Adult Naturopathic Intake Form

Krista Vetter N.D.
Gordon Street Chiropractic Centre
1460 Gordon Street South, Guelph, ON
www.kristavetternd.ca
519-837-0411

IMPORTANT INFORMATION FOR NEW PATIENTS

Congratulations for putting your health first and investigating Naturopathic Medicine and its benefits to your health care program. Naturopathic Doctors are trained like primary health care providers: we use similar physical exams and laboratory tests and recognize the same signs and symptoms. The main difference between a Naturopathic Doctor and your conventional family doctor is the philosophy of care and the treatments are different. Naturopathic Doctors strive to treat the whole person and find the underlying cause of the condition.

TREATMENTS INCLUDE:

- Diet and Nutritional supplementation
- Herbal medicine- the use of plants in tea, tincture or other extraction.
- Homeopathy-the use of dilute plant, mineral or animal substances.
- Hydrotherapy- the use of water treatments to affect circulation and detoxification.
- Traditional Chinese medicine and Acupuncture.

In making your appointment you have implied that you are ready to make some changes in your life to experience better health. Taking the time to fill out this health questionnaire fully will help us to understand your goals and expectations. Together, we will formulate a health care plan that will work for you. Please bring any medications or supplements that you are currently taking with you to your initial appointment.

All of the information that you share with us is kept confidential. Your Naturopathic Doctor is the only one that will review these forms unless you request that we consult on your case with another practitioner.

FEE SCHEDULE- HST is applicable to all fees. Adult initial visit (1.25 hours)- $150
Child initial visit (1.25 hours) - $130
Adult 2nd visit (45 minutes) - $95
Child 2nd visit (45 minutes) - $85
Adult regular visit (30 minutes) - $70
Child regular visit (30 minutes) - $60
Adult acupuncture visit (30 minutes)- $70
Child acupuncture visit (30 minutes)- $60
Brief return visit - $35
IM Visit- $15
Phone consult (per 10 minutes)- $35

Naturopathic treatment is not covered by OHIP; however naturopathic visit fees are covered by most extended health insurance plans. Payment at the time of service is expected and a receipt will be issued that complies with insurance companies requirements

for re-imbursement. Gordon Street Chiropractic Clinic accepts cash, debit, Visa and Mastercard.

CANCELLATION POLICY

If you need to cancel an appointment please give us at least 24 hours notice. A last minute cancellation prevents us from booking other clients who are waiting for a suitable time to come in. Appointments that are cancelled without notice will be charged a $65 fee (exceptions will of course be made in unavoidable circumstances).

WHAT TO DO WHEN YOU ARRIVE

When you arrive at the clinic please check in at the front desk.
Your first appointment will last approximately an hour and fifteen minutes. We will talk about your chief concerns as well as your lifestyle and any other issues that may arise in the visit. At the end of the appointment we will usually have a treatment plan that you are comfortable with and that is specific to your individual needs. Your treatment plan will be written out for you to take home after your appointment. We generally see patients one week after the initial visit to gather any additional information that we didn't discuss in the initial visit and to perform a general physical exam. The second visit is approximately 45 minutes in length. Return visits are 30 minutes long and will be used to monitor your progress.

DISPENSARY

We maintain a small dispensary in our clinic that can supply you with some of the supplements that you may be prescribed. We only carry supplements where quality or formulation is an issue or items that may be very difficult to find elsewhere. All of the supplements, herbs and homeopathics in the dispensary are professional products that are available by recommendation by one of our practitioners only. You are never required to get supplements from us- it is always your choice.

PEDIATRIC VISITS

Parents are asked to accompany children on their appointments for parental input. Pediatric visits usually take 1-1.25 hours as common growth and developmental issues are also discussed in addition to the child's chief concern.

HOW TO FIND US

Gordon Street Chiropractic Clinic is in the South end of Guelph, on Gordon Street between Arkell Drive and Clair Road.

We look forward to meeting with you,

Dr. Krista Vetter

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Name: ________________________ Age: _____ Date of birth: _________ Sex:__

Address: ____

City: ______________________________ Postal Code: ____________________

Phone numbers: (H) __________________ (W) __________________________

Email address: ____

How did you hear about us? ____

**Naturopathic and preventative health care are greatly facilitated when the practitioner has a complete picture of the client physically, mentally, and emotionally. Therefore, please take the time to thoroughly complete this health history questionnaire.

Primary Health Concerns: Please list in order of importance to you

1. _______________________________ 5. _____________________________
2. _______________________________ 6. _____________________________
3. _______________________________ 7. _____________________________
4. _______________________________ 8. _____________________________

Are there any traumatic events (surgeries, drug reactions, life trauma) that you feel may have caused or contributed to your health problems?

____
____
____

Please list all former treatments that you have used both conventional and alternative and the degree of effectiveness of each treatment.

____
____
____
____

If female are you currently pregnant? [ ] yes [ ] no

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Medical History

What childhood illnesses have you had?

[ ] Rubella (german measles- 3 day) [ ] Measles (2 week) [ ] Mumps
[ ] Chicken pox [ ] Whooping cough [ ] Polio
[ ] Rheumatic fever [ ] Scarlet fever [ ] Roseola
[ ] Asthma [ ] Other

Have you experienced any of the following conditions?

	Now	Past	Never		Now	Past	Never
Anemia	[ ]	[ ]	[ ]	High blood pressure	[ ]	[ ]	[ ]
Allergies	[ ]	[ ]	[ ]	Hyperthyroid	[ ]	[ ]	[ ]
Alcohol abuse	[ ]	[ ]	[ ]	Hypoglycemia	[ ]	[ ]	[ ]
Arthritis	[ ]	[ ]	[ ]	Hypothyroid	[ ]	[ ]	[ ]
Asthma	[ ]	[ ]	[ ]	Kidney disease	[ ]	[ ]	[ ]
Bleeding	[ ]	[ ]	[ ]	Liver dz/Jaundice	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	Overweight	[ ]	[ ]	[ ]
Candida	[ ]	[ ]	[ ]	Pneumonia	[ ]	[ ]	[ ]
Colitis	[ ]	[ ]	[ ]	Rheumatism	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	Tuberculosis	[ ]	[ ]	[ ]
Drug use	[ ]	[ ]	[ ]	Ulcers	[ ]	[ ]	[ ]
Eczema	[ ]	[ ]	[ ]	Other	[ ]	[ ]	[ ]
Emphysema	[ ]	[ ]	[ ]				
Headache	[ ]	[ ]	[ ]				
Heart murmur	[ ]	[ ]	[ ]				

Please indicate any serious conditions, illnesses or injuries and any hospitalizations; along with approximate dates.

____
____
____

Medications/Supplements: Please list all of your present medications including drugs, supplements, homeopathics and herbs along with dosages.

____
____
____

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Please list all past prescription medications.

____
____
____
____

How many times have you been treated with antibiotics? __________________

Do you have any allergies (drug, other substances, environmental)?

____
____
____
____

What symptoms do you experience with an allergy attack?

____
____

Check off any of the following types of allergy testing that you have had:

Intradermal	[ ]	Scratch	[ ]	Blood IgG food	[ ]
Food intolerance testing	[ ]	Kinesiology	[ ]	Blood IgE inhalant/food	[ ]

Do you frequently use any of the following?

Aspirin	[ ]	Laxatives	[ ]
Diet pills	[ ]	Antacids	[ ]

Immunizations: Please indicate what immunizations you have had.

DPT (diphtheria, pertussis, tetanus)	[ ]	Haemophilus influenza	[ ]
Hepatitis A	[ ]	Hepatitis B	[ ]
MMR (measles, mumps, rubella)	[ ]	Smallpox	[ ]
Polio	[ ]	Tetanus booster	[ ]
Flu	[ ]	Other	[ ]

Please indicate if any caused adverse reactions:

____
____

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Do you get regular screening tests done by another doctor? (Pap, blood tests etc.)
Yes [ ] No [ ]

Family History: Please list ages and if deceased, what they died from and at what age.

Mother's side
Mother ___________________________
Grandfather ______________________
Grandmother ______________________
Your sisters _______________________

Father's side
Father______________________
Grandfather _________________
Grandmother ________________
Your brothers ________________

Please indicate if a close relative has had any of the following:

Condition	**Who?**	**Condition**	**Who?**
Allergies		Hay fever	
Anemia		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Bleeding		Seizure/epilepsy	
Cancer		Sickle cell anemia	
Diabetes		Stroke	
Depression		Thyroid (hyper/hypo	
Drug/alcohol abuse		Tuberculosis	
Eczema		Venereal disease (std)	
Glaucoma		Other	
Gout			

Social History:
Occupation: ____
Do you enjoy your work? Or is it a job that you feel you must do in order to make a living?
____
____

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How would you describe your relationship with your co-workers?
____
____

Are you currently [ ] married [ ] divorced Number of children ___________
How would you describe your family relationships?
____
____
____

Have you traveled outside of Canada in the past year? ______________________

Do you exercise regularly? [ ] yes [ ] no What do you do for exercise, how much, how often?
____
____
____

What are your hobbies? ____
____
____

How often do you drink wine __________beer__________ other alcohol_______
Do you use tobacco or have you in the past? [ ] yes [ ] no Years since quitting_____
Are you exposed to significant tobacco smoke (work, home etc.)? ____________
____

Do you now or have you in the past used marijuana or other recreational drugs?
[ ] yes [ ] no
If yes, what type, how often and how long? ____________________________
Have you ever been exposed to toxic chemicals, solvents or other possible toxins?
____

Do you make time for rest, relaxation or meditation during the day and/or before bed? How do you relax?
____
____

How would you describe the emotional climate of your home? ________________
____
____
____

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

Sleep:

Do you have trouble falling asleep?	[ ]	yes	[ ]	no
Do you have trouble staying asleep?	[ ]	yes	[ ]	no

Home environment:

Are your home and work environments well-ventilated?	[ ] yes	[ ] no
Are your home and work environments excessively	[ ] moist	[ ] dry

Diet:

Do you have any food intolerances or allergies? Please list.
____
____
____

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

How many meals do you generally eat each day? _____________________________
Where do you usually buy your food?____

Describe a typical day's diet:

Breakfast ____
Snack ____
Lunch ____
Snack ____
Dinner ____
Snack ____
Beverages (and total quantity)____

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Do you regularly consume any of the following (include approximate amount)?
Coffee [ ] ____
Caffeinated teas [ ] ____
Processed foods [ ] ____
Refined foods [ ] ____
Other food that you suspect may be harmful to your health __________________
____

List any foods that you crave regardless of their nutritional value (includes chocolate, sweets, sour, salty, bread, rich/fatty food):
____
____
____
Are you thirsty? [ ] yes [ ] no Amount of water you drink each day ______________
Are you satisfied with your diet the way it is now? Why or why not? ____________
____
____

Symptoms: Please mark 1= mild, 2=moderate, 3= severe next to the following symptoms that apply to you now or in the past.

Now	Past	Skin	Now	Past	Skin
		Dry, rough scaly, itchy skin			Pimples
		Rashes, warts			Loss of hair
		Moles, cysts			Hives
		Any of above change size/color			Scars
		Light/dark patches of skin			Color changes, ridges, pits, white spots on nails?

Now	Past	Lymphatic,Immune system	Now	Past	Endocrine
		Painful lymph nodes			Unexplained weight loss/gain
		Difficulty stopping bleeding			Prefers hot weather
		Bleeding from unusual places			Prefers cold weather
		Bruising easily			Can't stand cold
		Wounds heal slowly			Can't stand heat
		Anemia			Cold hands and feet
		Swollen glands			Fatigue- long term

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		Fluid retention			Weakness
		Date of last blood tests			Increased thirst
					Increased hunger

Now	Past	Head	Now	Past	Ears
		Dizziness			Discharge from ears
		Severe headaches			Hearing problems
		Seizures, Convulsions			Sensitivity to noise
		Double vision			Pain in ears
		Fainting spells			Ringing in ears

Now	Past	Eyes	Now	Past	Nose
		Poor eyesight (near or far)			Nose bleeds
		Light hurts eyes			Sinus congestion
		Date of last glaucoma check			Nasal scabs/crusts
					Loss of smell

Now	Past	Mouth	Now	Past	Throat
		Sore mouth or throat			Persistant hoarseness
		Speech difficulties			Difficulty swallowing
		Bleeding gums			Recurrent strep throat
		Loss ofteeth			Loss of voice
		Cold sores, blisters			Chronic sore throat or pain
		# ofmercury amalgams			

Now	Past	Respiratory	Now	Past	Cardiovascular
		Unexplained fever			Chest pain when walking
		Chest pain when breathing			Chest pain when sitting/lying
		Wheezing			Ankle or abdominal swelling
		Difficulty breathing at night			Heart palpitations
		Chest congestion			Leg vein problems
		Dry sweats			Leg pain when walking
		Night sweats			Numbness/tingling in arm/leg
		Shortness of breath			Heart murmur
		Daily cough			

Have you ever been exposed to tuberculosis? ____________________________________
Have you ever had rheumatic fever or syphilis? ____________________________________
How far can you comfortably walk? ____
Do you get out of breath when climbing stairs? ___________________________________

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Now	**Past**	**Male Reproductive**	**Now**	**Past**	**Male Reproductive**
		Prostate problems			Painful erection
		Swelling/lumps/pain in testicles			Difficulty with erection
		Discharge from penis			Premature ejaculation
		infertility			Difficulty with ejaculation

Date of last prostate exam? ____
Are you currently sexually active? ____
What type of contraception do you use? _______________________________________

Now	**Past**	**Gastrointestinal**	**Now**	**Past**	**Gastrointestinal**
		Constipation			Distress from fat/greasy food
		Diarrhea			Bad breath
		Alternating const/diarrhea			Body odor
		Change in bowel movements			Indigestion immed after meal
		Strain at stool			Bloating 2-3hr after meal
		Hemorrhoids			Pain 5-6hr after eating
		Black stool			Above symptoms worse stress
		Blood in stool			Heavy, full after eating
		Stool- yellow, grey, green			Nervous, shaky better sweets
		Stool- foul odor			Cravings sweets or alcohol
		Stool- undigested food			Irritable if miss meal
		# of bowel movements			Appetite change inc/decrease
		Vomiting blood			Loss of appetite
		Frequent or severe nausea			Insatiable appetite
		Heartburn			Weight change- inc/decrease
		Trouble swallowing			Diet but fail to lose weight
		Excessive belching			Eat but fail to gain weight
		Excessive lower bowel gas			Overweight
		Difficulty belching			Underweight
		Stomach cramps, colic			Compulsive eating
		Abdominal bloat/ distension			Addictive eating
		Anorexia			Yellowjaundice
		Bulimia			Bad taste in mouth
		Stomach/abdominal pain			Intestinal parasites suspected

Date of last sigmoidoscopy: ____

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Now	Past	Female Reproductive	Now	Past	Female Reproductive
		Lumps in breast			
		Nipple discharge			Painful sex
		Breast pain			Lack of sexual desire
		Pelvic pain			Difficulty feeling sex. aroused
		Discharge from vagina			Never/seldom have orgasms
		Vaginal itching/burning			Menstruation excessive
		Genital eruptions			Menstruation absent
					Bleed/spot between periods

Do you perform regular breast self examinations? ________________________________
Date of last mammogram: ____
Are you sexually active? ____
Type of contraception used? ____
Have you ever used birth control pills? _______________________________________
Did you experience any side effects? ____
Age of first menstruation ________ Did you have a normal puberty? ________________
Is your cycle regular? [ ] yes [ ] no Periods occur every ____days and usually last ____ days
Date of last period:____
Date of last pap smear: _____________ Was it normal? [ ] yes [ ] no
Have you ever had any issues with fertility? ____________________________________
____
# of pregnancies: ____ # of births: _____ # of miscarriages: _____ # of abortions: ____
Have you ever had any pregnancy complications? _________________________________
____

Now	Past	Pituitary	Now	Past	Pituitary
		Failing memory			Low blood pressure
		Increased sexual desire			Decreased sexual desire
		Splitting headaches			Menstrual disorders
		High/low sugar tolerance			Intestinal bloating
		Abnormal thirst			Chunky hips or waist
		Ulcers, colitis			

Now	Past	Thyroid	Now	Past	Thyroid
		Overweight			Decreased appetite
		Difficulty losing weight			Nervousness
		Constipation			Heart palpitations
		Tired upon rising			Irritable/restless
		Easily fatigued			Increased appetite
		Dry or scaly skin			Underweight
		Chilly/sensitive to cold			Flush/get hot easily

		Mental slowness			Insomnia

Now	Past	Adrenals	Now	Past	Adrenals
		Easily stressed			Nails weak, ridged
		Easily/chronically fatigued			Tendency to get hives
		Dizziness			Rheumatism/arthritis
		Headaches			Poor circulation
		Hot flashes			Increased blood pressure
		Bronzing of the skin			Weak after getting a cold
		Craves salt			Facial hair for women

Now	Past	Sympathetic nervous system	Now	Past	Sympathetic nervous system
		Upset from acid foods			Cold extremities
		Dry eyes, nose, mouth			Light sensitive
		Nervousness			Decreased urine output
		Wounds that heal slowly			Heart pounds when lying
		Gag easily			Reduced appetite
		Very quick mentally			Frequent cold sweats

Now	Past	Parasympathetic nervous syst	Now	Past	Parasympathetic nervous syst
		Joint stiffness on rising			Frequent vomiting
		Muscle/leg/toe cramps			Alt. constipation/diarrhea
		Butterflies in stomach			Pulse slow/regular
		Digestion rapid			Breathing irregular
		Indigestion after eating			Poor circulation
		Perspiration scant/absent			Eyelids swollen/puffy
		Perspire easily/profusely			

Now	Past	Central/peripheral nerv. syst	Now	Past	Central/peripheral nerv. syst
		Loss of balance/fainting			Paralysis
		Dizziness regularly			Numbness/tingling
		Convulsions (seizures)			Temporary loss of sensation
		Blurred/double vision			Lack of strength
		Tremor (shaking, trembling)			Continual headache

Now	Past	Musculoskeletal system	Now	Past	Musculoskeletal system
		One arm or leg shorter			Muscle cramps
		Joint pain/stiffness swelling			Unusual redness of palms
		Backaches			Coughing, sneezing or straining At stools intensifies back pain
		Burning on soles of feet			

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Now	Past	Mental status	Now	Past	Mental status
		Anxiety			Memory difficulties
		Restlessness			Mental confusion
		Excessive worry			Concentration difficulties
		Depression			Make a lot of mistakes
		Despair/discontent			Shy and timid
		Suicidal thoughts			Self-critical
		Suicidal attempts			Overly critical of others
		Loneliness			Lack of self-confidence
		Mood swings			Jealous and suspicious
		Prefer to be with people			Sensitive to noises
		Like to be alone			Organized and very neat
		Afraid when alone			Affectionate
		Confident and secure			Powerful and assertive

What makes you angry? ____
____
Do you get angry often/easily? ____
Do you have difficulty expressing anger? __________________________________
How do you express anger? ____
____

Have you experienced major incidents of grief/loss in your life? ______________
____
____

Do you have any fears? ____
____
____

Is your present sex life satisfactory? Have you experienced any physical or sexual abuse in your past? ____
____
____

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NATUROPATHIC CONSENT TO TREATMENT FORM

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.

A number of different approaches are used. Diet and Nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy and lifestyle counseling are the mainstays of naturopathic medicine.

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

Botanical Medicine is a plant based medicine using herbal teas, tinctures, capsules and other forms of herbal preparations to assist in the recovery from injury and disease. These compounds are also used to boost the body's immune system and prevent disease.

Homeopathy is a form of medicine based on the Law of Similars- that is the use of tiny extremely diluted doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal or mineral origins are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool and affects healing on a physical and emotional level.

Asian Medicine includes acupuncture, as well as the use of botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Botanical formulas may be given in the form of pills, tinctures or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

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

As naturopathic medicine is a holistic approach to health, lifestyle is considered relevant to most health problems. I will try to help you to identify risk factors and make recommendations to help you optimize your physical, mental and emotional environment.

I will take a thorough case history, do a screening physical examination including breast examination if indicated.

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Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform me immediately of any disease process that you are suffering from or if you are taking any medications. If you are pregnant, suspect you are pregnant or you are breast-feeding please inform me as well.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Temporary aggravation of pre-existing symptoms
- Allergic reactions to herbs or supplements
- Bruising from acupuncture or intramuscular injection

A record will be kept of health services provided to you. This record will be kept confidential and will not be released to others unless you give your consent or the law requires it. You may look at your medical record at any time and can request a copy of it by paying the appropriate fee for copying charges.

I ______________________________________ understand that my naturopathic doctor will answer any questions to the best of her ability. I understand that results are not guaranteed. I do not expect my naturopath to be able to anticipate and explain all risks and complications. I will rely on my naturopathic doctor to exercise judgement during the course of the procedure which they feel at that time is in my best interests based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list any exceptions below)

____

I understand this consent form to cover the entire course of my 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 of Patient or Guardian: _______________________________________

Date: __________________________