***Naturopathic Intake Form***



*Mind Body Soul Integrative Clinic*

*#302-1630 Pandosy Street Kelowna, V1Y 1P7*

***T: 250-868-0221*** *F: 250-869-4927*

PATIENT MEDICAL PROFILE

Last Name       First Name       Today’s Date

Nickname       E-Mail       Birthdate (d/m/y)       Sex

Home Address       City       Postal Code

Home Phone       Work Phone       Cell Phone

Preferred Method of communication: Home [ ]  Cell [ ]  Work [ ]  or email [ ]

How did you hear about Naturopathic Medicine at Mind Body Soul?

Would you like to receive a quarterly newsletter via e-mail? YES [ ]  NO [ ]

**A note to our patients**: Please complete this questionnaire as thoroughly as possible in order to best aid in your diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

**What is your commitment level to being proactive in your health care?**

### Present Health Concerns

|  |  |
| --- | --- |
| **Please list most important health concerns in their order of significance.** | **Is there a prior diagnosis of this problem? If so, what was diagnosis, when was it made and by whom?** |
| 1.       |       |
| 2.       |       |
| 3.       |       |
| 4.       |       |

**Please list prescription medications that you are currently taking, with dosages:**

1.       2.       3.

4.       5.       6.

**List vitamins, minerals, herbs, homeopathic remedies you are currently taking, with dosages:**1.       2.       3.

4.       5.       6.

**Please list any severe or life-threatening allergies:**

**Explain:**

Name       DOB:

***Current Symptoms***

|  |  |  |  |
| --- | --- | --- | --- |
| **General**[ ]  Chills[ ]  Fatigue[ ]  Fever[ ]  Night Sweats[ ]  Weight Change**Eyes**[ ]  Blurred Vision[ ]  Eye Drainage[ ]  Eye Pain[ ]  Glasses/contacts[ ]  Light Sensitivity**Ears/Nose/Throat**[ ]  Ear pain[ ]  Hearing problems[ ]  Ringing in ears[ ]  Nose bleeds[ ]  Nasal congestion[ ]  Nasal ulcers[ ]  Runny nose[ ]  Bleeding gums[ ]  Gum disease[ ]  Dentures present[ ]  Hoarseness[ ]  Oral ulcers[ ]  Sore throat[ ]  Sore tongue[ ]  Thrush[ ]  Tooth pain**Cardiovascular**[ ]  Chest pain[ ]  Leg pain w/ walking[ ]  Dizziness[ ]  Shortness of breath[ ]  Palpitations[ ]  Swollen feet/ankles[ ]  Rapid heart rate[ ]  Varicose veins | **Respiratory**[ ]  Cough[ ]  Difficulty breathing[ ]  Coughing up blood[ ]  Chest wall pain[ ]  Wheezing**Gastrointestinal**[ ]  Abdominal pain[ ]  Indigestion[ ]  Sour taste in mouth[ ]  Poor appetite[ ]  Bloating[ ]  Difficulty swallowing[ ]  Clay-colored stools[ ]  Constipation[ ]  Diarrhea[ ]  Heartburn[ ]  Vomiting blood[ ]  Bloody stools[ ]  Hemorrhoids[ ]  Dark/tarry stools[ ]  Nausea[ ]  Vomiting[ ]  Painful chewing[ ]  Stool caliber change**Genitourinary**[ ]  Bleeding after intercourse[ ]  Blood in urine[ ]  Change in urine stream[ ]  Frequent bacterial vaginosis[ ]  Frequent Bladder infections[ ]  Frequent urination[ ]  Genital lesions[ ]  Heavy periods[ ]  Impotence[ ]  Irregular periods[ ]  Menopausal bleeding[ ]  Menopausal symptoms | **Genitourinary (con’t.)**[ ]  Nighttime urination[ ]  Painful intercourse[ ]  Painful menstruation[ ]  Painful urination[ ]  Sexual abuse[ ]  Unprotected sex[ ]  Urinary incontinence[ ]  Vaginal discharge[ ]  Vaginal itching**Musculoskeletal**[ ]  Arm or leg pain[ ]  Back pain[ ]  Joint pain[ ]  Joint stiffness[ ]  Muscle aches**Skin**[ ]  Acne[ ]  Concerning moles[ ]  Dry skin[ ]  Fingernail problems[ ]  Jaundice (Yellow skin)[ ]  Itching[ ]  Rashes[ ]  Warts**Breast**[ ]  Lump[ ]  Skin changes[ ]  Breast tenderness[ ]  Nipple discharge[ ]  Regular self-breast exams**Neurological**[ ]  Difficulty walking[ ]  Dizziness (fainting)[ ]  Fainting[ ]  Headaches[ ]  Memory loss[ ]  Numbness | **Neurological (con’t.)**[ ]  Seizures[ ]  Tremor[ ]  Vertigo (Dizziness)[ ]  Weakness**Hematologic**[ ]  Easy bruising[ ]  Excessive bleeding[ ]  Blood transfusions[ ]  Enlarging lymph nodes**Endocrine****[ ]** Enlarging hands/feet[ ]  Hair loss[ ]  Heat intolerance[ ]  Cold intolerance[ ]  New hair growth[ ]  Hot flashes[ ]  Darkening skin[ ]  Infertility[ ]  Increased thirst[ ]  Increased hunger[ ]  Stretch marks[ ]  Sweating excessive**Allergies/Immunologic**[ ]  Allergies[ ]  Hay fever[ ]  Frequent colds[ ]  HIV exposure[ ]  Urticaria (Hives)**Psychiatric**[ ]  Anxiety[ ]  Depression[ ]  Stress[ ]  Mood Disorders[ ]  PMS[ ]  Poor concentration[ ]  Trouble sleeping[ ]  Suicidal thoughts |

Name       DOB:

***Past Medical History***

|  |  |  |  |
| --- | --- | --- | --- |
| **Cardiovascular**[ ]  Abnormal Heart Rhythm[ ]  Arterial Clot[ ]  Carotid Artery Disease[ ]  Congestive Heart Failure[ ]  Coronary Artery Disease[ ]  Deep Vein Thrombosis[ ]  High Cholesterol[ ]  Hypertension[ ]  Heart Attack[ ]  Peripheral Vascular Disease[ ]  Superficial Vein Clot[ ]  Phlebitis[ ]  Heart Valve Disease**Pulmonary**[ ]  Asthma[ ]  Bronchiectasis[ ]  Chronic Bronchitis[ ]  COPD[ ]  Croup[ ]  Cystic Fibrosis[ ]  Pneumonia[ ]  Pulmonary Embolism[ ]  Pulmonary Hypertension[ ]  Respiratory Syncytial Virus [ ]  Sarcoidosis[ ]  Sleep Apnea[ ]  TB**Gastrointestinal**[ ]  Gall Stones[ ]  Cirrhosis[ ]  Colon Polyps | [ ]  Crohn’s Disease[ ]  Incontinence of Feces[ ]  GERD or Heartburn[ ]  Hepatitis[ ]  Irritable Bowel Syndrome [ ]  Pancreatitis[ ]  Peptic Ulcer Disease[ ]  Ulcerative Colitis**Renal**[ ]  Benign Prostatic Hypertrophy[ ]  Chronic Renal Failure[ ]  Endometriosis[ ]  Bed Wetting [ ]  Erectile Dysfunction (Impotence)[ ]  Glomerulonephritis[ ]  Infertility[ ]  Kidney Stones[ ]  Urinary Incontinence[ ]  Frequent Bladder Infections**Musculoskeletal/Connective tissue**[ ]  Chondromalacia Patellae[ ]  Chronic Pain[ ]  Fibromyalgia[ ]  Fractures[ ]  Gout[ ]  Juvenile Rheumatoid Arthritis[ ]  Osgood-Schlatter Disease[ ]  Osteoarthritis[ ]  Osteoporosis | [ ]  Osteopenia [ ]  Rheumatoid Arthritis[ ]  Systemic Lupus Erythematous[ ]  Other**Endocrine**[ ]  Addison’s Disease[ ]  Carcinoid Syndrome[ ]  Cushing’s Disease[ ]  Diabetes I or II[ ]  Hyperthyroidism[ ]  Hypothyroidism[ ]  Panhypopituitarism[ ]  Pituitary Tumor**Neurological**[ ]  Alzheimer’s Disease[ ]  ADD/ADHD[ ]  Autism[ ]  Cerebral Palsy[ ]  Stroke[ ]  Dementia[ ]  Degenerative Disc Disease[ ]  Headaches[ ]  Huntington’s Disease[ ]  Meningitis[ ]  Mental Retardation[ ]  Multiple Sclerosis[ ]  Muscular Dystrophy[ ]  Myasthenia Gravis[ ]  Parkinson’s Disease[ ]  Sensory Neuropathy**Hematologic**[ ]  Hemolytic Anemia | [ ]  Iron Deficiency Anemia[ ]  Pervasive Developmental Delay[ ]  Seizures[ ]  Transient Ischemic Attacks (TIA’s)[ ]  Pernicious Anemia[ ]  Sickle Cell Disease[ ]  Thallasemia**Allergy/Immune/Skin****[ ]** Allergies (food or environmental)[ ]  Angioedema[ ]  Chicken Pox[ ]  Eczema[ ]  Giardiasis[ ]  Immune Deficiency[ ]  Ear Infections (frequent)[ ]  Psoriasis[ ]  Sinusitis**Psychiatric**[ ]  Anxiety[ ]  Anorexia Nervosa[ ]  Bipolar Disorder[ ]  Bulimia[ ]  DepressionObsessive Compulsive[ ]  Schizophrenia**Other**[ ]  Cataract[ ]  Glaucoma[ ]  Over weight[ ]       [ ]       [ ]        |

Name       DOB:

**Other Healthcare Providers you are currently seeing (Please list all – conventional, holistic, integrative…etc.)**

Dr.       specialty       Phone:

Dr.       specialty       Phone:

Dr.       specialty       Phone:

Dr.       specialty       Phone:

Date of last physical/annual exam:        Date of last blood tests:

Date of last Pap/Breast Exam:       (N/A –not applicable for men)

Have you had a Colonoscopy?       Year:

Have you had a Bone Density Scan?       Year:

Any X-Rays (body part)?       Year:

Any CTscans/MRI’s (body part )?       Year:

***Surgical History (please list surgeries, dates and outcomes):***

1.

2.

3.

***Family History***

|  |  |  |  |
| --- | --- | --- | --- |
| **Relation** | **Medical Condition** | **Age at Death** | **Cause of Death** |
| Father |  |  |  |
| Mother |  |  |  |
| Brother(s) |  |  |  |
| Sister(s) |  |  |  |
| Son(s) |  |  |  |
| Daughter(s) |  |  |  |
| Paternal GF |  |  |  |
| Paternal GM |  |  |  |
| Maternal GF |  |  |  |
| Maternal GM |  |  |  |

Name:       DOB:

***Pregnancy/Gynecological History***

|  |  |  |
| --- | --- | --- |
| Pregnancies #       | [ ]  Menstrual problems | Current Birth Control Method      |
| Children #       | [ ]  Hysterectomy | Are you happy with current birth control method? [ ]  Yes [ ]  No |
| Miscarriages #       | [ ]  Total | Age periods started:       |  |
| Terminations #       | [ ]  Partial (ovaries retained) | Age at menopause:       |  |
|  |  |  |  |

Problems during pregnancy?       Last Mammogram (date):

***Social History***

|  |  |  |  |
| --- | --- | --- | --- |
| **Occupation:**      **Marital Status:**      **Hobbies:**      **Exercise:** (type and frequency)      **Children?** Names and ages:      | **Caffeine**Type and number of drinks per day:      **Smoking:**[ ]  Current? [ ]  In the past? [ ]  Never?**How long?** **Type:** [ ]  Cigarettes? [ ]  Cigar? [ ] Smokeless?  | **How often do you use Alcohol?**[ ]  None[ ]  Rare[ ]  Social[ ]  Regular[ ]  Occasional Binge[ ]  Current Alcoholic[ ]  Past Alcoholic[ ]  Used alcohol in past | **Recreational Drugs**Frequency:      Types:      How long?      **Additional Comments**:      |

**Dietary Habits**: Briefly list what you eat and drink at a typical meal.

Breakfast: Lunch:       Dinner:       Snacks:

How do you rate your diet? [ ]  Excellent [ ]  good [ ]  average [ ]  poor [ ]  terrible

**Do you Restrict any Foods?** Which?

What goals do you have for your visit with Dr. Jasarevic today?

Please include any other comments or health concerns that you would like to discuss:

**Declaration and Consent for Naturopathic Care**

I would like to take this opportunity to welcome you to our clinic. As a naturopathic doctor (ND) I will conduct a thorough case history, a physical exam and may utilize specific blood, urinary or other laboratory reports as part of the treatment work-‐up. I integrate supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, intravenous therapy, and lifestyle counseling to assist the body’s ability to heal and improve the quality of life and health.

**Statement of Acknowledgement**

Printed name of patient:

As a patient of Dr. Emina Jasarevic, ND, I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. Slight health risks of some naturopathic treatments include, but are not limited to:

• temporary aggravation of pre-‐existing symptoms

• allergic reaction to supplements or herbs or injectible therapies

• pain, fainting, bruising or injury from venipuncture or acupuncture

• muscle strains and spasms, disc injuries from spinal manipulations

I also recognize the following:

* I will be given the opportunity to discuss and consent to any treatment plan.
* Any treatment or advice provided to me as a patient of Dr. Jasarevic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. I understand results are not guaranteed.
* I understand that a record will be kept of my visits. This record will be kept confidential and will not be released without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
* I am responsible for payment at the time services are rendered. Dispensary items and laboratory tests must be paid for in full before leaving the office.
* I am aware that 24 hours notice must be given for all cancelled appointments or a cancellation fee will be applied, in addition to any IV’s drawn up for visit.
* I understand that Dr. Jasarevic reserves the right to determine which cases fall outside of her scope of practice, in which case the appropriate referral will be recommended.
* There is a $30 charge for e-mail correspondence, as patients may need and returned phone calls lasting 5-10 minutes.

 [ ]  I consent to receive naturopathic treatment. I understand this consent is voluntary and may be

 revoked at any time.

Signature of patient or guardian:       Date: