts)?	Y N P
⊗Do you use birth control?	Y N P	Syphilis?	Y N P
⊗What type?		Do you do breast self-exams?	Y N P
Date of last PAP?		Breast pain or tenderness?	Y N P
Abnormal PAP?	Y N P	Breast lumps?	Y N P
Endometriosis?	Y N P	Nipple discharge?	Y N P
Ovarian cysts?	Y N P	Have you had a mammogram(s)?	Y N P
Uterine fibroids?	Y N P	Date of last breast exam?	

Mental/Emotional

Treated for emotional problems?	Y N P	Memory problems?	Y N P
Mood swings?	Y N P	Anxiety or nervousness?	Y N P
Poor concentration?	Y N P	Depression?	Y N P
Tension and/or stress?	Y N P	Considered/attempted suicide?	Y N P
Phobias?	Y N P	Insomnia?	Y N P

General

Current weight? _____lbs Maximum Weight? _____ lbs When? _____

Rate your energy from 1 to 10 (1=lowest and 10=highest): _____

What time of day is your energy best? _____ What time of day is your energy worst? _____

What is your present level of commitment to address any underlying causes of your health concerns that relate to your lifestyle? Rate on a scale from 1 to 10, with 10 indicating 100% commitment.

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

What behaviours or lifestyle habits do you currently engage in that you believe support your health? Please list. _____
_____
_____

What behaviours or lifestyle habits do you currently engage in that you believe are destructive to your health? Please list. _____
_____
_____

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the treatment plan that I will be sharing with you? _____
_____
_____

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

"Those who do not find time every day for health must sacrifice a lot of time one day for illness."
Father Sebastian Kneipp

Better health begins with nature

Ezentials
NATURAL HEALTH
CENTRE & SPA

INFORMED CONSENT

Naturopathic Medicine is the treatment and prevention of disease 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 to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatments include diet and nutritional supplements, botanical medicine, homeopathy, Asian medicine, hydrotherapy, physical medicine, and lifestyle counselling.

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, improved digestion, improved immunity, and general well being.

Botanical medicine is a plant-based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine based on the Law of Similars – i.e., the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plants, animals, or minerals are used to stimulate the body's ability to heal itself.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Dietary advise is based on traditional Chinese medical theory.

Physical medicine refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, your Naturopathic Doctor will take a thorough case history, do a physical examination, and when indicated, take blood and urine samples. The physical examination may include more specific examinations such as gynecological (e.g., PAP), rectal, prostate, or genital exams.

Even the gentlest therapies may cause complications in certain physiological conditions (e.g., pregnancy, lactation, very young children, or those taking multiple medications). Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important, therefore, that you inform your doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your doctor immediately.

There are some slight health risks associated with Naturopathic Medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Fainting with acupuncture needles
- Pain, bruising or injury from venipuncture
- Allergic reactions to supplements/herbs
- Pain, bruising or injury from acupuncture

_____ Initials I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medial record and can request a copy of it by paying the appropriate fee.

_____ Initials I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

_____ Initials I understand that charges are to be paid at the time of the visit unless specific arrangements have been made **prior** to my scheduled appointment. Payment for all dispensary items is due at the time of the visit.

_____ Initials I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or late cancellations (less than 24 hours notice).

As the patient, I am responsible for the total charges incurred at each visit. Ezentials accepts cash, debit, or visa. I am responsible for billing my own insurance company (if applicable) – Ezentials will provide all of the information necessary to send in a claim for reimbursement.

The Naturopathic Doctor may prescribe supplements that can be purchased at Nature's Apothecary or elsewhere. Most insurance companies do not cover the supplements that are prescribed and dispensed.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print) _____

Signature: _____ Date: _____

Better health begins with nature

Ezentials
NATURAL HEALTH
CENTRE & SPA

PATIENT CONSENT FORM
FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our clinic, while providing you with quality 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.

In this clinic, Tracy Gilbert (Naturopathic Doctor) acts as the Privacy Information Officer.

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 our clinic 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 and the law.

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

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our clinic is using and disclosing your information.

This clinic 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 comply with legal and regulatory requirements of our regulatory body
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this clinic to comply with all regulatory requirements
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed 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 your clinic will use my personal information and the steps your clinic is taking to protect my information.

I understand that this clinic has a Privacy Policy that I can ask to see at any time.

I agree that ***Ezentials*** can collect, use and disclose personal information about

Patient Name
_____ as set out above in the information about the clinic's privacy policies.

Signature: _____ Print Name: _____

Date: _____ Signature of Witness: _____