

## ADULT Patient Intake Form

Last Name		First Name		Middle Name	
Date of Birth M/D/Y		Occupation		Sex	Age
<b>Contact Information</b>					
Street Address		Town/City		Province	Postal Code
Home Phone Number		Alternative Phone Number		May we leave messages regarding your appointment? Yes/No	
Email address					
<b>Emergency Contact Information</b>					
Name		Relation		Phone Number	
Name		Relation		Phone Number	
<b>Other Health Care Providers</b>					
Name		Specialty/Focus		Contact Info	
Name		Specialty/Focus		Contact Info	
Name		Specialty/Focus		Contact Info	
Date of Last Medical Visit		Date of Last Physical Exam		Date of Last Blood Work	
List of Routine Screening Tests Performed by Other Physicians:					
How did you hear about this clinic?				If referred → please let us know by whom:	
Have you been treated by a Naturopathic Doctor (ND) before?		Name of ND:		Date of Last Visit	

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## Health History

In your opinion what are your most important health concerns?

1.

2.

3.

4.

5.

Current Height

Current Weight

**List all Diagnosed Medical Conditions:**

**Treatments Received:**

**Year of Diagnosis:**

**List all Surgeries/Medical Procedures:**

**Reason:**

**Date (Year/Month)**

**List all Allergies (medications, foods, supplements, environmental, etc.)**

**Reaction Type**

**List all prescription drugs (oral contraceptive, etc), over-the-counter medications (pain killers, antacid, etc), herbs and natural supplements (vitamins, homeopathics, etc) that you are taking:**

**Medication**

**Dosage**

**Start Date**

## Family History

Include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, headaches, neurological conditions, hyper/hypothyroid and other relevant information

<b>Father</b> Age: _____  Related Health History: _____	<b>Mother</b> Age: _____  Related Health History: _____																																
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## Dietary & Lifestyle Habits

<b>Exercise</b>	How many times do you exercise per week? 1x 2x 3x 4x 5x 6x 7x For how long? _____(min) What kind of exercise?    Strength Building                      Cardio/Aerobic                      Flexibility		
<b>Caffeine</b>	#cups consumed per day: Coffee: # _____      Tea: # _____      Cola: # _____		
<b>Tobacco</b>	Do you use tobacco: Yes/No		If YES, how many/day?
	What type(s) of tobacco:		How Many Years?
	Are you exposed to second hand smoke?		
<b>Alcohol</b>	Do you consume alcohol? Yes/No How many drinks per week: _____		What type(s) of alcohol do you consume?
<b>Drugs</b>	Do you <b>currently use</b> recreational drugs? Yes/No → If YES – which kind(s), and how often:  Have you used recreational drugs <b>in the past</b> ? Yes/No → If Yes – which kind(s), and how often:		

# INFORMED CONSENT

## COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of care rendered by Newcastle Family Chiropractic. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. 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 we are 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, College of Naturopaths Ontario
- **How our Clinic Collects, Uses and Discloses Patients' Personal Information**
- The clinic will collect, use and disclose information about you for the following purposes:
- To assess your health concerns, provide health care and advise you of treatment options
- To establish and maintain contact with you by sending newsletters/information mailings and making reminder calls for 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 invoice for goods and services, process payments, collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

## INFORMED CONSENT: Please note that this form must be signed prior to your first 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. Dr. Amy Henehan, ND will take a thorough case history and perform a physical examination. If your case requires, the physical may include more specific examinations such as breast, gynecological, rectal, prostate or genital exams and blood and urine samples may be taken.

**It is very important that you inform the Naturopathic Doctor, Dr. Amy Henehan, ND immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Also, please advise Dr. Amy Henehan, ND immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.**

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise us of any allergies
- Pain, bruising or injury from acupuncture.
- Fainting or puncturing of an organ with acupuncture

## CANCELLING OR RESCHEDULING APPOINTMENTS

We require that you give us at least 24 hours notice when cancelling or rescheduling an appointment. A missed appointment, without proper notice, can result in a full appointment charge to be paid before another appointment is booked.

## STATEMENT OF ACKNOWLEDGMENT/CONSENT

As a patient of Dr. Amy Henehan, 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 \_\_\_\_\_ (print patient name) have read and understand how Dr. Amy Henehan, ND will use my personal information and the steps which the staff is taking to protect my information. I am giving my informed consent to the collection, use and/or disclosure of my personal information as detailed above.

I \_\_\_\_\_ (print patient name) have read and understand the above information. I recognize that this consent form covers the entire course of treatment for my present condition. I understand that treatment results are not guaranteed. I also understand that I am free to withdraw my consent and to discontinue treatment at any time. I give my informed consent to Dr. Amy Henehan, ND to provide naturopathic medical consultation, assessment and treatment to me.

Patient Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

ND Signature: \_\_\_\_\_