LEDUC NATUROPATHIC CLINIC.

Dr.Veronika Botova, BSc., ND
Dr. Luis Flores, Homeopath

NEW PATIENT INTAKE FORM

Personal Information

Name _____ Date of First Visit _____

Address _____

City _____ Province _____ Postal Code _____

Telephone # (home)_____ (work)_____

E-mail Address _____ Relationship Status _____

Age _____ Date of Birth (M/D/Y)_____ Gender: female ____ male ____

Occupation _____Hours per week _____ Employer_____

Has any other family member already been a patient at the clinic? _____

Emergency contact _____

Relationship _____ Phone _____

Do you have extended health insurance? Y N Name of Provider: _____

How did you hear about our clinic: _____

Health Overview

Name of current general practitioner (MD) _____

GP's contact information _____

When was your last visit to your GP? _____

What was the reason? _____

Are you seeing a medical specialist? Y N

If yes, for what reason? _____

Name of medical specialist_____

Do you have any known contagious diseases at this time? Y N If yes, what?_____

What are your most important health problems? List as many as you can in order of importance:

1) _____
2) _____
3) _____
4) _____

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General

Height: _____Weight:_____ lbs.
Weight 1 year ago: _____lbs.
Maximum Weight: _____ When:_____
When during the day is your energy the best? _____worst? _____
On a scale of 1-10 (10 being the most) please rate your: Energy ____ Stress ____
What is your ethnic heritage? _____

Current Medications

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1)_____ 5) _____
2)_____ 6) _____
3)_____ 7) _____
4)_____ 8) _____

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CAT Scans, MRIs EEG, EKG's have you had?

_____year: _____ _____ year: _____
_____year: _____ _ _____ year: _____
_____year: _____ _____ year: _____

Recent travel and/or immunizations:

Scars, Tattoos, Piercings (where?):

Allergies (Are you hypersensitive or allergic to...)

Any drugs? _____
Any foods? _____
Any environmental or chemical? _____

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History

Do you have a family history **or personal history** of any of the following (please circle)?

Cancer	☐ Diabetes	☐ Heart Disease	☐ High Blood Pressure	☐
Kidney Disease	☐ Epilepsy	☐ Arthritis	☐ Glaucoma	☐
Tuberculosis	☐ Stroke	☐ Anemia	☐ Mental Illness	☐
Asthma/Hayfever/Hives	☐ Eating Disorder	☐ Abuse	☐	

Any other relevant history? _____

_____

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

REVIEW OF SYSTEMS

Head
Headaches?
Head Injury?
Migraines?
Jaw/TMJ problems

Neck
Lumps?
Swollen glands?
Goiter?
Pain or stiffness?

Nose and Sinuses
Frequent colds?
Nose Bleeds?
Hay-fever?
Sinus problems?

Eyes
Impaired vision?
Glasses or contacts?
Blurriness?
Eye pain/strain

Ears
Impaired hearing?
Ringing?
Earaches?
Dizziness?
Excessive wax?

Mouth and Throat
Frequent sore throat?
Teeth grinding?
Sore tongue/lips?
Gum problems?
Hoarseness?
Dental cavities?
Missing teeth? #_____
Root canals? #_____

Cardiovascular
Angina?
High/Low Blood Pressure?
Murmurs?
Blood clots?
Fainting?

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Blood / Peripheral Vascular
Easy bleeding or bruising?
Anemia?
Deep leg pain?
Cold hands/feet?
Varicose veins?

Endocrine
Heat or cold intolerance?
Excessive thirst?
Excessive hunger?
Fatigue?
Seasonal depression?

Immune
Reactions to immunizations?
Chronic infections?
Chronically swollen glands?
Slow wound healing?
Night Sweats?

Mental / Emotional
Depression?
Mood Swings?
Anxiety or nervousness?
Considered/Attempted suicide?
Poor concentration?
Memory problems?

Neurologic
Muscle weakness?
Numbness or tingling?
Loss of memory?
Vertigo or dizziness?

Skin
Rashes?
Eczema, Hives?
Acne, Boils?
Itching?
Color Change?
Hair Loss?

Musculoskeletal
Joint pain or stiffness?
Arthritis?
Broken bones?
Weakness?
Muscle spasms or cramps?
Sciatica?

Respiratory
Cough?
Sputum?
Asthma?
Bronchitis?
Difficulty breathing?
Pain on breathing?
Shortness of breath?

Gastrointestinal
Trouble swallowing?
Heartburn?
Ulcer?
Abdominal pain or cramps?
Change in appetite?
Belching or passing gas?
Nausea/vomiting
Constipation?
Diarrhea?
Hemorrhoids?
How many bowel movements per day? _____

Urinary
Frequent infections?
Pain on urination?
Increased frequency?
Frequency at night?
Inability to hold urine?
Kidney stones?

Female Reproduction
Age of first menses? _____
Are cycles regular?
Length of cycle? _____ days
Duration of menses? _____ days
Date of last annual exam/ PAP _____
Hx Abnormal PAP?
PMS?
If yes, what symptoms?
_____
Painful menses?
Clotting?
Heavy or excessive flow?

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Are you sexually active?
Birth control?
Type?_____
Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____
Difficulty conceiving?
Sexual difficulties?
Pain with intercourse?
STDs?
(Chlamydia,Gonorrhea,Herpes,Syphilis,Warts)
Age of last menses? (if menopausal) _____
Menopausal symptoms?
If yes, what symptoms?_____
_____

Male Reproduction
Hernias?
Testicular masses?
Testicular pain?
Discharge or sores?
Are you sexually active?
Birth control?
Type? _____
Sexual difficulties?
Impotence?
Premature ejaculation?
STDs?
(Chlamydia,Gonorrhea,Herpes,Syphilis,Warts)
Syphilis?

Lifestyle
Do you exercise?
If yes, what kind?_____
How often? _____
Average 6-8 hrs. sleep?
how many hours? _____
Sleep well?
Awake rested?
Enjoy your work?
Take vacations?
Spend time outside?
how many hours? _____
Use recreational drugs?
Use alcoholic beverages?
How many drinks/week _____
Do you use tobacco?
How many per day? _____
Do you eat 3 meals a day?
Do you eat out often?
Do you drink coffee?
How many cups per day? _____
Drink black/green tea?
Do you drink cola/other sodas?
Do you drink water?
How many cups per day? _____

Is there anything else you would like to add?

CONTEXT OF CARE:

What expectations do you have from working with our clinic?

What expectations do you have of me personally as your doctor?

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CLINIC POLICIES

To facilitate the efficiency of providing you with Naturopathic health care in a clinic setting, and to ensure that you will receive maximum benefit from the care offered, the following policies have been established.

- We reserve the right to refuse any patient based upon patient clinical history and/or physical examination findings.

- We reserve the right to refer any case where
  - Dr Botova feels that the case is beyond her scope of practice
  - The patient refuses to co-operate with the recommendations mutually agreed upon

- If you are more than 15 minutes late, unfortunately your appointment will be considered as a 'missed appointment' and you will be responsible for the appointment fee (Does not apply to emergencies)

- We request a minimum of **24 hours** notice in the event that you need to cancel or reschedule an appointment. Failure to do so will result in a no show charge for the missed appointment. We understand that there are unforeseen circumstances and these will be taken into consideration. Our answering machine is always operating.

- Full payment is mandatory at the time of your visit. We accept Visa, MasterCard, Debit or Cash. We do not accept returns on products unless due to an allergic reaction

- Telephone consultations, letters and forms are all subject to a fee. Patients are responsible for any long distance telephone charges.

- Please refrain from wearing perfume or using heavily scented products in the clinic in consideration to our environmentally sensitive patients.

- We request that you discontinue all vitamin-mineral, herbal and non-essential supplements for 24 hrs before each visit but bring all your remedies and supplements with you to your appointment**. Do NOT discontinue any prescription medications but bring them with you.**

- If during the course of your treatments, you notice that suddenly your remedies are not working, you have an aggravation or reaction, or a concurrent viral infection please call the office immediately so that it can be addressed appropriately.