***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  Depression Obsessive 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: