SAGE ELEMENTS
NATUROPATHIC CLINIC

Dr. Colin J.L. Huska, ND
5991 Spring Garden Road, Suite 465
Halifax, NS B3H 1Y6
Phone: 902-406-0100

PATIENT INTAKE FORM

General Information **Date**: ________________________________

Name: ____ **Age:** ______ **Date of Birth:** _____________________
Last First Initial Day/Month/Year

Address: ____

City: ___________________ **Province**: _____________________ **Postal Code**: ___________________

Phone: **Home**: ________________________ **Cell:** ________________________ **Business**: ________________________

Email: ________________________________ **Can messages be left confidentially?** Y__ N__

Sex: Male __ Female__ **Gender**: ___________________ **Marital status**: ________________________

Occupation: ___________________________________

Medical Doctor: ________________________ **Date of last physical exam:** _______________ **Blood tests done**?Y__ N__

How did you find out about the clinic? ____

Emergency Contact

Name: _________________________________ **Relation to you:** __________________________

Phone: _________________________________

General Intake

What is your main reason for coming in today?

____

____

List in order of importance other health problems that are troubling you:

1. _______________________________________ Length of Time: ________________
2. _______________________________________ Length of Time: ________________
3. _______________________________________ Length of Time: ________________
4. _______________________________________ Length of Time: ________________

What kind of conventional treatment have you received?

____

Have you ever seen a: (check all that apply)

Naturopathic Doctor __ Chiropractor __ Acupuncturist __ Massage Therapist __ Other? ________________

Osteopath

Current Medications (please list dosage)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Nutritional Supplements (please list dosage)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Please list the five most significant stressful events in your life:

1. ____ Date: ______________
2. ____ Date: ______________
3. ____ Date: ______________
4. ____ Date: ______________
5. ____ Date: ______________

Are you currently working with a professional counselor, psychologist, social worker or therapist? Y__ N__

Have you in the past? Y__ N__ When? ____

<u>**Past Medical History**</u>: Which conditions do you have now (N) or in the past (P)

	N	P		N	P		N	P		N	P
Allergies			Weight problems			Stroke			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/tingling		
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					
Sinusitis			Jaundice			Parasites					
Canker sores			Hepatitis			Rectal bleeding					
Acne			Heart disease			Herpes					
Tonsillitis			Alcoholism			Headaches					

Do you have any specific allergies? Y__ N__

Please List: ____

Have you had any major injuries? Y__ N__
If yes, please explain:

____

____

Have you had previous surgeries or hospitalizations? Y__ N__
If yes, please explain: (include dates if known):

____

____

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

____

Family History: please indicate who, if anyone, is dealing with the following conditions in your family

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

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 _____________________________
Tobacco _____________________________
Coffee _____________________________
Hormones _____________________________

Laxatives _____________________________
Sedatives _____________________________
Antacids _____________________________
Cortisone _____________________________

Recreational drugs (please specify) ____

What do you enjoy most in life? ____________________

What are your main interests and hobbies? ____________________

What do you worry most about in life? ____________________

What nurtures you? ____________________

Do you have a religious/spiritual practice? ____________________

Do you exercise? Y__ N __ **If so, what do you do?** ____________________

How would you rate the quality of your sleep? ____________________

Do you have troubles falling or staying asleep? ____________________

How many hours of sleep do you get per night? _________ **How many do you feel you need?** ____________

Do you nap or rest during the day? _______________

How would you describe your energy? _______________________

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?** ____________________

<u>Female</u>

Age of first menses: _______ **If periods have stopped, age at which they did so:** __________

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__

Premenstrual symptoms: ____________________

Number of pregnancies? ________ **Live Births?** ________ **Miscarriage?** _________ **Abortion?** _________

Have you had any fertility concerns? Y__ N__

Do you have or have a history of venereal disease? Y__ N__ **If so, which one(s)?** ____________________

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 had: Endometriosis ___ Fibroids ___ Ovarian cysts ___ Fibrocystic breasts ___

Male

How often do you get up at night to urinate? _______ **Has this number changed?** Y__ N__

Do you have difficulty: achieving an erection ___ maintaining an erection ___ (Check which 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?** ____________

Digestion

How would you describe your digestion? ___________________________________

How frequently do you have a bowel movement? ________________________

Any history of: (check all that apply)

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

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__

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? Y__ N__ **Do you smoke or are you exposed to second hand smoke?** Y__ N__

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

Is there anything else you feel I should know?

____

____

____

____

____

Thank you for filling out this lengthy questionnaire!

SAGE ELEMENTS
NATUROPATHIC CLINIC

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.

- Information revealed during counseling and discussion sessions is strictly confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others, and where there is reasonable suspicion of emotional, physical and/or sexual abuse of a minor. Your record and the information within will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.

- Naturopathic medical treatments are in no way meant to replace conventional medical care or care from another licensed health practitioner. Please let your naturopathic doctor know if you are being treated by other health care providers. It is your responsibility to disclose changes in your condition, symptoms, contact information or treatments between visits.

- Naturopathic medicine uses non-invasive methods for the assessment of bodily dysfunction and the use of natural therapeutics for their correction. This may include: physical examination, nutrition, supplementation, homeopathy, botanical medicine, acupuncture/traditional Chinese medicine, hydrotherapy, detoxification techniques, bodywork, counseling, and lifestyle modifications. If at any time the patient wishes to discontinue a particular therapy/treatment they are free to do so.

- The treatment plan will be explained to you, as well as potential side effects 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 other doctor(s), 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 your doctor and the naturopathic clinic to inform them 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 treatment. My questions, if any, were answered to my satisfaction.

______________________________ ___________________

SIGNATURE of patient or guardian Date

Fee Schedule and Cancellation Policy

FEE SCHEDULE

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

Initial Visit - Adult	Up to 90 Minutes	$215
Initial Visit – Student/Senior (>65yo)	Up to 90 Minutes	$190
Initial Visit - Child (<12yo)	Up to 60 Minutes	$165
Subsequent – Adult Subsequent	Up to 45 Minutes	$120
Subsequent - Student/Senior/Child	Up to 45 Minutes	$105
Emergency/Acute Visit	Up to 15 Minutes	$65
Acupuncture Visit	Up to 45 Minutes	$120

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 by MSI, 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 in other forms of medicine. 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.

At this time, we are unable to provide reminder calls. As such, should you need please feel free to call the clinic to confirm your appointment time.

During unusual circumstances, 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.

________________________________ ______________________________

Name/Signature Date