FULL CIRCLE

HEALTH CARE ● SUPPLEMENTS ● FITNESS ● EDUCATION

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION:

Name: _____

Birth date: day____/mo____/yr____

Age: _____

Address: _____

city: _____ postal code: _____

Phone: home: _____ alt: _____

Email: _____

Can we contact you through:

Phone: Y / N

Email: Y / N

Mail: Y / N

Occupation: _____

Employer: _____

If the patient is under 16, please indicate the following:

Mothers' Name: _____ Phone: _____

Fathers' Name: _____ Phone: _____

Contact information for a relative or friend in case of emergency:

Name: _____ Relationship: _____

Address: _____ Phone: _____

How did you hear about us? _____

Name and address of family doctor:

Name: _____

Address: _____

Phone: _____ Fax: _____

Reason(s) for your visit:

_____

_____

_____

_____

MEDICAL HISTORY:

Have you had any of the following conditions?

	Allergies		Eczema		Stomach ulcer
	Asthma		Epilepsy		Stroke
	Anemia		Genetic Disease		Substance abuse
	Arthritis		Hay fever		Suicide attempt
	Bleeding disorders		Heart disease		Thyroid disease
	Cancer		High blood pressure		Tuberculosis
	Depression		Nervous breakdown		Autoimmune disease
	Diabetes (type 1 or 2) - insulin dependant		Sexually transmitted infection		Other:

Have any immediate, blood relatives had any of the following?

	Allergies		Eczema		Stomach ulcer
	Asthma		Epilepsy		Stroke
	Anemia		Genetic Disease		Substance abuse
	Arthritis		Hay fever		Suicide attempt
	Bleeding disorders		Heart disease		Thyroid disease
	Cancer		High blood pressure		Tuberculosis
	Depression		Nervous breakdown		Autoimmune disease
	Diabetes (type 1 or 2) - insulin dependant		Sexually transmitted infection		Other:

Have you ever had a bad reaction to am immunization/vaccination? Y / N

Which one(s): _____

What reaction(s) did it cause: _____

How many times have you been treated with antibiotics: _____

Are you allergic to any medications, foods, or anything else:

_____

_____

_____

Have you ever had surgery or been hospitalized? If so, please indicate when and for what reason: _____

_____

_____

What medicines are currently taking, including prescriptions, over-the-counter, supplements and herbs (please indicate dosages as well):

_____

_____

_____

_____

DIETARY INFORMATION:

What would you eat in a typical day:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

Do you, or are you exposed to tobacco smoke? Y / N
Do you have, or are you exposed to pets? Y / N

How would you rate your energy level (on a scale from 1 to 10):

After waking: _____
After lunch: _____
In the evening:_____

How would you rate your stress level (on a scale from 1 to 10) and why:

_____
_____

INSURANCE INFORMATION:

If your naturopathic visits are covered through a private insurance company (such as extended health care benefits), please bring any forms with you on your first visit in order to facilitate your refund. All fees must be paid by the patient at the time of the visit. Any reimbursement through insurance will be the responsibility of the patient.

Please sign and return to attending Naturopathic Doctor:

I acknowledge that I am financially responsible for all charges, whether or not they are covered by insurance.

Signature: _____
Date: _____

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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 in order to stimulate the body's inherent healing capacity. The mainstays of naturopathic medicine include diet and nutritional supplements, botanical medicine, homeopathy, Chinese medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counselling. Before treatment can begin, your Naturopathic doctor will take a thorough case history, do a complete screening physical exam and may request that you either bring in recent blood test or imaging results, or have these tests performed. It is essential that you inform your Naturopathic doctor of any disease process that you are suffering from, if you are on any medication or over-the-counter drugs or supplements, if you are pregnant, suspect you are pregnant, or if you are breast-feeding.

As with any medical intervention, it is essential to understand that with benefits, come risks. Some examples include, but are not limited to: aggravation of pre-existing symptoms (or "healing crisis"), allergic reactions, or fainting/pain/bruising/nerve/organ/arterial damage/swelling due to acupuncture or venipuncture. If you do not understand these risks, please ensure that you ask for, and receive clarification. Full and complete understanding of the process of disease and treatment allows you to make informed decisions about your own health. If you are uncomfortable with any of the treatment options suggested, you can certainly refuse treatment, or withdraw your consent to treatment at any time.

The path toward healing and health is an ongoing process, and results will undoubtedly vary amongst individuals. It is for this reason that no treatment is guaranteed. If you ever develop concerns or questions about your individualized treatment protocol, you are encouraged to speak with your Naturopathic doctor in order to understand what is happening.

Unfortunately, as Naturopathic medicine is not covered by OHIP, you will be required to pay for your visits and any treatments that you receive. Fortunately, many private insurance companies do cover Naturopathic care. If you have Naturopathic health coverage, you are responsible for providing payment at the time services are rendered.

I hereby have read and understand the process of Naturopathic Medicine and agree to the terms and conditions outlined above. I understand that no treatment is guaranteed and no treatment is without risk. I understand that I am financially responsible for all charges resulting from my treatment. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures described by my Naturopathic doctor. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue any and all treatment or procedure at any time.

Signature: _____ **Date:** _____

Name: **(please print)**_____

Witness/ND: _____ **Date:** _____