SAGE ELEMENTS
NATUROPATHIC CLINIC

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PATIENT INTAKE FORM

General Information **Date**: _____

Name: _____ **Age**: _____ **Date of Birth**: _____

Address: _____

City: _____ **Province**: _____ **Postal Code**: _____

Phone: **Home**: _____ **Cell:** _____ **Business**: _____

Email: _____ **Can messages be left confidentially?** Y N

Marital status: _____ **Would you like to subscribe to Dr. Priya's Blog?** _____

Occupation: _____ **Employer**: _____

Family Medical Doctor: _____ **Date of last physical exam:** _____

Date of last blood test: _____ ***Please bring in any relevant test results***

How did you find out about my office? _____

Emergency Contact

Name: _____ **Relation to you:** _____

Phone: _____

General Intake

What is your main health concern?

_____

_____

List in order of importance other health concerns:

1. _____ Length of Time: _____
2. _____ Length of Time: _____
3. _____ Length of Time: _____
4. _____ Length of Time: _____

What kind of conventional treatment have you received? _____

_____

Are you currently under the care of another physician or healthcare professional (ND, Chiropractor, Acupuncturist, Osteopath, Homeopath)? If yes, what treatment are you receiving? _____

_____

Current Medications (please list dosage)

1. _____
2. _____
3. _____
4. _____
5. _____

Nutritional Supplements (please list dosage)

1. _____
2. _____
3. _____
4. _____
5. _____

What is the general state of your health? _____

What changes would you like to achieve in 6 months? _____

Please list the five most significant stressful (emotional and physical) events in your life:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Are any of these situations continuing to impact your life? _____

Are you currently working with a professional counselor, psychologist, social worker or therapist? Y N

Have you in the past? Y N When? _____

Past Medical History: Which conditions do you have now (N) or in the past (P)

	N	P		N	P		N	P		N	P
Allergies			Weight concerns			Stroke/TIA			STI/STD		
Asthma			Gallstones			Cancer			HIV/AIDS		
Eczema			Gout			Epilepsy			Reflux		
Psoriasis			Arthritis			Migraine			Miscarriage		
Ear infections			Thyroid problems			Pneumonia			Varicose veins		
Strep throat			Anemia			Diabetes			High Cholesterol		
Hay fever			High blood press.			Malaria			Numbness		
Measles			Rheumatic fever			Tuberculosis			Cold hands/feet		
Mumps			Fainting			Small pox			Visual problems		
Chicken pox			Poor memory			Polio			Warts		
Whooping cough			Balance problems			Yeast infections			Mono		

Eye infections			Speech problems			Gas/bloating			Depression		
Scarlet fever			Ringing in ears			Hemorrhoids			Child abuse		
Sinusitis			Jaundice			Parasites			Physical abuse		
Canker sores			Hepatitis			Rectal bleeding			Sexual abuse		
Acne			Heart disease			Herpes			Emotional abuse		
Tonsillitis			Addictions			Headaches			Rape		

Other: _____

Are there any of these from which you feel you have never been well since? _____

_____

Do you have any specific allergies (drugs, herbs, foods, animal, environmental, other)? Y N

Please List: _____

Have you had any major injuries or accidents? Y N

If yes, please list (include dates if known): _____

_____

Have you had previous surgeries or hospitalizations? Y N

If yes, please list (include dates if known): _____

_____

Have you had any of these tests over the past year: cholesterol colonoscopy endoscopy celiac mammogram PSA CT scan MRI laparoscopy X-rays Ultrasound

Please include dates: _____

How often do you get colds/flu/sore throat in a year? _____

In your opinion, what is your weakest system (e.g. digestive, immune, cardiovascular, etc.)? _____

Family History

	Mother	Father	Sister/Brother	Grandparents
Cancer				
T.B.				
Heart Disease				
Arthritis				
Diabetes				
High Blood Pressure				
Asthma				
Kidney Disease				
Depression/mental illness				
Anemia				
Alzheimer's				
Parkinson's				
Multiple Sclerosis				
Lupus				
Celiac Disease				

Vaccination

Have you been vaccinated? Y N **Any adverse reactions?** _____

Other Activities

Which of the following do you currently use? (Please list how much & how often)

Alcohol _____ Sedatives _____
Tobacco _____ Antacids _____
Coffee _____ Cortisone _____
Hormones _____ Aspirin or NSAIDs _____
Laxatives _____
Recreational drugs (please specify) _____
Have you ever had a dependency on any of the above? _____

Personal

Who do you currently live with? _____

How is the emotional climate at home? _____

Are you currently in a happy supportive relationship? _____

What do you enjoy most in life? _____

What are your main interests and hobbies? _____

What do you worry about most in life? _____

What nurtures you? _____

Do you have a religious/spiritual practice? _____

Are there any ethical/religious/cultural considerations I should be aware of? _____

Lifestyle

Do you exercise? Y N **If so, what do you enjoy doing?** _____

How would you rate the quality of your sleep? _____

Do you have trouble falling or staying asleep? _____

How many hours of sleep do you get per night? _____ Do you wake feeling refreshed? _____

Do you nap or rest during the day? _____

How would you describe your energy? _____

How well do you cope with stress? _____

Do you enjoy your work? _____ Do you take regular vacations? _____

How much time do you spend in front of a computer/smartphone/tablet? _____

How do you learn: read listen visual stories

Reproductive

Are you sexually active? Y N **Are you experiencing a loss in sexual desire?** Y N

Sexual orientation: _____

Do you use birth control? Y N **If so, what form? _____**

Female

Age of first menses: _____ If periods have stopped, what age were you: _____

Have you had a partial or complete hysterectomy? _____

Are your cycles regular? Y N **Periods begin every _____ days, and last _____ days**

Are your periods: heavy medium light **What color is the blood: _____ Are there any clots?** Y N

Do you have any spotting or bleeding between your periods: _____ Any vaginal discharge: _____

Premenstrual symptoms: _____

Number of pregnancies _____ Live Births _____ Miscarriage _____ Abortion _____

Have you had any fertility concerns? Y N

Do you get regular PAPs? Y N **Any abnormal findings?** Y N **If so, results? _____**

Do you do regular self breast exams? Y N **Have you noticed any breast lumps? _____**

Have you had: Endometriosis Fibroids Ovarian cysts Fibrocystic breasts

Male

How often do you get up at night to urinate? _____ Has this number increased recently? Y N

Do you have difficulty: achieving an erection maintaining an erection (circle one if applies)

Do you have any: sores on the penis? Y N **abnormal discharge?** Y N

Do you have or have a history of venereal disease? Y N **If so, which one(s)? _____**

Do you have prostate problems? Y N **Have you had your prostate examined?** Y N **When? _____**

Kidneys

How often have you had a urinary tract infection in the past year: _____

How was it treated? _____

Digestion

How would you describe your diet? _____ What is the worst item in your diet? _____

How would you describe your digestion? _____

How often do you have a bowel movement? _____

Any history of: (circle all that apply)

gas bloating diarrhea constipation blood in stool undigested food black stools strong odor
reflux fullness after a meal rectal itching

Do you experience any symptoms after a meal? _____

Have you traveled outside of Canada in the last year? _____

Have you been camping in the last year? _____

Musculoskeletal

Do you have muscle aches and pains? Y N **If so, where? _____**

Do you have joint aches and pains? Y N **If so, where? _____**

Does this interfere with your daily activity? Y N **Is this due to an accident/injury?** Y N

Do you have any herniated discs? _____ Have you had any falls or injuries to your head or tailbone? _____

Environment

Is your home damp or moldy? Y N **Do you have specialized air filtration at home?** Y N

Do you live/work in the city? Y N **Do you work in an office building?** Y N **Do the windows open?** Y N

Are you exposed to toxic materials (home, work, hobbies)? Y N **Are there animals in your home?** Y N

Do you smoke or are you exposed to second hand smoke? Y N

How many mercury fillings do you have? _____ Do you react to strong scents (perfume, gas, tobacco)? _____

How is your home heated: gas electric wood

What do you use as drinking water? Tap Bottled Filtered Reverse osmosis

General

How is your body temperature compared to others: cooler warmer average

Do you perspire at times other than exercising? _____

Thank you for taking the time to fill out this intake form! Is there anything else you feel I should know?

_____

_____

_____

_____

_____

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MUTUAL UNDERSTANDING AND CONSENT TO TREATMENT

The following information is provided to enable our sharing of a common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have understood and agreed to the following:

- I understand that all that has been discussed between Dr. Joshi and myself during our office visits is strictly confidential. Exceptions to this confidentiality include disclosure by myself regarding intention to harm myself or others, and where there is reasonable suspicion of emotional, physical and/or sexual abuse of a minor. My records and the information within will not be disclosed to others unless I direct Dr. Joshi to do so, or unless the law authorizes or her to do so.

- Naturopathic medical treatments are in no way meant to replace conventional medical care or care from another licensed health practitioner. I understand I am at liberty to seek or continue care from other healthcare practitioners. I will let Dr. Joshi know if I am being treated by other health care providers. I understand it is my responsibility to disclose changes in my condition(s), symptoms, contact information, or treatments between visits.

- Naturopathic medicine includes taking a detailed case history and a performing a concern-oriented physical exam. Naturopathic doctors use non-invasive methods for the assessment of imbalances within the body, and the use of natural therapies for treatment. These may include: nutritional counseling, supplementation, homeopathy, herbal medicine, traditional Chinese medicine, hydrotherapy, detoxification techniques, maya abdominal therapy, and lifestyle counseling. If at any time, I wish to discontinue a particular therapy/treatment, I understand that I am free to do so.

- The treatment plan suggested by Dr. Joshi will be explained to you, as well as potential side effects or reactions of any therapies. You are encouraged to ask any questions you may have. As with any form of medicine, we cannot guarantee the outcome of any treatment offered.

- If you have a serious health problem that requires immediate attention, call your medical doctor, call 911, or have someone take you to the emergency room. If you notice an adverse effect from one of the components of your health plan, discontinue it and call Dr. Joshi to inform her of what has occurred.

- I agree to pay my full account at the time of each visit for services, cost of supplements/remedies, lab tests or other fees. I am aware that said fees are not covered by MSI.

- CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24-hours notice is required for rescheduling or cancellation of an appointment. The full fee will be charged for missed sessions without such notification.

- The contact information, health history, and other information that I provided on my intake form are complete and accurate.

I _____ (Print Name) understand and agree to the information on this page and give my consent to present and future treatment by Dr. Priya Joshi ND.

_____ _____

SIGNATURE of patient Date

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Fee Schedule and Cancellation Policy

FEE SCHEDULE

Please read the following information carefully and keep for your records.

Initial Visit	Up to 90 Minutes	$165
Subsequent Visit	Up to 45 Minutes	$90
Pediatric (<12 yrs old) Initial Visit	Up to 60 Minutes	$115
Pediatric Subsequent	Up to 45 Minutes	$90
Acupuncture Visit	Up to 30 Minutes	$72
Emergency Visit	Up to 15 Minutes	$40
Injection Visit	Up to 5 Minutes	$13.50

NSF Cheques are subject to a $25 fee.

Phone consults may be arranged (depending on circumstances and with the exception of initial visits) with the same fees outlined above.

All payments are due as services are rendered

While fees are not covered under provincial healthcare, many insurance companies offer coverage of naturopathic services. Check with your insurance provider for more information.

CANCELLATION POLICY

In naturopathic medical practice, scheduled visits are significantly longer than other medical appointments. As such, missed or inappropriately cancelled appointments can account for a significant amount of lost appointment time over the course of the day. We do not overbook patients in this practice to account for missed or cancelled appointments. It is therefore necessary to enforce the following cancellation policy.

You are responsible for the full fee of a missed appointment unless you provide at least 24 hours notice of cancellation.

In the case of unforeseen, such as illness or bad weather, in the absence of adequate cancellation or attendance, you can request that your appointment be conducted over the phone. Please note, however, normal visit charges will apply.

If you need to cancel or rebook your appointment time, please call 406-0100 at your earliest convenience.

By signing below you acknowledge your understanding of the above listed fee structure and cancellation policy.

Thank you in advance for your cooperation.

_____ _____

Name/Signature Date