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!

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

<u>Fee Schedule and Cancellation Policy</u>

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

Initial Appointment - Adult	Up to 90 Minutes	$215
Follow up Appointment - Adult	Up to 45 Minutes	$120
Initial Appointment - Pediatric	Up to 60 Minutes	$165
Follow up Appointment - Pediatric	Up to 45 Minutes	$110
Initial Appointment – Student/Senior	Up to 90 Minutes	$200
Follow up Appointment – Student/Sr	Up to 45 Minutes	$110
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 **<u>24 hours notice</u>** 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. <u>Please note</u>: 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