Brantford Integrative Health Centre

Naturopathy | Osteopathy | Acupuncture | Counselling

PATIENT INTAKE SHEET 2016

Patient Name: ____

Last First Middle

D.O.B.: ________________________ **Sex:** ☐ **M** ☐ **F**

Year Month Day

Address: _____________________________

Street Address

____

City

____

Postal Code

May we leave a detailed message?

Phone : _______________ **Yes [ ] No [ ]**

Residence

_______________ **Yes [ ] No [ ]**

Work

_______________ **Yes [ ] No [ ]**

Cell

Email: ____

Emergency Contact Name______________**Emergency Contact Telephone Number**________________

Date of first Assessment: ______________________ / **Previous Patient [ ]**

(Day) (Month) (Year)

Please note: Cancellation of an appointment requires 24 hours notice. As of Jan 1, 2014 a $75 cash deposit or a Visa/MC/AMEX number will be kept on file and used if you fail to attend a scheduled appointment without 24 Hours notice.

_____ _____ _____ _____ Exp Date: ________

[ ] Visa, [ ] Master Card [ ] American Express [ ] Cash [ ] Cheque

($75 cash refunds will be returned on your last appointment, all other documents with your credit card information will be shredded)

By signing this form, you acknowledge and accept responsibility for payment of missed appointments.

____

Signature of Patient

____

Signature of Parent or Legal Guardian

Date: ____________________

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Phone 519-304-7044 Fax 519-304-4635 bich2014@rogers.com

Statement of Acknowledgment

Welcome to Brantford Integrative Health Centre. Our system of health care is supportive of your body's own ability to heal. Each person seeking care in our clinic should understand that we are Naturopathic Doctors and NOT Medical doctors. We work within a Naturopathic scope of practice. Treatment and referral to other health practitioners is based upon assessment and laboratory testing. If at any time, during your course of treatment, you would like to receive services from a different clinician, please ask. In order to maintain consistency and quality of care, an administrative fee when transferring between Naturopathic Doctors will apply.

If conventional medical treatment is desired, it must be obtained from a licensed medical doctor. We encourage you NOT to abandon contact with your medical doctor. Naturopathy uses noninvasive methods for the assessment of bodily functions and natural therapies for correction (i.e. dietary recommendations, lifestyle changes, acupuncture, body work, and certain remedies and/or supplements). There is an emphasis on patient education, as the ultimate responsibility for the patient's health is his/her own.

Changes in dietary habits are not a prerequisite for treatment, but it should be understood that failure to follow sound nutritional and exercise programs could undermine the positive results.

The patient is responsible for any fees incurred during care and treatment and agrees to fully discharge this responsibility at the time of the visit. If you have not been in for an appointment in the last 12 months a reactivation fee will apply. A fee of $75.00 will be charged for any appointment missed without at least a 24 hour cancellation notice.

The patient accepts or rejects this care of his/her own free will and choice.

I, ____________________ have read, understood and acknowledge the above Statements.

SIGNATURE DATE

WITNESS DATE

Michael Meade, HBSc, BEd., MM (counselling), ND Doctor of Naturopathic Medicine

BRANTFORD INTEGRATIVE HEALTH CENTRE
Adult Intake

Date: ______________________

General Information

Please complete the following information in full. Thank you.

Occupation:____
Marital Status:________________   Number of children:__________________
Emergency Contact
Name:___________________Relationship:____________Telephone:__________
Primary Physician
Name: ___________________Telephone:_________________
Other health care practitioners that you are seeing:
1.____
2.____
3.____
How did you hear about our clinic? Referral Advertisement Friend/Family Sign
Referred by:____

Health and Lifestyle Information

What is your main health concern?
____
____
____
Please list any other health concerns in order of importance (physical, emotional, mental):
1.____
2.____
3.____
Please list any dietary restrictions and/or
alleries:____
How much water do you drink a day?_____________________________________?
Do you have regular bowl movements? Y/N
How many and what type of alcoholic beverages do you have per week?___________
Do you smoke? Y / N   How many cigarettes daily?_________________
Have you ever smoked? Y/N   When did you quit?______________________
On average how many hours do you sleep a night?__________________________
Do you have trouble falling asleep? Y / N
Do you wake up during the night? Y / N   Any specific time?___________________
Do you exercise regularly? Y / N
What type of exercise and how often?______________________________________
How do you rate your overall health?   Poor 1--2--3--4--5--6--7--8--9--10 Excellent

How do you rate your overall energy level? Poor 1--2--3--4--5--6--7--8--9--10 Excellent
How do you rate your stress level? Low 1--2--3--4--5--6--7--8--9--10 High
Which factors contribute to your stress? (please circle)
Health Work Family Marriage Other:______________________

Medications and Supplements

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.
Medication: ____________ Daily Dose: ____________ How long? ________________
____________ ____________ ________________
____________ ____________ ________________
____________ ____________ ________________

Please list all current vitamins/minerals, herbs or homeopathic remedies, the daily dose and how long you have taken it.
Supplement:___________ Daily Dose: ____________ How long**?**________________
____________ ____________ ________________
____________ ____________ ________________
____________ ____________ ________________

How many courses of anti-biotic's have you had in the last 10 years?_______________
Have you had a bad reaction to any medication? Y / N If yes which one? ___________

Medical History

Please briefly describe your dental history (root canals, fillings, extractions, etc.)
____
____
____

Do you grind or clench your teeth at night? Y / N Do you wear a splint? Y / N
Do you have any pain or discomfort in your jaw? Y / N
Please list (with approximate dates) any serious conditions, illnesses or injuries, surgeries and any hospitalizations:
____
____
____

Have you had any Motor Vehicle Accidents? Y / N
If yes, please explain (approximate date, nature of accident,injuries):____

Please indicate if you have had any of the following childhood illnesses (please circle):

Asthma Measles Rheumatic fever Eczema Mumps Scarlet fever

Frequent ear infections or colds Rubella (German measles) Whooping cough

Chickenpox Polio Other:________________________________

Family History

Please indicate whether any of your family members have, or have had any of the following (indicate which relative):

Cancer (which type?) __________ Diabetes ______ Heart disease ______
High Blood pressure _______ Stroke ______ Glaucoma ______
Alcoholism _______ Kidney disease ______ Thyroid disease ______
Epilepsy _______ Mental Illness ______ Asthma ______
Allergies _______ Anemia ______ Other________________

Women's Health

Are you currently pregnant? Y / N Is your period regular? Y / N
Is your period painful? Y / N
Do you experience low back pain? Y / N Any other symptoms? _________________
Length of monthly cycle (days): _________________
Average length of period and flow (days): _____________________
Do you get regular Pap smears? Y / N Date of last Pap smear: _______________
Are you menopausal? Y / N If yes, date of last period:______________
Are you currently sexually active? Y / N
Current forms of contraception? ____
Do you experience vaginal infections?! Never!! Rarely! Frequently
Do you experience bladder infections?! Never!! Rarely! Frequently
Number of pregnancies? _____Births? ______ Miscarriages? ______ Abortions? _____

Men's Health

Do you have regular screening tests done (blood work, prostate examination)? Y / N
Date of last prostate examination? ______________
Do you have difficulty urinating completely? Y / N
How many times do you get up from your sleep to go to the bathroom at night? _______

Review of Systems

Please circle if you are currently experiencing any of the following or write P if you experienced it in the past.

General Symptoms

Headache Head Injury Concussion Fever Chills Sweats Dizziness

Fainting Loss of sleep Fatigue Nervousness Weight Loss

Numbness in extremities Convulsions Internal pins/ wires/artificial joints or special equipment

Skin

Hives or allergy Acne or skin eruptions Itching Dryness Boils Sensitivity

Easy Bruising Varicose Veins

Kidneys & Reproduction

Urinary Incontinence   Frequent urination   Painful urination   Blood in urine

Kidney Infections   Bladder Infections   Prostate trouble   Sores on genitals

Eyes, ears, Nose, Throat

Gum trouble   Frequent colds   Enlarged Thyroid   Tonsillitis   Sore throat   Hoarseness

Enlarged glands   Glaucoma   Failing vision   Eye pain   Deafness   Ear ache

Nasal drainage   Nasal obstruction   Sinus infection   Hay fever   Mercury tooth fillings

Cardio-Vascular

Low blood pressure   High blood pressure   Hardening of the arteries   Swelling in the ankles

Poor circulation   Irregular heart beat   Shortness of breath   Chest pain

Gastro-Intestinal

Excessive thirst   Excessive hunger   Belching   Gas (flatulence)   Bloating   Nausea

Vomiting   Abdominal cramps   Constipation   Diarrhea   Hemorrhoids (piles)

Liver problems   Gallbladder problems   Jaundice   Colitis

Respiratory

Asthma   Chronic cough   Spitting up phlegm   Spitting up blood   Difficulty breathing

Musculo-Skeletal

Muscle Stiffness   Muscle weakness   Back pain   Swollen joints   Painful tailbone

Herniated discs   Bulging discs   Arthritis   Fractures   Dislocations   Strains/Sprains

What are your treatment goals and expectations?

____

____

____

Is there anything else that you feel has not been covered?

____

____

Please continue to the next page

Thank you for taking the time to complete this form!

____

Client/Parent/Guardian

____

Date:

____

Michael Meade, HSBc, BEd, MEd, ND

____

Date: