north toronto naturopathic clinic
1940 avenue road toronto, ontario M5M 4A1 p.416.385.9277 **www.nt-nc.com**

Patient Intake Form

Please take time to fill out the following form. It provides a basis for further questions during your visit and helps properly assess your situation. All information is for office use only and will be kept confidential.

General:

Date of visit: _____

Full Name: _____
Date of Birth: _____ Age: _____ Gender: male female

Complete Address: _____
City: _____ Postal Code: _____
Tel. No.: Home: _____ Work:_____ Cell: _____
E-mail:_____
Would you like you receive clinic updates/ special offers/upcoming events? Yes No
(Your e-mail address is kept strictly confidential)
Occupation: _____ Full-time or Part-time? _____
Marital Status: single married separated divorced other: _____
Children: yes no If yes, please list ages: _____

Extended Healthcare Insurance Company (if applicable):
_____

In case of emergency contact: _____
Relationship to patient: _____ Tel. No. _____

How did you find out about the naturopathic services at this clinic? _____

Last physician seen and when? _____

When was your last blood test and what was it for? _____
_____ Blood type: _____

Health Concerns:

What are your chief health concerns? (in order of importance to you)
_____
_____
_____
_____

General state of health: □ poor □ fair □ good □ very good □ excellent
Comments:
_____
_____

Indicate which of the following you have or may have had:

☐ Abscess ☐ Abortion ☐ Alcoholism ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Chicken pox ☐ Cold Sores ☐ Depression ☐ Diabetes ☐ Eczema ☐ Emphysema ☐ Epilepsy ☐ Fibrocystic breast disease ☐ Frequent colds ☐ Gallstones	☐ Genital herpes ☐ Genital warts ☐ Gonorrhea ☐ Gout ☐ Hay fever ☐ Headaches ☐ Heart disease ☐ HIV ☐ Influenza ☐ Kidney disease ☐ Leukemia ☐ Low/High blood pressue ☐ Malaria ☐ Measles ☐ Malaria ☐ Menstrual cramps	☐ Miscarriage ☐ Mono ☐ Multiple sclerosis ☐ Mumps ☐ Parasites ☐ Peritonitis ☐ Pelvic inflammatory disease ☐ Pleurisy ☐ PMS ☐ Pneumonia ☐ Prostatitis ☐ Psoriasis ☐ Rheumatic fever ☐ Rubella ☐ Scarlet fever	☐ Rubella ☐ Scarlet fever ☐ Skin diseases ☐ Sinusitis ☐ Stroke ☐ Strep throat ☐ Substance abuse ☐ Syphilis ☐ Tonsillitis ☐ Tuberculosis ☐ Warts ☐ Whooping cough ☐ Worms

Others: _____
_____
_____

List any accidents, injuries, and hospitalizations (including type and year of occurrence):
_____
_____
_____
_____

List any known allergies (including food, drugs, herbs, environmental, etc.):
_____
_____
_____
_____

Typical diet (usual daily intake as well as any dietary restrictions):
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks:_____

List daily intake of supplements (vitamins, minerals, herbs, etc.):
_____
_____
_____
_____

Are you currently working with a medical doctor (MD)? □ Yes □ No
State diagnosis given by MD (if applicable): _____
_____

List any medical treatments you are undergoing and/or medications you are currently taking (if applicable), including dosage and duration of use:
_____
_____
_____
_____

Please indicate if you have worked or are currently working with other practitioners (e.g. chiropractor, physiotherapist, professional counsellor, psychologist, social worker, etc.). If in the past, please state when and duration of treatment:
_____
_____
_____

Screening tests (include year of test and results):
_____
_____
_____
_____

Immunizations (include date and if you experienced any adverse effects from them):
_____
_____
_____
_____

Sleep patterns (include usual time of sleep and wake, daytime naps, and any difficulties in falling asleep or staying asleep):
_____
_____
_____

What do you feel is your weakest organ system and why? _____
_____
_____

Do you exercise? □ Yes □ No
If yes, include type, frequency and duration:
_____
_____
_____

What is your: Height? _____ Weight now? _____ Max. weight? _____ Min. weight? _____

Have you lost any weight lately? □ Yes □ No If so, how many pounds? _____

Indicate whether you have been or are exposed/use the following (and if so, how much):

□ tobacco smoke _____
□ coffee _____
□ tea _____
□ pop _____
□ alcohol _____
□ recreational drugs _____
□ excess stress _____
□ chemicals _____

Indicate below any health conditions that have afflicted members of your family:

Relative	**Age if alive**	**Age at death**	**Health condition(s)**
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Describe you family/work relationships:

_____
_____
_____

List important events/experiences in your life:

_____
_____
_____
_____

What is a typical day like for you?

_____
_____
_____

Thank you for taking the time to fill out this form.

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Informed consent

Naturopathic Medicine is the treatment and prevention of disease 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.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include diet, lifestyle counselling, clinical nutrition (primary via supplementation), botanical medicine, homeopathy, Asian medicine and acupuncture, hydrotherapy, and physical medicine

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, improved gastrointestinal function, enhanced immunity, and general well-being.

Botanical medicine is plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine based on the Law of Similars; that is, the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses, of plant, animal, or mineral origin, are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

Physical medicine refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, your Naturopathic Doctor will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take urine samples for further testing, or blood samples for lab investigation.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important, therefore, that you inform your naturopathic doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your doctor immediately.

Health risks associated with Naturopathic Medicine include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process.
- Allergic reactions to supplements or herbs.
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles
- Muscle strains and sprains or disc injuries from spinal manipulation

_____ Initials 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 without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____ Initials I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

_____

_____ Initials I understand that fees and supplements are to be paid for at the time of the consultation.

_____ Initials I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours notice.

As the patient, you are responsible for the total charges incurred for each visit. We accept cash, debit, cheque or visa. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company – we will provide you with all of the information necessary to send your claim for reimbursement.

Your Naturopathic Doctor may prescribe supplements that can be purchased from our in-house dispensary, or elsewhere. Most insurance companies do not cover the supplements that we prescribe and dispense.

I have read and understand the above-stated policies and information. I hereby authorize and consent to naturopathic treatment and examination by Ruth Anne Baron, ND or Via Bitidis, ND. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print): _____

Signature of Patient or Guardian: _____

Date: _____