kw health connection
chiropractor • naturopath • massage

New Patient Intake Form

Please fill this out entirely and bring it with you to your first office visit.

This form is meant to gather as much information as possible. Please fill it out to the best of your knowledge. If there are areas you can not or would not like to answer, please leave that area blank.

Contact Information

Full Name _____ Date _____

Address _____ City _____

Province _____ Postal Code_____

Telephone: Home (___)_____ Work (____)_____

Mobile (____)_____ Other (____)_____

Email Address_____

(email addresses will only be used for appointment reminders and our monthly newsletter)

Date of Birth _____ Age _____ Gender Male / Female

Ethnicity_____ Marital Status_____

Occupation _____

Number of hours worked per week _____

Name of Medical Doctor_____

Telephone ( )_____ Fax (____)_____

Are you currently under his/her care? Yes / No

If yes, for what condition(s)?_____

Date of last physical_____

How or by whom were you referred to this clinic?_____

Have been treated by a Naturopathic Doctor before?

If yes, by whom?_____ When?_____

In case of Emergency:

Contact _____

Full Name Relation

Telephone ( )_____

We will call patients at times, and we wish to ensure your privacy regarding treatment at our clinic. In the event that we are unable to reach you by phone, please indicate where it is appropriate to leave messages for you (please circle):

Home machine With family members At work Never leave messages

Current Health

What are your primary health concerns? List as many as you can, in the order of their importance to you. (attach a separate sheet if necessary)

1) _____

2) _____

3) _____

4) _____

5) _____

Are you aware of having allergies or sensitivities to any of the following? If so, describe your specific sensitivity and reaction to each one.

Drugs_____

Foods_____

Chemicals_____

Animals_____

Other_____

Please list, all ***current*** prescription medications, over-the-counter medications, and all vitamins/supplements/herbs you take regularly. What is their effectiveness? ***Please bring each of these with you to your first visit.***

_____

_____

_____

_____

Do you regularly get screening tests done by a health care professional? Yes / No

Which ones? (Please circle)

Blood tests
Bone density scan (DEXA)
Mammogram
Pap
Digital Rectal Exam (Prostate exam)
Fecal occult blood
Other _____

Are you exposed to tobacco smoke or other types of inhalants? Y / N

Please circle all that apply in your home:

Pet
Mostly Carpet
New home
Gas heating

Do you frequently use any of the following? (Please circle)

Laxatives
Pain Relievers
Antacids
Appetite Suppressants
Antidepressants
Antibiotics
Birth control (pills/implants/injections/patch)
Cholesterol-lowering medication
Ulcer medication
Sleeping medication

- Alcohol → Type and amount per week? _____
- Tobacco → Form and amount per day? _____
- Caffeine → Form and amount per day? _____
- Recreational Drugs → Form and frequency? _____

Females only:
Are you currently pregnant? Yes / No

General Information

Height _____ Weight _____

Weight 1 yr ago _____ Maximum weight _____ When _____

What time of day is your energy and alertness best? _____ Worst? _____

Primary interests and hobbies _____

Primary form of exercise, if any _____
How often?_____

Medical History

Which of the following conditions do you currently experience or have had in the past? (please circle)

Abuse	Heart Disease	Prostatitis
Alcoholism	Hemorrhoids	Rheumatic Fever
Asthma	Hepatitis	Scarlet Fever
Cancer	Herpes	Strep Throat
Chicken Pox	Influenza	Sinusitis
Cold Sores	HIV	Stroke
Depression	Kidney Disease	Syphilis
Diabetes	Malaria	Thyroid Problems
Emphysema	German Measles	Tuberculosis
Endometriosis	Mononucleosis	Typhoid Fever
Epilepsy	Mumps	Warts
Gall Stones	Parasites	Whooping Cough
Gonorrhea	PID	Worms
Gout	Pneumonia	
Hay Fever	Psoriasis	

Please list any serious illnesses, injuries, hospitalizations, surgeries and conditions along with approximate dates***. Include dental work (even regular fillings).***

_____

_____

_____

Please list all past medications taken in the past 12 months

_____

_____

_____

_____

Please indicate which immunizations you have had (Please circle)

DPT (diptheria, pertussis, tetanus)
Tetanus booster (Date?_____)
MMR (measles, mumps, rubella)
Smallpox
Chicken Pox
Hepatitis B
Hepatitis A
Polio
Haemophilus Flu vaccine (Date?_____)
Other

Have you ever had an adverse reaction to an immunization? Y / N
If yes, please describe_____

Please list past places of travel in the last 12 months

_____

Family History

Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known.
Check all that apply.

	Father	Mother	Child	Other (please specify)
Age (if living)				
Health (good,poor)				
Age at death				
Cause of death				
Cancer				
Diabetes				
Epilepsy				
Heart Disease				
High Blood Pressure				
Drug Abuse/Alcoholism				
Depression				
Mental Illness				
Asthma / Eczema				
Allergies				
Kidney Disease				
Autoimmune (MS, Lupus, RA)				
Psoriasis				

Please list other significant family medical history not listed above:

_____

_____

Nutrition

Do you have any dietary restrictions (e.g. vegetarian, religious, ethical etc.)? Please describe

_____

_____

Indicate which of the following are true (please circle).

Eat 3 meals or more per day

Go on diets more than once yearly

Drink tea / coffee

Drink soft drinks

Use products with artificial sweeteners

Add sugar/salt to food

Eat out more than twice a week

Describe a typical day's diet.

Breakfast_____

Snack_____

Lunch_____

Snack_____

Dinner_____

Snack_____

Amount of water _____

Lifestyle

Please indicate which of the following are true (please check).

- ❑ Get 6-8 hours of sleep per night
- ❑ Sleep well
- ❑ Awake feeling rested
- ❑ In a supportive relationship
- ❑ History of abuse
- ❑ Suffered major life trauma
- ❑ Enjoy your work
- ❑ Take vacations How often?_____
- ❑ Spend time outside
- ❑ Watch TV Hours daily?_____
- ❑ Read Hours daily?_____

Using the scales below, please rate yourself in terms of satisfaction and dissatisfaction in areas of your life. Number 1 means you are very dissatisfied or stressed. Number 10 means you are very satisfied or comfortable.

	0	1	2	3	4	5	6	7	8	9	10
Friends & Family											
Physical Environment											
Health											
Career											
Relationships/Romance											
Recreation											
Money											
Personal Growth / Spirituality											

Do you have any other concerns that have not been covered?

_____
_____
_____
_____
__

_____ _____
Signature Date

Thank you for your time and effort.

CLIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our Clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

In this Clinic, Erika Holenski acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our Clinic is doing to ensure that:

 Only necessary information is collected about you;

 We only share your information with your consent;

 Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;

 Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

How our clinic collects, uses and discloses client's personal information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our Clinic is using and disclosing your information.

This Clinic will collect, use and disclose information about you for the following purposes:

 To assess your health concerns

 To provide health care

 To advise you of treatment options

 To establish and maintain contact with you

 To send you newsletters and other information mailings

 To remind you of upcoming appointments

 To communicate with other treating health-care providers

 To allow us to efficiently follow-up for treatment, care and billing

 To complete claims for insurance purposes

 To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the *Drugless Practitioners Act*

 To invoice for goods and services

 To process credit card payments

 To collect unpaid accounts

 To assist this Clinic to comply with all regulatory requirements

 To comply generally with the law

 To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale.

By signing the consent section of this Client Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

Client Consent

I have reviewed the above information that explains hour your Clinic will use my personal information, and the steps your Clinic is taking to protect my information.

I agree that Erika Holenski N.D. can collect, use and disclose personal information about _____print name_____ as set out above in the information about the Clinic's privacy policy.

_____ _____

signature print name

_____ _____

date signature of witness

Adult Consent Form

PLEASE NOTE THAT THESE FORMS MUST BE SIGNED AND FILLED OUT PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history, and may do a screening physical examination, including taking blood and urine samples.

It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, and if you are on any medications or over the counter drugs.

There are some slight health risks to treatment by Naturopathic Medicine.

These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. If required, I understand that my Naturopathic Doctor may discuss my case with other healthcare providers.

I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee.

I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the Doctors to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Naturopathic care. 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 my participation at any time.

Patient Name: (Please Print) _____

Signature of Patient: _____

Date: _____ Naturopathic Doctor: _____