HAWTHORNE NATUROPATHIC CENTRE

NEW PATIENT INTAKE FORM

PATIENT INFORMATION DATE: _____

First name _____ Last name: _____ Nickname _____
Date of birth (mm/dd/yy) _____ Age _____ Gender: _____

MSP Care Card Number _____ Do you have extended coverage? **Y / N**

Address: _____

City _____ Prov _____ Postal Code _____

Phone (home)_____(cell) _____ (work) _____

Okay to leave messages re: appointments**? Y / N Email** _____

Occupation:_____ Hours/week _____ Employer _____

Name of **current medical doctor (MD)** _____ Phone _____

Emergency Contact _____ Relation? _____ Phone _____

Where did you hear about us? _____

HEALTH INFORMATION

Main concern:

_____

_____

_____

Please list any other health concerns (physical, emotional or mental) in order of importance

1) _____

2) _____

3) _____

Please list **other current health professionals** you are seeing, and what they are helping you with

_____ Phone _____

_____ Phone _____

_____ Phone _____

ALLERGIES/SENSITIVITIES Please list any allergies or sensitivities in the following categories:

Medications _____
Foods _____
Environmental/chemical_____

HAWTHORNE NATUROPATHIC CENTRE

Patient Name: _____

MEDICATIONS

Please list all current medications (prescription and over the counter):

Medication(s)	Dose	Used for how long and for what?
1)		
2)		
3)		
4)		
5)		
6)		
7)		

How many times have you taken antibiotics (approximately?) _____
Have you been on antibiotics for more than 1 month over the last 10 years? **Y / N**

SUPPLEMENTS

Please list all current supplements/herbals/homeopathics, ect

Supplement(s)	Supplement(s)
1)	7)
2)	8)
3)	9)
4)	10)
5)	11)
6)	12)

FAMILY HISTORY Please check if you have a family history of any of the following:

☐ Alzheimers
☐ Arthritis
☐ Asthma/allergies
☐ Bleeding disorders
☐ Cancer:_____
☐ Celiac disease
☐ Depression
☐ Diabetes: Type 1 / Type 2
☐ Drug/alcohol abuse
☐ Epilepsy/seizures
☐ High blood pressure
☐ High cholesterol
☐ IBD (Crohns or colitis)
☐ Infertility
☐ Kidney disease
☐ Mental illness
☐ Stroke
☐ Thyroid disease
☐ I don't know my family history
☐ Other: _____
_____

IMMUNIZATIONS
Did you receive general childhood immunizations? Y / N
Describe any adverse reaction(s): _____
Check any other vaccinations taken:

□ Hepatitis A
□ Hepatitis B
□ Flu shot
□ Gardasil
□ Other:_____

Please list (with approximate dates) any serious illnesses, injuries, surgeries or hospitalizations
_____
_____
_____
_____

HAWTHORNE NATUROPATHIC CENTRE

Patient Name: _____

SCREENING/IMAGING TESTS (ie. xrays, CAT scans, MRI's, EKG's, ect)

Test/reason _____Year _____ Result (circle): Abnormal / Normal
Test/reason _____Year _____ Result (circle): Abnormal / Normal
Test/reason_____ Year _____ Result (circle): Abnormal / Normal

CHILDHOOD MEDICAL HISTORY Please check if you have had any of the following childhood illnesses:

☐ Asthma	☐ Diptheria	☐ Polio
☐ Measles	☐ Scarlet fever	☐ Whooping cough
☐ Rheumatic fever	☐ Mono (how long? _____)	☐ Frequent ear infections/colds
☐ Chicken pox	☐ Tuberculosis	☐ Rubella (German measles)
☐ Mumps	☐ Eczema	☐ Other: _____

Were you breastfed? Y / N / Unknown
Were you a C-section birth or vaginal birth?

LIFESTYLE

Relationship status? _____ Number of children + ages _____

Sleep: Time you fall asleep: _____ Time you wake up: _____ Wake well rested? **Y / N**
Do you have troubles falling asleep or staying asleep? _____

Diet: Any current dietary restrictions? _____

Energy: Do you have enough energy to get through the day? Y / N

When is it highest? _____ Lowest? _____ What makes it worse? _____

Environmental exposures: Please check all that apply to you

□ Microwave food in plastic containers	□ Mold in home/at work	□ Travel often (car/plane)
□ Eat non-organic foods/meat	□ Smoker. Present / Past	□ Carpets in home
□ Use of perfume / cosmetics / hair dye	□ Amalgam fillings	□ Use plastic water bottles/ canned foods
□ Clean with bleach, household chemicals	□ Regular use of cellphone/computer	□ Other: _____

Stress: What is your current stress level (circle)? LOW AVERAGE HIGH UNBEARABLE

What are your major stressors? _____

Please list the most significant stressful events that you feel have had an impact on your life (past or present). Include year events occurred, if possible:

_____

_____

_____

_____

_____

_____

_____

HAWTHORNE NATUROPATHIC CENTRE

Patient Name: _____

FEMALE

Are you pregnant? **Y / N / Maybe** If yes, when is your due date? _____

Do you get regular PAP smears? **Y / N** Date of last annual exam/PAP _____ Normal? **Y / N**

Age of first menses _____ Age of last menses (if menopausal) _____ Have you had a hysterectomy? **Y / N**

Typical length of menstrual cycle (eg 28, 30) _____ Average length of menses/flow (eg 5,7) _____

Do you experience vaginal infections? NEVER / RARELY / FREQUENTLY

Are you sexually active? **Y / N / PAST** Current contraception _____

Please check all that apply, now or in the past. Key: P=Past N=Now B=Both

P N B	P N B	P N B
☐ ☐ ☐ Irregular cycles	☐ ☐ ☐ Vaginal discharge	☐ ☐ ☐ Sexual difficulties
☐ ☐ ☐ Premenstrual syndrome (PMS)	☐ ☐ ☐ Heavy or excessive flow	☐ ☐ ☐ Painful intercourse
☐ ☐ ☐ Menstrual cramps	☐ ☐ ☐ Clotting	☐ ☐ ☐ Sexually transmitted disease
☐ ☐ ☐ Breast lumps	☐ ☐ ☐ Uterine fibroids	☐ ☐ ☐ Difficulty conceiving
☐ ☐ ☐ Breast pain/tenderness	☐ ☐ ☐ Endometriosis	☐ ☐ ☐ Menopause symptoms
☐ ☐ ☐ Nipple discharge	☐ ☐ ☐ Abnormal Pap	
☐ ☐ ☐ Ovarian cysts	☐ ☐ ☐ Cervical dysplasia	

MALE

Do you have regular annual health screening tests? (blood work, prostate) **Y / N**

Date of last prostate exam (month/year)_____ Any abnormalities? _____

Are you sexually active? **YES / NO / PAST** Current contraception _____

Please check all that apply, now or in the past. Key: P=Past N=Now B=Both

P N B	P N B	P N B
☐ ☐ ☐ Difficulty with urination	☐ ☐ ☐ Hernia	☐ ☐ ☐ Erectile dysfunction
☐ ☐ ☐ Testicular pain	☐ ☐ ☐ Sexually transmitted disease	☐ ☐ ☐ Genital lesions
☐ ☐ ☐ Testicular lumps	☐ ☐ ☐ Discharge	

HAWTHORNE NATUROPATHIC CENTRE

Patient Name: _____

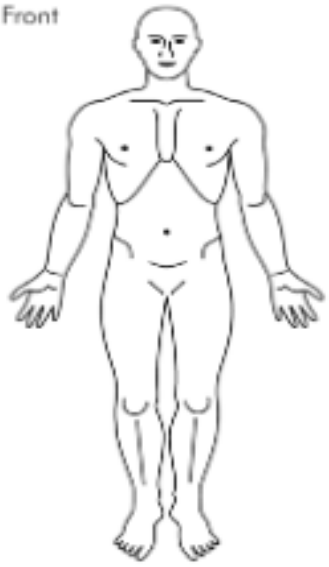
REVIEW OF SYMPTOMS: _____

Please check the appropriate box for any of the following symptoms **Key:** P=Past N=Now B=Both

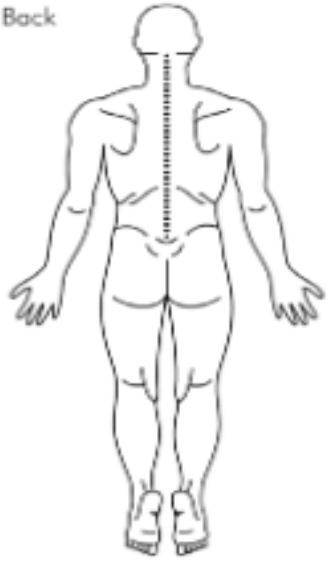
Please indicate on the body diagrams below the area of your complaint and the type of pain experienced

X Sharp ☐ Dull/achy
O Burning Δ Numbness/tingling

Front



Back



P N B

General
☐☐☐ Insomnia
☐☐☐ Fatigue
☐☐☐ Anemia
☐☐☐ Weight loss
☐☐☐ Weight gain

Head/Eyes/Nose/Throat
☐☐☐ Headache
☐☐☐ Dizziness
☐☐☐ Head trauma
☐☐☐ Fainting
☐☐☐ Migraine
☐☐☐ Cataracts
☐☐☐ Blurry vision
☐☐☐ Glaucoma
☐☐☐ Itching/redness
☐☐☐ Near-sided/Far-sided
☐☐☐ Bleeding gums
☐☐☐ Canker sores
☐☐☐ Cold sores
☐☐☐ Sore throat
☐☐☐ Jaw/TMJ problems
☐☐☐ Hoarseness
☐☐☐ Enlarged thyroid
☐☐☐ Hay-fever
☐☐☐ Loss of smell
☐☐☐ Postnasal drip
☐☐☐ Sinus issues
☐☐☐ Nosebleeds
☐☐☐ Frequent ear aches
☐☐☐ Dizziness
☐☐☐ Ringing in ears

Endocrine
☐☐☐ Diabetes
☐☐☐ Hypoglycemia
☐☐☐ Thyroid issues
☐☐☐ Cold intolerance
☐☐☐ Heat intolerance
☐☐☐ Excessive thirst
☐☐☐ Excessive hunger
☐☐☐ Excessive sweating
☐☐☐ Night sweats

P N B

Neurological
☐☐☐ Seizures/ epilepsy
☐☐☐ Numbness/tingling
☐☐☐ Muscle weakness
☐☐☐ Difficulty walking
☐☐☐ Paralysis
☐☐☐ Loss of memory

Emotional
☐☐☐ Depression
☐☐☐ Considered suicide
☐☐☐ Mood swings
☐☐☐ Anxiety/nervousness
☐☐☐ Tension
☐☐☐ Phobia

Bladder/Kidneys
☐☐☐ Difficulty urinating
☐☐☐ Pain with urination
☐☐☐ Blood in urine
☐☐☐ Incontinence
☐☐☐ Bed-wetting
☐☐☐ Frequent urination
☐☐☐ Frequent UTI's
☐☐☐ Kidney stones

Muscle and Bone
☐☐☐ Joint pain
☐☐☐ Swollen joints
☐☐☐ Stiffness
☐☐☐ Muscle ache/cramps
☐☐☐ Bone pain
☐☐☐ Fractures
☐☐☐ Dislocations
☐☐☐ Gout

Vascular
☐☐☐ Chest pain
☐☐☐ Murmurs
☐☐☐ Angina
☐☐☐ Palpitations
☐☐☐ Ankle swelling
☐☐☐ Varicose veins
☐☐☐ Low blood pressure
☐☐☐ High blood pressure

P N B

Skin
☐☐☐ Rash
☐☐☐ Itching/ dry skin
☐☐☐ Hives
☐☐☐ Change in moles
☐☐☐ Acne
☐☐☐ Eczema

Gastrointestinal
☐☐☐ Bloating/gas
☐☐☐ Heartburn
☐☐☐ Ulcers
☐☐☐ Liver disease
☐☐☐ Gallstones
☐☐☐ Vomiting/nausea
☐☐☐ Abdominal pain
☐☐☐ Diarrhea
☐☐☐ Constipation
☐☐☐ Blood in stool
☐☐☐ Hemorrhoids
☐☐☐ Hernias

Lungs
☐☐☐ Asthma
☐☐☐ Shortness of breath
☐☐☐ Persistent cough
☐☐☐ Emphysema
☐☐☐ Bronchitis

Conditions
☐☐☐ AIDS/HIV
☐☐☐ Eating disorders
☐☐☐ Heart disease
☐☐☐ Rheumatic fever
☐☐☐ Cancer/tumor
☐☐☐ Parkinson's
☐☐☐ Multiple sclerosis
☐☐☐ Osteoporosis
☐☐☐ Osteoarthritis
☐☐☐ High cholesterol
☐☐☐ Fibromyalgia
☐☐☐ Chronic Fatigue
☐☐☐ Hepatitis
☐☐☐ TIA
☐☐☐ Stroke

HAWTHORNE
NATUROPATHIC CENTRE

Patient Name: _____

Confidentiality Agreement and Informed Consent to Treatment

Naturopathic doctors (ND's) assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual and how they affect health and well being. Your doctor will take a thorough case history and may conduct physical exam when needed or requested, including a breast exam, a pelvic/PAP exam or prostate exam. We realize these tests may provoke discomfort in some people. Please feel free to discuss your concerns in advance so that we may do what we can to make all procedures as comfortable as possible. Lab tests, when deemed appropriate, may be ordered. The purpose of the testing and costs will be discussed in advance. Treatment may involve botanical medicine, acupuncture, nutrition, massage, craniosacral therapy, allergy testing and desensitization, lifestyle counseling, vitamin supplementation and intravenous therapies. If you have any known allergies or have had reactions in the past to any natural medicines, please advise the doctor. Procedures will be discussed briefly and questions answered. The doctors will do their best to assist you in reaching your health goals but cannot guarantee results.

The physicians at Hawthorne Naturopathic Centre are trained in the use of pharmacognosy (medicinal drugs obtained from plants or other natural sources) and pharmacology (prescription drugs). It is important that we are aware of all prescription drugs and supplements you are currently taking and any changes to your medication or supplementation program. If you are pregnant or become pregnant or are breast-feeding, please inform us.

Your identity will be protected at all times. A record will be kept of the health services that are provided to you. This record will be kept confidential and will not be released to others unless directed by yourself or unless the law requires it. Confidentiality will be superseded if we become aware of child abuse, neglect, threats to harm others or yourself. A copy of your record can be requested at any time with an appropriate fee charged for this service.

Fees are payable at the time of the appointment, including fees for services, prescriptions, and laboratory tests.

The clinic requires at least 24 hours notice for appointment cancellation. The full cost of the appointment may be charged if no notice is given. We do understand there are extenuating circumstances at times.

I certify that I have read and understand the above Confidentiality and Informed Consent for Treatment and that, unless withdrawn, will prevail over the entire course of treatment at the clinic.

Patient Name: (Please print)

_____

Name of guardian if patient is a child:

_____

Signature of patient or guardian:

_____

Date:

_____

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