

**WHOLSOME WELLNESS
ADULT INTAKE FORM**

Dr. Julia Gill, Bsc. (Hon), ND
Naturopathic Doctor

PATIENT INFORMATION

Name: _____ Today's Date: ___/___/___ (M/D/Y)
Age: _____ Gender: Male Female Date of Birth: ___/___/___ (M/D/Y)
Address: _____
City: _____ Province: _____ Postal Code: _____
Cell Phone: _____ Home Phone: _____ Other/Fax: _____
Occupation: _____ Email: _____
How did you hear about our Clinic? _____

Emergency Contact

Name: _____ Relationship: _____ Phone Number: _____
Do you have extended health care insurance for Naturopathic Medicine? Y / N
Are you: Married Separated Divorced Widowed Single Partnership
Live with: Spouse Partner Alone Friends Children Parents

PLEASE COMPLETE THE FOLLOWING QUESTIONS

Please list your current health concerns (In the order of importance):

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

Please list all accidents, surgeries or hospitalizations and the year they occurred:

1. _____
2. _____
3. _____

Family Doctor's Name: _____ Phone Number: _____

Last physical exam: _____ Last blood test: _____

Please list all medications and supplements that you are currently taking:

	Medication/Supplement	Dosage	Reason for use
1.			
2.			
3.			
4.			
5.			

Please list all allergies: _____
 Stress Level (Daily Average 1-10) _____ Energy Level (Daily Average 1-10) _____
 Stressors _____

Alcohol: amount per day or week _____
 Tobacco: form and amount per day _____
 Caffeine: form and amount per day _____
 Recreational Drugs: what and how often _____

FAMILY HISTORY

Please indicate if a close relative (Parent, Child, Sibling) has had any of the following:

	Who?		Who?
Allergies		High blood pressure	
Alcoholism		Kidney disease	
Asthma		Mental illness	
Arthritis		Mononucleosis	
Cancer (type?)		Multiple Sclerosis	
Chronic Bronchitis		Osteoporosis	
Diabetes		Rheumatic Fever	
Depression		Skin disease	
Drug abuse		Strep throat	
Emphysema		Stroke	
Hepatitis		Tuberculosis	
Heart disease		Other	

I don't know my family medical history

TYPICAL DIET

Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____
 Beverages (and total quantity): _____
 Cravings: _____
 Aversions: _____
 Do you have any dietary restrictions (religious, vegetarian, etc)? _____

Do you experience any of the following? (Please circle)

- | | | |
|------------------|-----------------------|------------------------|
| Unusual fatigue | Decreased motivation | Decreased libido |
| Excessive stress | Decreased self-esteem | Decreased satisfaction |

Do you consider yourself a happy person? Y / N

ENVIRONMENT

How many hours do you sleep per night? _____ Do you sleep well? Y / N

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

Number of bowel movements in a day: _____ Gas Y / N Bloating Y / N

Are you exposed to significant tobacco smoke at home or at work? 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 indicate: _____

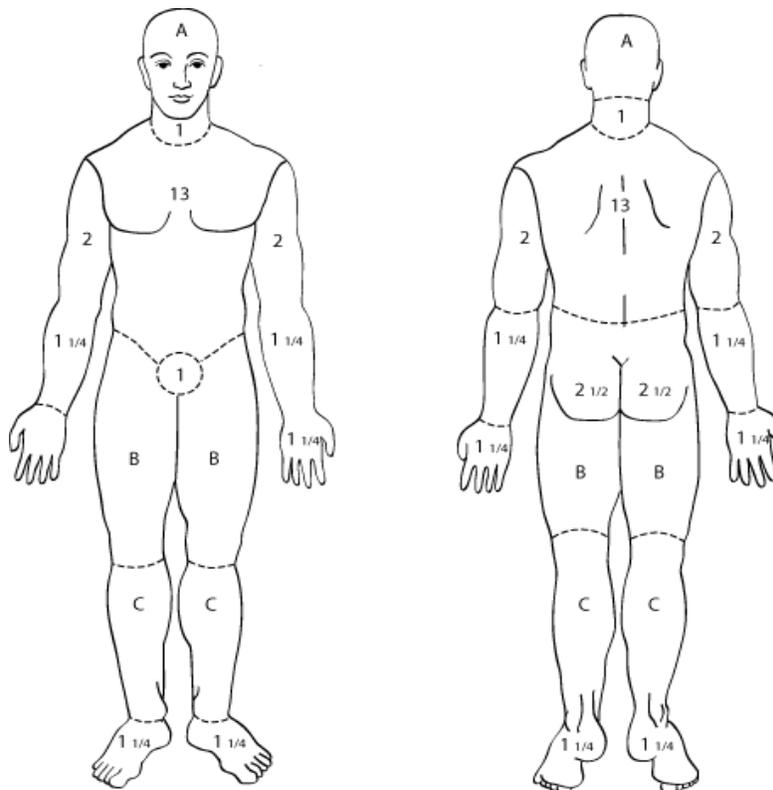
What are your interests and hobbies? _____

Describe the emotional climate at home and at work: _____

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

PAIN LOCATION

Please circle, shade or otherwise indicate painful location or any affected area. Use descriptive words where possible.



Thank you for taking the time to complete this form!

**WHOLSOME WELLNESS
CONSENT TO TREATMENT**

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PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Your ND will take a thorough case history, perform a physical examination that may include a breast exam and take blood and urine samples. Therefore, it is very important that you inform your ND immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise your ND immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

(Initials)_____ I understand that although all therapies are natural and non-invasive, there may be potential health risks and complications including but not limited to: aggravation of current symptoms; Allergic reactions to the supplements or herbs; Bruising from Biopuncture, Vitamin Injections or Acupuncture; Fainting from needling or at a sight of blood; Accidental burning of the skin from the use of Moxa; and Muscle strains and sprains, disc injuries from spinal manipulation.

(Initials)_____ I understand that charges are to be paid in full at the time of the visit. Payment for all dispensary items is due at the time of the visit.

(Initials)_____ I understand that a \$50 fee will be charged for any missed appointments or late cancellation (less than 24 hours).

As the patient, I am responsible for the total charges incurred for each visit including costs of supplements. If I have coverage for naturopathic medicine, it is my responsibility to bill my insurance company. I understand that most insurance companies do not cover the cost of supplements. I have read and understood 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 of Patient or Guardian: _____ Date: _____

“The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease”

-Thomas Edison -