SAGE ELEMENTS
NATUROPATHIC CLINIC

Patient Intake Form

General Information

Name _____ **Gender** _____ **Pronouns** _____

Age _____ **Date of Birth** _____

Address _____

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

Phone - Home _____ **Cell** _____ **Work** _____

Can messages be left confidentially at one of the phone numbers? Y N _____

Email _____

Relationship/Marital status _____ **Children** _____

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 hear about me? _____

Emergency Contact

Name _____ **Relation to you** _____

Phone _____

General Intake

What is your main health concern?

_____

_____

Please list your other health concerns:

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

Have you received conventional medical treatment for your health concerns _____

_____

Are you currently under the care of other healthcare professionals (ND, Chiropractor, Acupuncturist, Osteopath, Homeopath) for your health concerns? Please list names and treatments_____

_____

Current Medications (please list name & dosage)

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

Nutritional Supplements (please list brand & dosage)

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

How would you describe your health? _____

What health goal(s) would you like to achieve in 6 months – 1 year? _____

Do you feel ready and motivated to make the changes to reach your health goal(s)? _____

Past Medical History

Have you ever been diagnosed with any of the following? Please indicate Currently (C) or in the Past (P):

	C	P		C	P		C	P		C	P
Alcoholism			Diverticulitis			Hypertension			Thyroid concerns		
Alzheimer's dz			Eating disorder			Kidney stones			Tonsillitis		
Anemia			Eczema			Migraines			Ulcers		
Asthma			Emphysema			Mono			Urinary Tract Inf'n		
Autoimmune dz			Epilepsy			Osteoarthritis			Varicose veins		
Bronchitis			Fibromyalgia			Osteoporosis			Chicken pox		
Cancer			Gallstones			Pancreatitis			Ear infections		
Celiac disease			Glaucoma			Pneumonia			Measles		
Chronic fatigue			Gout			Psoriasis			Mumps		
Colitis/Crohn's			Head injury			Rheumatoid Arth.			Polio		
Concussion			Heart disease			Sinusitis			Rheumatic Fever		
Dementia			Hepatitis			Strep throat			Rubella		
Depression			High cholesterol			STI/STD			Tuberculosis		
Diabetes			HIV			Stroke/TIA			Whooping cough		

Are there any illnesses, traumas, or stressors which you feel you have never been well since? _____

_____

_____

Do you have any allergies or sensitivities (drugs, herbs, foods, animal, environmental, other) _____

_____

Do you carry an epi-pen? Y N

Please list any major injuries & accidents (include dates) _____

_____

Please list any hospitalizations, surgeries, medical procedures (include dates) _____

_____

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

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

How often have you been treated with antibiotics in your life? _____

Have you had any adverse reactions to immunizations/vaccinations? _____

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

Family History

	Mother	Father	Sister/Brother	Grandparents
Autoimmune disease				
Alcoholism				
Alzheimer's/Dementia				
Arthritis				
Cancer				
Celiac disease				
Depression/Mental illness				
Diabetes				
Drug use				
Epilepsy				
Heart disease				
High cholesterol				
High blood pressure				
Kidney disease				
Multiple sclerosis				
Osteoporosis				
Parkinson's				
Thyroid concerns				
Tuberculosis				

Other Activities

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

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

Personal & Lifestyle

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 interests and hobbies? _____
What nurtures you? _____
What do you worry about most in life? _____

Do you have a religious or spiritual practice? _____
Are there any ethical/religious/cultural considerations I should be aware of? _____

Do you take time for movement/exercise? Y N If yes, 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? _____

What is the level of stress you are currently experiencing? _____
Please list the major causes of stress for you: _____
How do you cope with stress? _____
Are there any significant or life changing situations or events you would like to share with me?

_____

_____

_____

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

Are you currently, or have you in the past, worked with a counselor/therapist/psychologist/social worker _____

_____

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

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

How do you learn: read listen visual stories

Sexual and Reproductive Health

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

Sexual orientation: _____

Barrier and/or contraceptive methods you are using: _____

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: _____

Symptoms before your period: _____

Number of pregnancies _____ Live Births _____ Miscarriages _____ Abortion _____

Have you had any fertility concerns? Y N Do you know if you ovulate? _____

Do you get regular PAPs? Y N Any abnormal findings? Y N _____

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

Have you been diagnosed with: Endometriosis Fibroids Ovarian cysts Fibrocystic breasts Yeast infections

Digestion

How would you describe your digestion? _____

How often do you have a bowel movement? _____

Do you have any dietary restrictions I should be aware of _____

Do you currently experience, or have a history of, the following

gas bloating diarrhea constipation blood in stool undigested food black stools strong odor

reflux fullness after a meal rectal itching parasites hemorrhoids canker sores

Have you traveled outside of Canada in the last couple of years? _____

Have you been camping in the last year? _____

Musculoskeletal

Do you have muscle and joint aches and pains? Y N If yes, 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? Y N Have you had any falls or injuries to your head or tailbone? _____

Environment

Is your home damp or moldy? Y N Are there animals in your home? Y N

How is your home heated: gas electric wood

Are you sensitive to strong scents (perfume, gas, tobacco)? _____

Are you exposed to toxic materials (home, work, hobbies)? _____

Do you smoke or are you exposed to secondhand smoke? Y N

How many mercury fillings do you have? _____ Have you had a root canal? _____

Have you ever been bitten by a tick or spider? Y N

Is there anything else you feel I should know?

_____

_____

_____

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

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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 my appointment 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 released to others without my consent or unless required by the law.

- 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 who the practitioners are and the treatments. I understand it is my responsibility to disclose changes in my condition(s), symptoms, contact information, or treatments (change in medication or supplements) between appointments. I will advise Dr Joshi if I am pregnant, suspect I am pregnant, or am breastfeeding.

- During your appointment, a thorough medical and health history will be taken, and a concern-oriented physical exam may be done. A number of different modalities may be used throughout the treatment process. These include: diet and nutritional counseling, supplementation, homeopathy, herbal medicine, traditional Chinese medicine, hydrotherapy, 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, please 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 treatment modalities of your health plan, discontinue it and call or email Dr. Joshi to inform her of what has occurred.

- I agree to pay the full account at the time of each appointment for services, cost of supplements/remedies (that may be recommended as part of therapeutic protocols - if I choose to purchase them at the clinic dispensary), or lab tests. I am aware that all fees are not covered by MSI.

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

I _____ (**Print Name**) have read and understand the policies and information stated above. I 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

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

Initial Appointment - Adult	60 – 90 Minutes	$215
Follow up Appointment - Adult	30 - 45 Minutes	$130
Initial Appointment - Pediatric	Up to 60 Minutes	$165
Follow up Appointment - Pediatric	30 – 45 Minutes	$115
Initial Appointment – Student/Senior	60 – 90 Minutes	$200
Follow up Appointment – Student/Sr	30 – 45 Minutes	$115
Acute Appointment	Up to 15 Minutes	$65

Payment is due at the time of the appointment.

We will provide an official receipt that you can submit to your extended health insurance plan.

Naturopathic appointments are not covered by MSI.

Scheduling of an appointment reserves the time specifically for you. To respect the time of Dr Joshi and to offer availability to a patient who may want that appointment time, we kindly ask for **24 hours notice** to reschedule or cancel your appointment.

In the absence of 24 hours notice, or in the case of a missed appointment, the **full fee** of the appointment will be charged. Please note: This fee cannot be charged to insurance plans.

In unforeseen circumstances - emergency, illness, or bad weather, certain considerations will be made by your naturopathic doctor at their discretion.

If you need to cancel or reschedule your appointment, please call 902-406-0100.

I have read and agree to the above fee and cancellation policy.

_____ _____

Signature of patient Date