

# Patient Intake

(please print clearly)

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of birth \_\_\_\_\_ (mm/dd/yy) Sex M F

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

E-mail Address: \_\_\_\_\_

Telephone number: Home: \_\_\_\_\_ Work: \_\_\_\_\_

May we leave messages relating to your visits? Y / N

Emergency contact: Name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Relation: \_\_\_\_\_

How did you hear about our Clinic: \_\_\_\_\_

Other health care providers you are seeing (Name and Profession):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your health concerns, in order of importance to you:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO  
YOUR 1<sup>ST</sup> APPOINTMENT**

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your licensed Naturopathic Doctor will take a thorough case history, will perform when appropriate a screening physical examination, including a urine sample and breast exam when indicated, and may request that bloodwork or further laboratory testing be performed. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your naturopath immediately.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.
- Muscle strains and sprains, disc injuries from spinal manipulation.
- The potential for stroke is a concern in neck manipulation, but tests will be done to screen for this possibility. Clinical research has shown that stroke-like occurrences are rare – approximately 1 in 1.5 million manipulations.

I understand that as a patient at this clinic, my identity will be protected at all times and if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the naturopath to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (Please Print) \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ N.D.: Erik Boudreau, N.D. Lic.#1270

# **PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION**

Privacy of your personal information is an important part of our Clinic, while providing you with quality Naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

In this Clinic, Erik Boudreau, ND acts as the Privacy Information Officer regarding Naturopathic care.

All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our Clinic is doing to ensure that:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy

## **How Our Clinic Collects, Uses, and Discloses Patients’ Personal Information**

Our Clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our Clinic is using and disclosing your information.

This Clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care, and billing
- To complete claims for information purposes

- To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the *Drugless Practitioners Act / Naturopathy Act*
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this Clinic to comply with all regulatory requirements
- To comply generally with the law
- To allow potential purchasers, practice brokers, or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information as outlined above.

### **Patient Consent**

I have reviewed the above information that explains how your Clinic will use my personal information, and the steps your Clinic is taking to protect my information.

I agree that Erik Boudreau, ND can collect, use, and disclose personal information about (patient name) \_\_\_\_\_ as set out above in the information about the Clinic's privacy policies.

\_\_\_\_\_  
signature

\_\_\_\_\_  
print name

\_\_\_\_\_  
date

- Y A condition you have now  
 N A condition you have NEVER had  
 P A condition you have had in the past

Responses and Comments:

1. GENERAL				
Weight				
Weight 1 year ago				
Maximum weight (not including pregnancy)				
When				
Height				
Fatigue/Weakness	Y	P	N	
Fever/Chills	Y	P	N	

2. SKIN				
Rashes	Y	P	N	
Eczema, hives	Y	P	N	
Acne, boils	Y	P	N	
Itching	Y	P	N	
Colour change	Y	P	N	
Lumps	Y	P	N	
Night sweats	Y	P	N	
Dryness/Moistness	Y	P	N	
Temperature	Y	P	N	
Nail changes	Y	P	N	
Change in Mole Size/Shape/Colour	Y	P	N	
Skin Cancer	Y	P	N	

3. HEAD				
Headache	Y	P	N	
Head injury	Y	P	N	
Dizziness	Y	P	N	

4. EYES				
Impaired vision	Y	P	N	
Glasses/Contacts	Y	P	N	
Eye pain	Y	P	N	
Tearing or dryness	Y	P	N	
Double vision	Y	P	N	
Glaucoma	Y	P	N	
Cataracts	Y	P	N	
Blurring	Y	P	N	
Bothered by sun	Y	P	N	
Itching	Y	P	N	
Redness	Y	P	N	
Discharge	Y	P	N	
Blind spot	Y	P	N	

<b>5. EARS</b>				
Impaired hearing	Y	P	N	
Earache	Y	P	N	
Dizziness	Y	P	N	
Discharge	Y	P	N	
Infections	Y	P	N	

<b>6. NOSE and SINUSES</b>				
Frequent colds	Y	P	N	
Nose bleeds	Y	P	N	
Stuffiness	Y	P	N	
Hay fever	Y	P	N	
Sinus problems	Y	P	N	

<b>7. MOUTH and THROAT</b>				
Frequent sore throat	Y	P	N	
Sore tongue/mouth	Y	P	N	
Gum problems	Y	P	N	
Hoarseness	Y	P	N	
Dental cavities	Y	P	N	
Loss of taste	Y	P	N	

<b>8. NECK</b>				
Lumps	Y	P	N	
Swollen glands	Y	P	N	
Goiter	Y	P	N	
Pain or stiffness	Y	P	N	

<b>9. RESPIRATORY</b>				
Cough	Y	P	N	
Sputum	Y	P	N	
Spitting up blood	Y	P	N	
Wheezing	Y	P	N	
Asthma	Y	P	N	
Bronchitis	Y	P	N	
Pneumonia	Y	P	N	
Pleurisy	Y	P	N	
Emphysema	Y	P	N	
Difficulty breathing	Y	P	N	
Pain on breathing	Y	P	N	
Shortness of breath	Y	P	N	
Shortness of breath at night	Y	P	N	
Shortness of breath lying down	Y	P	N	
Tuberculosis	Y	P	N	
Tuberculin Test	Y	P	N	
Last Chest X-ray				

<b>10. CARDIOVASCULAR</b>				
Heart disease	Y	P	N	
Angina	Y	P	N	
High blood pressure	Y	P	N	
Murmurs	Y	P	N	
Rheumatic fever	Y	P	N	
Chest pain	Y	P	N	
Swelling in ankles	Y	P	N	
Palpitations, fluttering	Y	P	N	
Cyanosis	Y	P	N	
Past ECG	Y	P	N	
Other heart tests				

<b>11. BREASTS</b>				
Do you do self exams?	Y	P	N	
Lumps	Y	P	N	
Pain (or tenderness)	Y	P	N	
Nipple discharge	Y	P	N	

<b>12. GASTROINTESTINAL</b>				
Trouble swallowing	Y	P	N	
Heartburn	Y	P	N	
Change in thirst	Y	P	N	
Change in appetite	Y	P	N	
Nausea	Y	P	N	
Vomiting	Y	P	N	
Vomiting blood	Y	P	N	
Bowel movements - How often?				
Is this a change?	Y		N	
Blood in stool	Y	P	N	
Belching or passing gas	Y	P	N	
Jaundice (yellow skin)	Y	P	N	
Liver disease	Y	P	N	
Gall Bladder disease	Y	P	N	
Ulcer	Y	P	N	
Indigestion	Y	P	N	
Diarrhea	Y	P	N	
Rectal bleeding	Y	P	N	
Hemorrhoids	Y	P	N	
Black, tarry stool	Y	P	N	
Abdominal pain	Y	P	N	
Food allergy	Y	P	N	
Hernias	Y	P	N	

<b>13. URINARY</b>				
Pain on urination	Y	P	N	
Increased frequency	Y	P	N	
Frequency at night	Y	P	N	
Inability to hold urine	Y	P	N	
Frequent infections	Y	P	N	
Kidney stones	Y	P	N	
Blood in urine	Y	P	N	
Urgency	Y	P	N	
Hesitancy	Y	P	N	

<b>14. MALE REPRODUCTIVE</b>				
Hernias	Y	P	N	
Testicular masses	Y	P	N	
Testicular pain	Y	P	N	
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal disease	Y	P	N	
Discharge or sores	Y	P	N	

<b>15. FEMALE REPRODUCTIVE</b>				
Age menses began				
Average number of days				
Length of cycle				
Bleeding between periods	Y	P	N	
Are cycles regular	Y	P	N	
Pain during intercourse	Y	P	N	
Painful menses	Y	P	N	
Excessive flow	Y	P	N	
PMS	Y	P	N	
Birth control?	Y	P	N	
What type?				
Number of pregnancies				
Number of live births				
Number of miscarriages				
Number of abortions				
Difficulty conceiving	Y	P	N	
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal Disease	Y	P	N	
Last menstrual period				
Vaginal discharge	Y	P	N	
Vaginal itching	Y	P	N	
Last PAP - (date)				

<b>16. MUSCULOSKELETAL</b>				
Joint pain or stiffness	Y	P	N	
Arthritis	Y	P	N	
Broken bones	Y	P	N	
Muscle spasms or cramps	Y	P	N	
Weakness	Y	P	N	
Joint swelling	Y	P	N	
Backache	Y	P	N	

<b>17. PERIPHERAL VASCULAR</b>				
Deep leg pain	Y	P	N	
Cold hands/feet	Y	P	N	
Varicose veins	Y	P	N	
Thrombophlebitis	Y	P	N	
Leg cramps	Y	P	N	
Extremity numbness	Y	P	N	
Extremity coldness	Y	P	N	
Extremity swelling	Y	P	N	
Extremity ulcers	Y	P	N	

<b>18. NEUROLOGIC</b>				
Fainting	Y	P	N	
Seizures/Convulsions	Y	P	N	
Paralysis	Y	P	N	
Muscle weakness	Y	P	N	
Numbness or tingling	Y	P	N	
Loss of memory	Y	P	N	
Involuntary movement	Y	P	N	
Loss of balance	Y	P	N	
Speech problems	Y	P	N	

<b>19. ENDOCRINE</b>				
Heat or cold intolerance	Y	P	N	
Thyroid trouble	Y	P	N	
Excessive thirst	Y	P	N	
Excessive hunger	Y	P	N	
Excessive urination	Y	P	N	
Excessive sweating	Y	P	N	
Diabetes	Y	P	N	
Hypoglycemia	Y	P	N	
Hormone therapy	Y	P	N	

<b>20. BLOOD/LYMPHATIC</b>				
Anemia	Y	P	N	
Easy bleeding or bruising	Y	P	N	
Past transfusions	Y	P	N	
Lymph node swelling	Y	P	N	

<b>21. ALLERGIC HISTORY</b>				
Drug sensitivity	Y	P	N	
Reaction to vaccine	Y	P	N	
Allergies? Please list				

<b>22. EMOTIONAL</b>				
Depression	Y	P	N	
Mood swings	Y	P	N	
Anxiety or nervousness	Y	P	N	
Tension	Y	P	N	
Phobias	Y	P	N	
Alcohol/Drug abuse	Y	P	N	
Insomnia	Y	P	N	

<b>23. HOBBIES/HABITS</b>				
Please answer the following YES (Y) or NO (N):				
Do you eat three meals daily?	Y	N		
Do you awake rested?	Y	N		
Do you sleep well?	Y	N		
Do you average 6-8 hours sleep?	Y	N		
Do you enjoy your work?	Y	N		
Do you watch television?	Y	N		
How many hours/day?				
Do you read?	Y	N		
Do you exercise?	Y	N		
What forms? _____				
How many times/week?				
Do you take vacations?	Y	N		
Have you been treated for drug dependence?	Y	N		
Do you use recreational drugs?	Y	N		
Do you use alcoholic beverages?	Y	N		
Have you been treated for alcoholism?	Y	N		
How often?				