Naturopathic Initial Intake: Adults

Please take a moment to fill out our online intake form before your visit. All information is kept completely confidential.

*** First Name:** _____

*** Last Name:** _____

Preferred Name: _____

Prefix / Title (circle):

Dr. Mrs. Ms. Miss Mr. Mx.

*** Email:**_____

Please provide at least one phone number. Your mobile number can be used to look up your account and receive text message appointment reminders.

Mobile Phone:_____

Home Phone:_____

Country: _____

Street Address:_____

City: _____

Province: _____

Postal / Zip: _____

Date: _____

Gender:_____

Refers to current gender which may be different than what is indicated on your insurance policies.

Sex (circle): Male Female X

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file.

Guardian: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Emergency Contact Relationship: _____

Family Doctor: _____

Family Doctor Phone (if known): _____

Family Doctor Email (if known): _____

Name of referring professional: _____

Referring professional phone (if known): _____

Referring professional email (if known):_____

How did you hear about us? Friend Physician / Specialist Online Ad Web Search Other

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Chief Concern	
Chief Concern	
Chief Concern	

Past Medical History

Current Medical Conditions	
Illnesses	
Surgeries/Hospitalizations	
Physical Trauma	
Mental Trauma	
Emotional Trauma	
Other	

Medications: Prescription (oral contraception, etc) & Non-Prescription (aspirin, antacids, etc)

Natural Supplements (include details if possible and duration)

Allergies

Seasonal	
Animal	
Food	
Medication	
Supplement	

Family History

Asthma	
Arthritis	
Autoimmune disease	
Birth defects	
Bleeding problems	
Cancer	
Diabetes	
Eating disorders	
Epilepsy	
Fertility challenges	
Gout	
Hay fever/allergies	
Heart problems	
Hypertension	
Hypercholesterolemia	
Kidney problems	
Mental disorders	
Multiple Sclerosis	
Obesity	
Osteoporosis	
Parkinson's	
Stroke	
Substance abuse	
Tuberculosis	
Thyroid problems	
Other	

Social

Relationships	
Children	
Smoking	
Alcohol/number of drinks	
Recreational drugs	
Sexual history	
Actively trying to conceive	

Energy

0 (none) 1 2 3 4 5 6 7 8 9 10 (best)

Mood

Hours of Sleep

0 1 2 3 4 5 6 7 8 9 10

Sleep Quality

0 (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Sleep disturbances

Circle yes or no to all that apply.

Difficulty falling asleep	YES	NO
Difficulty staying asleep	YES	NO
Not rested upon waking	YES	NO
Excessive hours	YES	NO
Difficulty waking	YES	NO
Recurrent nightmares	YES	NO
Sleepwalking	YES	NO

Stress

0 (no stress) 1 2 3 4 5 6 7 8 9 10 (most stressed)

Source(s) of Stress

How do you cope with stress?

24 hour diet recall
Please indicate portion sizes of food/drinks.

Appetite	
Cravings	
Aversions	

Breakfast	
Lunch	
Dinner	
Snacks	
Water	
Coffee	
Tea- black	
Tea- herbal	
Juice	
Wine/alcohol	
Other	

Exercise

Describe your activity level and frequency.

Personal Medical History

General

Fatigue	
Change in appetite	
Change in thirst	
Cravings	
Weight gain	
Weight loss	
Poor sleep	
Chills or fever	
Night sweats	
Sweat easily	
Lack of sweating	
Allergies	
Cancer	
Diabetes	

Skin & Hair

Dryness	
Rash	
Itching	
Eczema	
Psoriasis	

Acne	
Recent moles	
Hives or allergic reactions	
Loss of hair	
Thinning hair	
Dandruff	
Skin/Hair/Nails recently brittle &/or dry	
Loss of eyebrow hair	
Other skin/hair concerns	

Eyes Ears Nost & Throat

Eye pain/strain	
Eye discharge Blurry/impaired vision	
Cataracts	
Ear aches/infections	
Ringing in ears	
Vertigo or dizziness	
Sinus infections	
Post nasal drip or nasal obstruction	
Nosebleeds	
Loss of smell/taste	

Sores in mouth	
Mercury fillings	
Jaw pain/clicks	
Recurrent sore throat/tonsillitis	
Enlarged glands	
Enlarged thyroid	
Facial pain/tics	
Headaches	
Other EENT concerns	

Cardiovascular

Chest pain	
Palpitations	
High blood pressure	
Low blood pressure Heart attack	
Congestive heart failure	
Irregular heartbeat	
Pacemaker	
Artificial heart valve	
Stroke	
Fainting	
Varicose veins	

Deep leg pain	
Cold hands/feet	
Anemia	
Swelling of limbs	
Easy bruising	
Other cardiovascular concerns	

Respiratory

Difficulty breathing	
Shortness of breath	
Chronic cough	
Bronchitis	
Emphysema	
Asthma	
Wheezing	
Coughing blood	
Phlegm in throat	
Exposure to lung irritants	
Other respiratory concerns	

Muscle Bone & Joints

Neck pain	
Back pain	

Shoulder pain	
Arthritis	
Bursitis	
Joint pain or stiffness	
Artificial joint	
Muscle pain	
Muscle weakness	
Injury or motor vehicle accident	
Surgery	
Other concerns	

Gastrointestinal

Nausea	
Vomiting	
Vomiting blood	
Reflux or heartburn	
Constant hunger	
Loss of hunger	
Ulcer	
Indigestion	
Gall stones	
Liver disease	

Jaundice	
Intestinal parasites	
Constipation	
Diarrhea	
Chronic laxative use	
Rectal burning/pain	
Hemorrhoids	
Blood in stool (red or black)	
Other gastrointestinal concerns	

List how many bowel movements you have in a day?

Neurological

Anxiety	
Depression	
Irritability	
Emotional problems	
Loss of balance	
Poor memory or concentration	
Dizziness	

Seizures/epilepsy	
Concussion	
Lack of coordiation	
Extremity numbness/tingling	
Paralysis	
Other neurological concerns	

Immunity

Repeated infections	
Difficulty healing	
Increased allergies	
Strep throat past or current infection	
Mononucleosis past or current infection	
Tuberculosis past or current infection	
Hepatitis past or current infection	
HIV/AIDS exposure	
Vaccination reactions	
Repeated or long-term antibiotic use	

Urinary

Frequent urination	
Urgency to urinate	

Incontinence	
Pain on urination	
Waking at night to urinate	
Urinary tract infection	
Blood in urine	
Kidney stones	
Pain in back, flank or groin	

Tell us about your Menstrual cycle

Menstrual History

Cramping	
Irritability	
Anxiety	
Mood swings	
Low mood	
Bloating/water retention	
Headaches	
Breast tenderness	
Cravings	
Low back pain	

Clotting	
Fibrocystic breasts	
Heavy flow	
Light flow	
Weight gain in waist	
Weight gain in hips	
Fibroids	
Cysts	
Oily skin	
Foggy thinking	
Fatigue or drowsiness	
Increased facial hair	
Bone loss	
Vaginal dryness	
Decreased sex drive	
Incontinence	
Loss of scalp hair	
Fertility challenges	
Abnormal Pap tests	
Vaginal discharge	
Vaginal itching	
Nipple discharge	

Men's Health.

Hernia	
Testicular mass or pain	
Low sex drive	
Discharge or sores	
Impotence or erectile dysfunction	
Difficulty with urination and/or frequent urination	
Night-time urination	
Prostate condition	
Prostate exam/bloodwork done in past	
Infertility	

Context of Care & Expectations

Why did you choose to come to our clinic?

What expectations do you have from your time here?

How committed are you to addressing underlying causes of your symptoms?

What obstacles to you foresee in your future healing?

COVID-19 screening

Have you experienced any of the following symptoms? Circle any that apply.

Fever
Cough (new)
Changes to a chronic cough (worsening)
Sore Throat
Runny nose
Nasal/Sinus congestion
Shortness of breath
Chills
Malaise/unexplained fatigue
Sudden onset diarrhea

Have you travelled internationally within the last 14 days?
No Yes

Have you travelled domestically in the last 14 days by plane?
No Yes

Has the patient had contact with individuals with a confirmed or presumptive diagnosis of COVID-19?
No
Yes (explain details of contact - were they wearing PPE? Etc.)

Have you had contact with anyone with cold/flu symptoms?
No Yes

Additional concerns or considerations

If the answer to any of these questions is "Yes" the patient should be advised to self isolate and call HealthLink at 811.

Dr. Ann-Marie Regina, ND
www.drannmarieregina-nd.com
https://massageconnection.ca
289-600-6110

Consent

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

*I would like email notifications of new, cancelled, and rescheduled appointments
Email 36 hours before appointment **AND/OR** Text Message (SMS) 24 hours before appointment

News and Special Promotions

Yes, I would like to receive news and special promotions by email.
No, I would not like to receive news and special promotions by email.

Accuracy of Information

*** I certify that the above medical information is correct to my knowledge.**
***Yes**

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

*** I agree**
*** I disagree**

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

*** I am aware of the Cancellation Policy**

Email Communication

I understand that I may have the option of communicating with the naturopathic doctor via email. I understand that my naturopathic doctor cannot provide medical advice, make treatment

recommendations or address health concerns via email, and that these must be addressed by making an appointment. Email may be used to clarify existing treatment protocols should you have any questions.

I understand the risks associated with communicating by email and understand that in-person verbal communication is the most secure method of communication.

For a naturopathic initial consult, Dr. Ann-Marie Regina, ND will take a case history to understand your current and past health, as well as your current health goals. Relevant physical exams may be performed.

*** I understand**

Naturopathic Fees

* I acknowledge the posted fees at https://massageconnection.ca/treatments

* I understand that naturopathic medicine is not covered by OHIP.

* I understand

Health Risks

*There are slight health risks associated with naturopathic treatment such as an allergic reaction to or side effects from a supplement and/or herb. I understand that my naturopathic doctor will inform me of the risks associated with my specific treatment plan.

I will give my naturopathic doctor full and accurate information about my health, medications and supplements, illnesses and allergies. I will notify my naturopathic doctor if I am pregnant, suspect I am pregnant or am breast-feeding.

I understand that I must let me practitioner know if I am carrying, or believe to have any infectious agents/illnesses, including but not limited to HIV, tuberculosis and hepatitis. In some cases where cross infection is high, my practitioner may withhold treatment.

*** I understand**

Informed Consent

As a patient, you receive information about your diagnosis, treatment, available reasonable alternatives, associated costs, expected benefits, risks, any side effects, and in each case the consequences of not having the treatment.

I understand that treatment results are not guaranteed. I understand that not all risks and complications can be foreseen and I will advise my naturopathic doctor immediately if I experience any adverse reactions.

I understand that in some cases, my symptoms may temporarily worsen before they begin to improve.

I understand that the naturopathic doctor has not suggested or recommended me to refrain from following or seeking the advice of another health care provider.

I understand that I have the right to withdraw consent at any time and for any reason.

*** I understand**

Virtual Care

We offer virtual consultations which involve the use of electronic communications to allow us to provide patient care. The virtual provision of our services allows us to use information gathered electronically for diagnosis, therapy and follow-up and/or education. As with any medical procedure, there are potential risks associated with virtual consultations. We use our best efforts to ensure that your personal and confidential information is kept securely and our electronic systems will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the date and to ensure its integrity against intentional or unintentional corruption. However, by agreeing to receive our services virtually you acknowledge and agree that:

1. In rare cases, information transmitted may not be of sufficient quality to allow for appropriate therapeutic decision making;
2. Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
3. In rare cases, security protocols could fail, causing your personal information to be accessed by third parties;
4. We cannot guarantee the availability of virtual consultations which may become unavailable due to system backup procedures, Internet traffic volume, upgrades, overload of requests to the servers, general network failures or delays, or any other cause which may from time to time make our virtual services inaccessible to you.

*** I understand**

Signature

Date

Witness
