Northshore
Naturopathic Clinic

156 West 3rd Street
North Vancouver, BC V7M 1E8
T: 604.986.7774 F: 604.986.3926
www.eatingalive.com

Naturopathic Intake Form

All information is completely confidential.

PERSONAL INFORMATION

Name: _____ Age: _____ Gender: _____

Home Address: _____ DOB (MM/DD/YYYY): _____

City/Province: _____ Occupation: _____

Postal Code: _____ Medical Doctor: _____

Home Phone: _____ PHN: _____

Email: _____ Referring Practitioner: _____

(to receive appointment reminders)

Emergency Contact: _____ Phone: _____

PAST MEDICAL CARE

Have you received Naturopathic Care previously? ☐Yes ☐No When: _____

Name of Naturopathic Physician: _____

For what reason? _____

PRIMARY HEALTH CONCERNS *(please list in order of importance to you)*

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

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MEDICATIONS AND SUPPLEMENTS

Please list all of your present medications including drugs, prescription medications, supplements, homeopathic and herbs along with dosages.

Medication	Dosage	Reason for Taking	Start Date

CURRENT MEDICAL CONTEXT

Do you have any known ***life threatening*** Allergies? ☐Yes ☐No _____

Do you have any contagious diseases at this time? ☐Yes ☐No _____

List all allergies, intolerances and sensitivities: _____

_____

_____

Are you currently pregnant? ☐Yes ☐No Number of Weeks: _____

LIFESTYLE

Stress and Relaxation:

On a scale of 1 to 10 (where 1 is the lowest and 10 is the highest), where would you rate your overall stress levels?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How well do you handle these stresses? ☐ Poorly ☐ Fairly ☐ Well ☐ Very well

On a scale of 1 to 10 (where 1 is the lowest and 10 is the highest), where would you rate your overall energy levels?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Sleep:

Do you have trouble falling asleep? ☐Yes ☐No Do you have trouble staying asleep? ☐Yes ☐No

Do you wake up feeling rested? ☐Yes ☐No How many hours of sleep/night? _____

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Please check the appropriate box for any of the following symptoms which you now have, or have had previously. If symptom does not apply, please leave blank.

Mild	Moderate	Severe	
			General
☐	☐	☐	Easily fatigued
☐	☐	☐	Nervousness / anxiety
☐	☐	☐	Failing memory
☐	☐	☐	Easily stressed
☐	☐	☐	Mood swings
☐	☐	☐	Difficulty concentrating
☐	☐	☐	Irritability / restlessness
☐	☐	☐	Mental confusion
☐	☐	☐	Night sweats
☐	☐	☐	Mental slowness
☐	☐	☐	Depression / suicidal thoughts
☐	☐	☐	Flushing / get hot easily
☐	☐	☐	Insomnia
☐	☐	☐	Excessive thirst
☐	☐	☐	Other: _____
			Skin
☐	☐	☐	Dry, rough, scaly, itchy skin
☐	☐	☐	Rashes, hives
☐	☐	☐	Warts
☐	☐	☐	Recent / changes in moles
☐	☐	☐	Light/dark patches of skin
☐	☐	☐	Pimples / acne
☐	☐	☐	Loss of hair
☐	☐	☐	Nails: colour changes, ridges, pits or white spots
☐	☐	☐	Other: _____
			Head
☐	☐	☐	Dizziness
☐	☐	☐	Severe headaches
☐	☐	☐	Seizures, convulsions
☐	☐	☐	Double vision
☐	☐	☐	Loss of balance / fainting spells
☐	☐	☐	Other: _____
			Nose / Ears / Eyes
☐	☐	☐	Nose bleeds
☐	☐	☐	Sinus congestion
☐	☐	☐	Loss of smell
☐	☐	☐	Excessive ear wax
☐	☐	☐	Hearing problems
☐	☐	☐	Sensitivity to noise
☐	☐	☐	Pain in ears
☐	☐	☐	Ringing in ears
☐	☐	☐	Corrected Vision
☐	☐	☐	Blurred / Double vision
☐	☐	☐	Dry eyes, nose, mouth
☐	☐	☐	Other: _____

Mild	Moderate	Severe	
			Mouth / Throat
☐	☐	☐	Grinding of teeth
☐	☐	☐	Speech difficulties
☐	☐	☐	Bleeding gums
☐	☐	☐	Loss of teeth
☐	☐	☐	Cold sores, blisters
☐	☐	☐	Silver/mercury fillings (teeth)
☐	☐	☐	Persistent hoarseness
☐	☐	☐	Difficulty swallowing
☐	☐	☐	Loss of voice
☐	☐	☐	Chronic sore throat or pain
☐	☐	☐	Copious saliva
☐	☐	☐	Sore tongue / lips
☐	☐	☐	Other: _____
			Gastrointestinal
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Alternating const/diarrhea
☐	☐	☐	Strain at stool
☐	☐	☐	Hemorrhoids
☐	☐	☐	Black stool
☐	☐	☐	Blood in stool
☐	☐	☐	High/low # of bowel movement
☐	☐	☐	Vomiting blood
☐	☐	☐	Frequent or severe nausea
☐	☐	☐	Heartburn / indigestion
☐	☐	☐	Trouble swallowing
☐	☐	☐	Distress from fat/greasy food
☐	☐	☐	Bad breath / taste in mouth
☐	☐	☐	Shaky: better after sugar
☐	☐	☐	Cravings: sweets & alcohol
☐	☐	☐	Cravings: salt
☐	☐	☐	Irritable if miss meal
☐	☐	☐	Appetite increase / decrease
☐	☐	☐	Diet but fail to lose weight
☐	☐	☐	Eat but fail to gain weight
☐	☐	☐	Excessive belching
☐	☐	☐	Excessive lower bowel gas
☐	☐	☐	Stomach cramps, colic
☐	☐	☐	Abdominal bloat, distension
☐	☐	☐	Anorexia / bulimia
☐	☐	☐	Stomach / abdominal pain
☐	☐	☐	Yellow / jaundice
☐	☐	☐	Frequent vomiting
☐	☐	☐	Other: _____

Bowel movements: How often? _____
Is this a change? ☐ **Yes** ☐ **No**

Mild	Moderate	Severe	
			Respiratory
☐	☐	☐	Coughing up blood
☐	☐	☐	Chest pain when breathing
☐	☐	☐	Wheezing
☐	☐	☐	Difficulty breathing at night
☐	☐	☐	Chest congestion
☐	☐	☐	Excessive sputum (mucous)
☐	☐	☐	Shortness of breath
☐	☐	☐	Daily cough
☐	☐	☐	Other: _____
			Cardiovascular
☐	☐	☐	Chest pain on exertion
☐	☐	☐	Ankle or abdominal swelling
☐	☐	☐	Heart palpitations
☐	☐	☐	Varicose veins
☐	☐	☐	Numbness / tingling in arm/leg
☐	☐	☐	Heart murmur
☐	☐	☐	Slow heart beat
☐	☐	☐	Rapid heart beat
☐	☐	☐	Poor circulation
☐	☐	☐	Low blood pressure
☐	☐	☐	High blood pressure
☐	☐	☐	Other: _____
☐	☐	☐	Pacemaker
			Endocrine
☐	☐	☐	Unexplained weight loss / gain
☐	☐	☐	Cold / heat intolerance
☐	☐	☐	Cold hands and feet
☐	☐	☐	Fatigue
☐	☐	☐	Seasonal depression
☐	☐	☐	Increased thirst
☐	☐	☐	Increased hunger
☐	☐	☐	Other: _____
			Muscles / Joints
☐	☐	☐	Joint paint, stiffness, swelling
☐	☐	☐	Neck pain / stiffness
☐	☐	☐	Pain between shoulders
☐	☐	☐	Low back pain
☐	☐	☐	Muscle weakness
☐	☐	☐	Muscle cramps
☐	☐	☐	Arthritis
☐	☐	☐	Tremors (shaking / trembling)
☐	☐	☐	Numbness
☐	☐	☐	Paralysis
☐	☐	☐	Sciatica
☐	☐	☐	Specific area pain: _____
☐	☐	☐	Other: _____

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REVIEW OF SYSTEMS (CONT'D)

Lymphatic / Immune

Mild	Moderate	Severe	
☐	☐	☐	Painful / swollen lymph nodes
☐	☐	☐	Difficulty stopping bleeding
☐	☐	☐	Unexplained fever
☐	☐	☐	Bruising easily
☐	☐	☐	Wounds heal slowly
☐	☐	☐	Fluid retention
☐	☐	☐	Other: _____

Genito-urinary

Mild	Moderate	Severe	
☐	☐	☐	Pain on urination
☐	☐	☐	Blood in urine
☐	☐	☐	Bed-wetting
☐	☐	☐	Frequent urination
☐	☐	☐	Kidney stones
☐	☐	☐	Frequent infections
☐	☐	☐	Inability to hold / control
☐	☐	☐	Wake up to urinate
☐	☐	☐	Odd smell / color of urine
☐	☐	☐	Difficulty in starting urination
☐	☐	☐	Other: _____

Female Reproductive

Mild	Moderate	Severe	
☐	☐	☐	Lumps in breast(s)
☐	☐	☐	Nipple discharge
☐	☐	☐	Breast pain / tenderness
☐	☐	☐	Absent menstruation
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Irregular menstruation
☐	☐	☐	Painful menstruation
☐	☐	☐	Spotting between periods
☐	☐	☐	PMS
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Vaginal discharge
☐	☐	☐	Vaginal itching / burning
☐	☐	☐	Genital eruptions / sores
☐	☐	☐	Pelvic pain
☐	☐	☐	Pain during intercourse
☐	☐	☐	Low libido
☐	☐	☐	Difficulty conceiving
☐	☐	☐	Other: _____

Male Reproductive

Mild	Moderate	Severe	
☐	☐	☐	Testicular pain / swelling
☐	☐	☐	Testicular mass(es)
☐	☐	☐	Hernias
☐	☐	☐	Premature ejaculation
☐	☐	☐	Erectile dysfunction
☐	☐	☐	Discharge / sores
☐	☐	☐	Painful erection
☐	☐	☐	Low libido
☐	☐	☐	Other: _____

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Declaration and Informed Consent to Naturopathic Care

I would like to take this opportunity to welcome you to our clinic. As a naturopathic physician I will conduct a thorough case history, a physical exam, and may utilize specific blood and/or urinary laboratory reports as a part of the treatment work-up. I use supportive therapies such as nutrition counseling, botanical medicine, acupuncture, Chinese medicine, supplementation, bodywork, injections, IV therapy, homeopathy and lifestyle counseling to assist the body's innate healing capacity and to improve overall health and wellbeing.

Statement of Acknowledgement

Printed Name: _____

I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information provided is complete, accurate and inclusive of all health concerns including the risk to pregnancy and all medications, including over the counter drugs and supplements. **Slight** health risks of some naturopathic treatments include, but are not limited to: temporary aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture, muscle strains and spasms, and disc injuries from spinal manipulations.

I also recognize the following:

- Information revealed during the course of a visit is **strictly confidential**. Exceptions to this confidentiality include disclosure regarding intention to seriously harm myself or others, and where there is reasonable suspicion of emotional, physical and/or sexual abuse of a minor;
- A record will be kept of my visits. This record and the information provided **will not be disclosed** to others without Dr Rivet's consent, or unless compelled to by law to do so. I understand that I may look at my medical records at any time and can request a copy of them;
- I will be given the opportunity to discuss and ask questions regarding any treatment plan. I have the ability to **accept or reject this care** of my own free will and choice;
- Any treatment or advice provided to me is not mutually exclusive from any treatment I may now be receiving or may in the future receive from another licensed health care provider. I am at liberty to seek or continue medical care from a medical doctor or other licensed healthcare provider. I will inform Dr. Rivet of other treatments that I may be receiving concurrently, or plan to receive while following his treatment plan. I understand that results are not guaranteed.
- I understand that Dr. Rivet reserves the right to determine which cases fall outside their scope of practice, in which case, the **appropriate referral will be recommended**.

I consent to receive naturopathic treatment and I understand this consent is voluntary and may be revoked at any time.

Signature of Patient or Guardian: _____ Date: _____