

**Naturopathic Patient Intake Form**

Our professional association requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission. E-mail will only be used by our office to inform you of our office events and to distribute our newsletter 4 times a year; it will not be distributed for any other use.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

E-mail: \_\_\_\_\_

Emergency Contact:

\_\_\_\_\_  
(Full name) (Relation) (Telephone)

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Past Occupations: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Number of children & their ages: \_\_\_\_\_

Blood Type: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Ideal Weight: \_\_\_\_\_

Religion or personal philosophy (optional): \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Date of last physical: \_\_\_\_\_

Have you been treated by a Naturopathic Doctor?

Other health practitioners?

Name: \_\_\_\_\_

Name: \_\_\_\_\_

When? \_\_\_\_\_

When? \_\_\_\_\_

Please list in order of importance your primary health concerns/ reason for your visit.	Please indicate any treatments that you have tried previously to address your health issues and how effective you found these treatments.

Please list all medications you have taken, **Pharmaceutical, Herbal, Vitamins and Supplements, including Dosages:**

Now	In the Past

Please list any **allergies** you have and what kind of **reaction** occurs:

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Please list all hospitalizations you have had:

Type of illness or operation/procedure: \_\_\_\_\_ Date \_\_\_\_\_ Any ongoing concerns? \_\_\_\_\_

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What would you rate your **energy** level at? (1-10, 10 being highest) \_\_\_\_\_

Do you wake-up feeling refreshed? Y\_\_ if N\_\_ , give details. \_\_\_\_\_

How many glasses of **water** do you drink per day?

Tap\_\_\_\_\_ Filtered\_\_\_\_\_ Distilled\_\_\_\_\_ Reverse Osmosis\_\_\_\_\_ Spring\_\_\_\_\_

How many glasses of **pop**\_\_\_\_\_ or **juice**\_\_\_\_\_ do you drink per day?

How many **cups/day** do you drink of the following?

Coffee\_\_\_\_\_ Black tea \_\_\_\_\_ Herbal tea \_\_\_\_\_ Do you add milk/cream? \_\_\_\_\_ Sugar? \_\_\_\_\_

Do you **smoke**? Y\_\_ # of cigarettes/ cigars day:\_\_\_\_\_ How many years?\_\_\_\_\_ In the past? Y\_\_ Quit when \_\_\_\_\_

Do you drink **alcohol**? N\_\_ Y\_\_ # of drinks and type of drinks per week: \_\_\_\_\_

Do you use **recreational drugs**? N\_\_ Y\_\_ in the past? Y\_\_

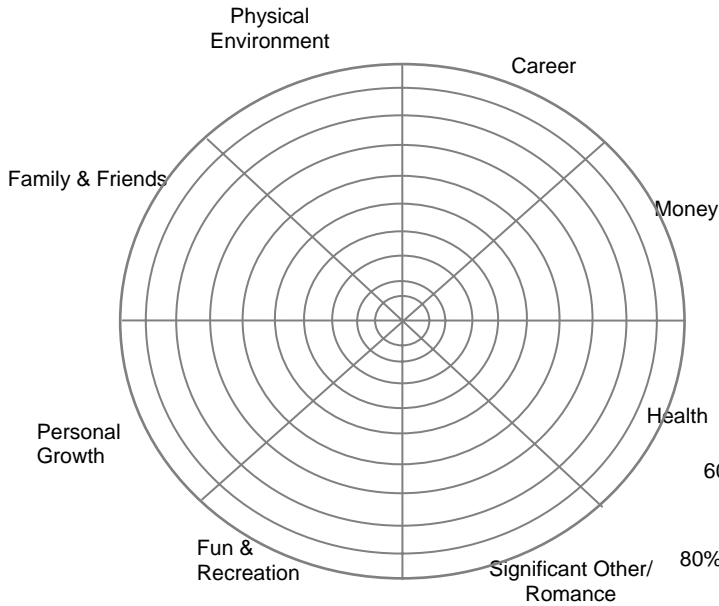
Do you watch TV? N\_\_ Y\_\_ number of hours per week: \_\_\_\_\_

Do you exercise? N\_\_ Y\_\_ Hours per week: \_\_\_\_\_ Type of exercise: \_\_\_\_\_

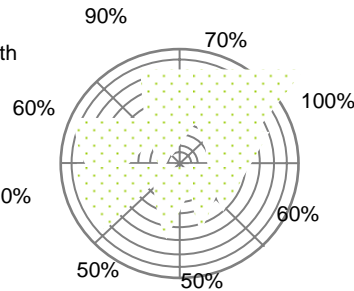
Please check all that are applicable to **you & your family** and note who:

	Alcoholism		Glaucoma/Cataracts	
	Allergies		Gout	
	Arthritis		Heart Disease	
	Autoimmune diseases		Heart murmurs	
	Anorexia/Bulimia		High blood pressure	
	Asthma		Hypothyroid	
	Cancer		Hyperthyroid	
	Crohn's or Colitis		Kidney disease	
	Depression		Liver disease	
	Diabetes		Mental illness	
	Eczema		Stroke or aneurysm	
	GERD/hiatal hernia		Ulcers	
	Other			

Wheel of Health



Example:



Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

## Context of Care Overview

1. Why did you choose to come to this clinic?

What do you know about our approach?

2. What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

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

3. What is your **present level of commitment** to address any underlying causes of you signs and symptoms that relate to your lifestyle?  
(Rate from 0 to 10, 10 being 100% committed)

1    2    3    4    5    6    7    8    9    10

4. a) What behaviours or lifestyle habits do you currently engage in regularly that you believe **support** your health? (please list)

b) What behaviours or lifestyle habits do you currently engage in regularly that you believe are **self-destructive** lifestyle habits? (please list)

5. What **potential obstacles** do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

7. What do you **LOVE** to do?

## Welcome to Naturopathic Care

I want you to enjoy and benefit from your visits.

Your first visit will consist of a **consultation, detailed history, a general physical exam and more specific naturopathic assessments**. Based on this information, initial recommendations for your treatment protocol will be made on your first visit. If it is necessary for a more complete analysis of your health status, you may be asked to have further laboratory tests done, these may include; blood testing, salivary hormone testing, urine, hair and stool analysis. Through this healthcare assessment, a baseline measure of health is established which will be used to monitor your progress.

Naturopathic treatment programs often include **dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy, acupuncture and Bowen therapy**. Any side effects or risks associated with your treatment will be explained to you. Part of the program will also involve lifestyle recommendations that are logical and sensible; I encourage you to have a support team as you make these changes, often having someone else, be it a partner, family member or friend, undergoing naturopathic care at the same time, will help ease you both toward better health. Your second visit is a good time to ask any questions that you may have had after your initial visit. If you need immediate clarification on remedies, dietary recommendations or have a concern over any unfamiliar symptoms that may arise, please call the office.

On your following visits your progress will be monitored and treatments will be modified accordingly. The second visit is usually one to four weeks after your initial visit. If you are receiving acupuncture treatments, visits will be more frequent, either once or twice weekly for 6-10 sessions, Bowen therapy sessions are usually 5-10 days apart. As you start to experience a new level of wellness, an office visit every three to four months is recommended for general disease prevention and health maintenance. If an acute, non-emergency condition occurs, please give us a call as we may be able to help with a naturopathic treatment.

Many patients have allergies and are environmentally sensitive. On the day of your visit to the office please do not wear any scented products (perfumes, shaving lotions, etc.).

**If you are unable to keep a scheduled appointment, please give the office 24 hours notice. We are then able to give the appointment time to someone else. If we do not receive sufficient notice you will be charged for the missed visit.**

Payment for visits shall be made at the time of the appointment

Please be advised of the fees effective April 1, 2008

### Dr. Rebecca Sagan ND

Initial visit	1.25 hr	\$150
Regular visit	30 min	\$75
Child Initial visit		\$100
Child Regular visit		\$60
Acupuncture Initial visit		\$100
Acupuncture follow-up		\$60
Bowen Therapy Initial		\$100
Bowen Follow-up		\$75
Hair Analysis		\$85
In-Office Urinalysis		\$55

A dispensary of professional quality supplements, botanicals and homeopathics is maintained for the treatment of our patients. Items are individually priced.

We accept the following methods of payment:

**Visa, MasterCard, Debit card, cheque or cash**

If you have any concerns please contact the office and we will happily help you to the best of our abilities.

# Naturally Good Health Clinic

## INFORMED CONSENT

I would like to take this opportunity to welcome you to the Naturally Good Health Clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. Your Naturopathic Doctor will complete a physical exam, as well as, specific blood, salivary and/or urinary laboratory reports as part of the treatment work-up if determined to be appropriate.

### Statement of Acknowledgement

Printed name \_\_\_\_\_

As a patient of this clinic I understand that the form of medical care is based on Naturopathic and other supportive principles and practices. All information that is disclosed will remain confidential and will only be released with my permission. I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

\_\_\_\_\_  
SIGNATURE/ Guardian Signature

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS