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ADULT INTAKE FORM

First Name _____ Date _____
Last Name _____ Middle Initial _____
Date of birth yyyy/mm/dd _____ Sex: M F
Address _____
City _____ Province _____ Postal Code _____
Care Card # _____ Email _____
Home Ph _____ Work Ph _____ Cell Ph _____
Emergency Contact _____ Phone _____
How did you hear
about Dr. Wrenshall? □ Local newspaper □ Internet □ Referral and by who? _____

Other health care providers: Please list name, address, phone number

1.	2.	3.

Please list your health concerns, in order of importance to you:

1.
2.
3.
4.
5.

If you are female, are you currently pregnant? Yes___ No___

Medical History

How would you describe your state of health? Excellent Good Fair Poor (please circle one)

Please list any past and current medical conditions, injuries, illnesses, and hospitalizations, including approximate dates:

Past prescription medications:

Current prescription medications (including supplements):

Do you suffer from allergies (environmental, food, medical)? Please list

How many times have you been treated with antibiotics? Please Circle

Never ***Less than 5X*** ***5-10X*** ***10-25X*** ***Greater than 25X***

Do you currently use any of the following? (please circle)

Aspirin Antacids Laxatives Diet pills Birth Control Pills/implants/injection Cortisone Sedatives

Alcohol---how much/day or week _____
Tobacco---how much/day or week _____
Caffeine (coffee, tea, cola)—how much/day or week _____
Recreational drugs---what and how often _____

Please indicate which immunizations you have had?

□ DPT (diphtheria, pertussis, tetanus) □ MMR (measles, mumps, rubella)
□ Haemophilus influenza B □ "Flu"
□ Polio □Hepatitis A
□ Hepatitis B □ Tetanus booster and date_____
Other_____
Please list any adverse reactions_____

Do you get regular screening tests done by another doctor? (Pap test, blood tests, prostate, etc) Y___ N____

DIET

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

Please describe a typical day's diet:

Breakfast_____
_____
Lunch_____
_____
Dinner_____
_____
Snacks_____
_____
Beverages (and quantity)_____
_____

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

_____

_____

FAMILY HISTORY

Please indicate if anyone in your family has had any of the following:

Allergies		Cancer		Autoimmune Diseases	
Asthma		Heart Disease		Drug abuse/alcoholism	
High blood pressure		Diabetes		Neurological disorders	
Stroke		Kidney Disease		Other	
Depression		Other mental illness			

□ I don't know my family medical history

ENVIRONMENT

Occupation:

_____

_____

Hobbies:

_____

_____

Do you exercise regularly? What form and how often?

_____

_____

Are you regularly exposed to toxins or other hazards (work, home, etc)? Please describe.

_____

_____

How would you describe the emotional environment of your home?

_____

_____

How stressful is your life (including work and home)? How do you handle these stressors?

_____

_____

Is there anything that you feel is important that hasn't been covered in this form?

_____

_____

REVIEW OF SYSTEMS

Please answer the following:
N=Never
P=Condition in the past
Y=Present condition

General:
Weight: _____
Weight 1 year ago :_____
Max Weight / When:_____
Weight fluctuations: Y/N
Height: _____

Skin,Hair,Nails:

Acne, Boils	N P Y
Eczema, hives	N P Y
Itching, rash	N P Y
Night sweats	N P Y
Psoriasis	N P Y
Nail changes	N P Y
Dryness/moistness	N P Y
Change in moles	N P Y
Skin Cancer	N P Y
Temperature change	N P Y
Loss of hair	N P Y
Changes to hair	N P Y

Head:

Headache	N P Y
Migraine	N P Y
Dizziness	N P Y
Head injury	N P Y

Other_____

Eyes:

Impaired vision	N P Y
Glasses or contacts	N P Y
Eye pain	N P Y
Tearing or dryness	N P Y
Double vision	N P Y
Glaucoma	N P Y
Cataracts	N P Y
Blurring	N P Y
Bothered by sun	N P Y
Itching	N P Y

Other_____

Ears:

Impaired hearing	N P Y
Ringing	N P Y
Earache	N P Y
Dizziness	N P Y
Excess wax	N P Y
Discharge	N P Y
Infections	N P Y

Nose and Sinus:

Frequent colds/flu	N P Y
Nose bleeds	N P Y
Stuffiness	N P Y
Hayfever	N P Y
Post nasal drip	N P Y
Runny nose	N P Y
Sinus pain	N P Y
Allergy	N P Y
Loss of smell	N P Y
Obstruction	N P Y

Mouth and Throat:

Frequent sore throat	N P Y
Gum problems	N P Y
Teeth pain	N P Y
Hoarseness	N P Y
Sore tongue	N P Y
Dental cavities	N P Y
Sores	N P Y
Loss of taste	N P Y

Neck:

Goiter	N P Y
Lumps	N P Y
Pain/stiffness	N P Y
Swollen glands	N P Y

Neurologic:

Fainting	N P Y
Shaking	N P Y
Vertigo	N P Y
Seizures	N P Y
Paralysis	N P Y
Loss of memory	N P Y
Loss of balance	N P Y
Speech problems	N P Y

Peripheral Vascular:

Deep leg pain	N P Y
Cold hands/feet	N P Y
Varicose veins	N P Y
Thrombophlebitis	N P Y

Endocrine:

Heat/cold intolerance	N P Y
Thyroid trouble	N P Y
Excessive thirst	N P Y
Excessive hunger	N P Y
Excessive urination	N P Y
Excessive sweating	N P Y
Diabetes	N P Y
Hypoglycemia	N P Y
Hormone Therapy	N P Y
Depression	N P Y
Sleep problems	N P Y

Emotional:

Depression	N P Y
Mood swings	N P Y
Anxiety	N P Y
Tension	N P Y
Phobias	N P Y
Alcohol/drug abuse	N P Y
Insomnia	N P Y
Worry	N P Y

Gastrointestinal:

Trouble Swallowing	N P Y
Heartburn	N P Y
Bloating	N P Y
Nausea/vomiting	N P Y
Ulcer	N P Y
Hernia	N P Y
Change in thirst	N P Y
Change in appetite	N P Y
Liver disease	N P Y
Gallbladder disease	N P Y
Gas/belching	N P Y
Hemorrhoids	N P Y
Rectal bleeding	N P Y
Jaundice	N P Y
Diarrhea	N P Y
Constipation	N P Y
Abdominal pain	N P Y
Blood in stool	N P Y
Food allergy	N P Y

Bowel movements/day: _____

Respiratory:

Difficulty breathing	N P Y
Cough	N P Y
Sputum	N P Y
Blood	N P Y
Wheezing	N P Y
Pleurisy	N P Y
Asthma	N P Y
Bronchitis	N P Y
Emphysema	N P Y
Pain on breathing	N P Y
Tuberculosis	N P Y

Urinary:

Pain/burning	N P Y
Difficulty	N P Y
Blood	N P Y
Inability to hold	N P Y
Infections	N P Y
Kidney stones	N P Y
Bladder infections	N P Y

Blood/Lymphatic:

Anemia	N P Y
Easy bruising, bleeding	N P Y
Lymph node swelling	N P Y
Blood transfusions	N P Y

Cardiovascular:

Angina/chest pain	N P Y
High blood pressure	N P Y
Heart disease	N P Y
Murmurs/palpitations	N P Y
Rheumatic Fever	N P Y
Ankle swelling	N P Y

Other:_____

Reproductive:

Sexual difficulties	N P Y
Venereal disease	N P Y
Sexually active	N P Y

Female Reproductive:

Pregnant	N P Y
Cycles regular	N P Y
Length of cycle _____days	
Unusual bleeding	N P Y
Discharge	N P Y
Vaginal itching	N P Y
Pain during menses	N P Y
Excessive flow	N P Y
Menopausal	N P Y
Hysterectomy	N P Y
Fibroids/cysts	N P Y
Endometriosis	N P Y
STD's	N P Y
Breast lumps/cysts	N P Y
Infertility	N P Y
Breast discharge	N P Y
Do you self exam?	N P Y
Last PAP smear_____	
Cancer	N P Y
Age of first menses_____	
PMS	N P Y
Birth control and type _____	

Male Reproductive:

Hernia	N P Y
Testicular masses	N P Y
Pain	N P Y
Herpes	N P Y
Discharge/sores	N P Y
STD	N P Y
Sexually difficulties	N P Y

TONGUE:

Musculoskeletal:

Joint swelling	N P Y
Joint pain	N P Y
Muscle weakness	N P Y
Backache	N P Y
Tingling/numbness	N P Y
Spasms	N P Y
Arthritis	N P Y
Broken bones	N P Y
Muscle pain	N P Y

Hobbies/Habits:

Do you eat 3 meals a day?	Y/N
Do you wake rested?	Y/N
Do you sleep well?	Y/N
Do you wake rested?	Y/N
Do you commute?	Y/N
Do you enjoy your work?	Y/N
Do you watch T.V.?	Y/N
↘ Hours/day_____	
Do you read?	Y/N
Do you take vacations?	Y/N
Do you drink alcohol?	Y/N
Do you smoke?	Y/N
↘ Cigarettes/day_____	
Use recreational drugs?	Y/N
↘ How often?_____	

_____

_____

Other:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Informed Consent

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person and use gentle, non-invasive techniques in order to stimulate the body's innate healing capacity. A number of different disciplines maybe used throughout the course of treatment. They are as follows:

Clinical Nutrition: Nutritional supplements and individualized diets maybe recommended to address deficiencies, treat disease processes, and promote health. Benefits include increased energy, improved gastrointestinal function, enhanced immunity, and fewer allergies.
IV Nutritional Therapy: Administration of high dose nutrients (minerals, vitamins, nutraceuticals, amino acids and herbal medicines) through the venous system in order to maximize absorption and assimilation.
Botanical Medicine: This plant-based medicine involves the use of tinctures, teas, capsules, and creams to assist the body in recovery from disease or injury.
Traditional Chinese Medicine: Acupuncture, Chinese herbs, and diet are combined to re-establish homeostasis in the body.
Homeopathy: Minute amounts of plant, animal, or mineral origins are used to stimulate the body's inherent healing capacity. It is an energetic type of medicine that affects the individual on a physical and emotional level.
Hydrotherapy: The use of hot and cold-water applications to improve blood circulation, stimulate the immune system, and move nutrients to areas that need to be healed.
Botanical Medicine: Use of medicinal herbs to facilitate healing and prevent disease.
Counseling: A discussion of an individual's background, risk factors, and lifestyle in order to assist the patient in strengthening their physical, mental and emotional environment.
Meso Therapy: Subcutaneous injections to individualized, local areas, which assist is tissue healing and recovery.
Prescription Medication: Prescription of pharmaceutical medication as deemed necessary by the physician. This includes Bio-Identical Hormone Therapy as well.

During your initial visit, your Naturopathic Doctor will take a thorough case history and perform a physical exam. Blood work maybe performed outside of the clinic if necessary. Even the gentlest therapies may cause complications in certain conditions. Therefore, it is important to inform your doctor if you are suffering from any heart complications, kidney problems, or liver disease. Please let your doctor know if you are pregnant or lactating since some treatments are contraindicated in these conditions. Let us know of any prescription, over-the-counter, or herbal medications you are taking.

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

- ❑ Aggravation of pre-existing symptoms
- ❑ Allergic reaction to supplements or herbs
- ❑ Pain, bruising or injury from acupuncture needles
- ❑ Muscle strains/sprains from spinal manipulation

→ I understand that a record will be kept of my visits. This record will be kept confidential and will not be released without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
→ I understand that the Naturopathic Doctor will answer any questions to the best of her ability. I understand that the results are not guaranteed.

→I understand that charges are to be paid at the time of the scheduled visit. Payment for all dispensary items are also due at the time of the visit. A 24 hour cancellation policy means that any missed appointments will be charged 75% of the visit fee.

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 treatment at any time.

Patient Name (please print): _____

Signature of Patient or Guardian: _____ Date: _____