Dr. Megan Parker, ND
It Starts With Nature Health Clinic

Adult Intake Form

Our professional association requires us to maintain contact information for our patient records. No information will be shared with any other individual or group without your expressed permission. E-mail will only be used by our office to inform you of our office events and will not be distributed for any other use.

First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Telephone (H) _____ (W) _____ (C) _____

E-mail _____

Date of Birth(MM/DD/YY) _____ Age_____ Sex _____ Marital Status _____

Occupation _____ Full or Part-time? _____ Shift work? yes ☐ no ☐

Emergency Contact _____ _____ _____

(Full name) (Relation) (Telephone)

How did you hear about our clinic? If referred please indicate from whom

_____

Name of Medical Doctor _____ Clinic _____ Telephone(___)_____

Date of last physical _____ Date of last lab tests _____

Saskatchewan Health Number:_____

Have you previously been treated by a Naturopathic Doctor? Yes ☐ No ☐

Name _____

When?_____

Other health practitioners you are seeing (including conventional & complementary practitioners). _____

_____

Health Concerns

What is your primary health concern? How long have you had this condition?

_____

_____

_____

What specialist(s) have you seen, if any? How has this condition been treated until now?

_____

_____

Please list all other health concerns or goals in order of importance to you and include the date when each particular health concern started, if possible.

1. _____
2. _____
3. _____
4. _____
5. _____

List any prescribed medications and doses you are currently taking:

Name:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List any over-the-counter medications, dietary supplements or herbs you are currently taking:

Name:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____

Health History

How do you rate your general state of health? ☐ Poor ☐ Fair ☐ Good ☐ Very good ☐ Excellent

How would you rate your energy level? _____ (from 1-10, **10 being highest)**

Do you wake up feeling refreshed? Y☐ N☐ If N, give details _____

How many cups/day do you drink of each of the following?

Coffee _____ Black Tea _____ Herbal Tea _____ add milk/cream?_☐_ Sugar? _☐__

Water _____ Pop _____ Juice_____

Do you smoke? N ☐ Y ☐ # per day_____ How many years? _____

In the past? Y ☐ Quit when_____

Do you drink alcohol? N ☐ Y ☐ Type_____# drinks per week___ In past but quit? Y ☐

Do you use recreational drugs? N ☐ Y ☐ In the past? Y ☐ What kind/how often? _____

Do you exercise? N ☐ Y ☐ Hours per week _____ Type of exercise _____

Do you watch TV? N ☐ Y ☐ Hours per week _____

Current/past illnesses, accidents, conditions and hospitalizations (include year of occurance):-

_____

_____

_____

List past prescription medications:_____

_____

Do you have any known allergies or intolerances? Please list: _____

_____

What is your height? _____ Current weight? _____ Max. wt? _____ Min. wt? _____

Has your weight changed lately? ☐ Lost / ☐ Gained / ☐ Neither If yes, how many pounds? _____

If female, are you currently pregnant? N ☐ Y ☐ Possible ☐ Breastfeeding? N ☐ Y ☐

Have you been vaccinated? N ☐ Y ☐ Did you have any adverse reactions? _____

What vaccines have you had recently? _____

Family History: Please list any diseases or conditions suffered by family members. If deceased, please include cause and age at death.

Mother _____

Father _____

Brother(s) _____

Sister(s) _____

Paternal grandmother _____

Paternal grandfather _____

Maternal grandmother _____

Maternal grandfather _____

Conditions to consider: autoimmune diseases, diabetes, heart disease, cancer, allergies, asthma, Crohn's or colitis, depression or mental illness, hypo/hyper thyroid, kidney disease, liver disease, stroke or aneurysm.

SYMPTOMS REVIEW

Please check (√) Y if you have the symptom now, and P if you had the symptom in the past.

SKIN	Y	P
Acne		
Boils		
Dry Skin		
Eczema		
Hives		
Itching		
Lumps		
Night sweats		
Psoriasis		
Rashes		
Other		

HEAD	Y	P
Dizziness		
Head Injury		
Migraine Headaches		
Tension Headaches		
Other		

EYE	Y	P
Blind spot Impaired visio		
Blurring		
Cataracts		
Discharge		
Double vision		
Dryness		
Eye Pain		
Glaucoma		
Impaired Vision		
Itching		
Light sensitive		
Redness		
Tearing		
Use of Contact lens		
Other		

EARS	Y	P
Discharge		
Dizziness		
Earache		
Excessive wax		
Impaired hearing		
Infections		
Other		

NOSE & SINUSES	Y	P
Frequent colds		
Hay fever		
Infections		
Nose bleeds		
Stuffiness		
Other		

MOUTH & THROAT	Y	P
Dental problems		
Difficulty swallowing		
Dryness		
Gum problems		
Hoarseness		
Loss of taste		
Sore throat		
Sores		
Other		

NECK	Y	P
Goiter		
Swollen Glands		
Pain or stiffness		
Lumps		
Other		

RESPIRATORY	Y	P
Asthma		
Bronchitis		
Cough		
Difficulty breathing		
Emphysema		
Pain on breathing		
Pleurisy		
Pneumonia		
Shortness of breath		
Shortness breath at night		
Shortness of breath when Laying down		
Spitting up blood		
Sputum		
Wheezing		
Positive tuberculin test		
Last chest X-ray:		
Other		

CARDIOVASCULAR	Y	P
Angina		
Chest pain		
Murmurs		
Palpitation, fluttering		
Swelling in ankles		
Last ECG:		
Other		

BREASTS	Y	P
Do you do breast self-exams?		
Lumps		
Nipple discharge		
Pain (or tenderness)		
Last mammogram:		
Other		

GASTROINTESTINAL	Y	P
Abdominal pain		
Belching		
Black, tarry stool		
Blood in stool		
Change in appetite		
Constipation		
Diarrhea		
Food allergy		
Gallbladder disease		
Heartburn		
Hemorrhoids		
Hiatus hernia		
Indigestion		
Jaundice		
Liver disease		
Nausea		
Passing gas		
Trouble swallowing		
Vomiting		
Last colonscopy:		
Other		

BLOOD/LYMPHATIC	Y	P
Anemia		
Easy bleeding/bruising		
Lymph node swelling		
Past transfusions		
Other		

ENDOCRINE	Y	P
Diabetes		
Excessive hunger		
Excessive sweating		
Excessive thirst		
Excessive urination		
Heat and cold intolerance		
Hormone therapy		
Hypoglycemia		
Thyroid trouble		
Blood Sugar		
Other		

EMOTIONAL	Y	P
Angry		
Anxiety		
Depression		
Drug abuse		
Insomnia		
Mood swings		
Nervousness		
Phobias		
Psychiatric care		
Psychological counseling		
Sexual difficulties		
Tension		
Other		

PEREPHERAL VASCULAR	Y	P
Cold hands/feet		
Deep leg pain		
Extremity numbness		
Extremity swelling		
Extremity ulcers		
Leg cramps		
Varicose veins		
Other		

FEMALE REPRODUCTIVE	Y	P
Age of first menses:		
Bleeding between periods		
Difficulty conceiving		
Excessive flow		
Hormone therapy		
Irregular cycles		
Last menstrual period:		
Length of cycle:		
Menopause		
PMS		
Painful menses		
Pain during intercourse		
Number of abortions		
Number of days of menses:		
Number of pregnancies:		
Number of live births:		
Number of miscarriages:		
Sexually active		
Sexual difficulties		
Vaginal discharge		
Vaginal itching		
Last gynecological exam:		
Last pap smear:		
Other		

NEUROLOGIC	Y	P
Fainting		
Involuntary movements		
Loss of balance		
Loss of memory		
Muscle weakness		
Numbness or tingling		
Paralysis		
Seizure/convulsions		
Speech problems		
Other		

URINARY	Y	P
Blood in urine		
Frequent infections		
Inability to hold urine		
Increased frequency		
Frequency at night		
Kidney stones		
Pain on urination		
Reduced urine flow		
Other		

MALE REPRODUCTIVE	Y	P
Discharge of sores		
Hernia		
Impotence		
Premature ejaculation		
STD		
Testicular masses		
Testicular pain		
Sexually active		
Last prostate exam:		
Past PSA level:		
Other		

MUSCULOSKELETAL	Y	P
Backache		
Broken bones		
Joint swelling		
Muscle spasms/cramps		
Weakness		
Other		

Glucose Control	Y	N
Blood Sugar		
Fatigue after eating		
Hunger headaches		
Hunger irritability		
Skin crawling sensations		
Symptoms from food		

TREATMENT GOALS

What is your motivation for making this appointment? _____

_____

What goals do you hope to achieve during your treatment?

1. _____
2. _____
3. _____

Is there anything that you feel is important that has not been covered? _____

_____

_____

Appointment Policy

Appointment times missed without notification will be charged half the price of the appointment fee if prior notice of cancellation is not given. We often have patients on standby lists that may need that appointment time. **Please allow 24 hours notice to cancel a follow up appointment.**

Informed Consent

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors 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 visit may consist of a thorough case history and a screening physical examination.

It is important that we are informed of any diseases that you are suffering from and if you are on any medication or over the counter drugs. If you are pregnant, suspect that you are pregnant, become pregnant or are breast-feeding, please let us know immediately.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

There are some slight health risks associated with 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 acupuncture; fainting or puncturing of an organ with acupuncture needles. Results are not guaranteed and not all risks and complications can be anticipated and explained.

I understand:

- The clinic does not guarantee treatment results.
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- I am free to withdraw my consent and to discontinue treatment at any time.

By signing the intake form, you are agreeing to the above terms.

Patient Name (please print): _____

Signature of Patient or Guardian: _____ Date: _____

Diet Diary:

Please complete the following 4-day diet diary prior to your visit. The diet diary provides the Naturopathic Doctor with essential information and is a key component in receiving an assessment. The days you record need not be in sequential order, however you should include at least one day from the weekend. Most importantly, be sure the information you provide is ACCURATE and representative or your TYPICAL DIET.

*Include: What and how much was consumed (eg. cup, tsp, etc) for breakfast, lunch, supper and snacks, as well as any condiments.

Any additional information:

WE ARE A SCENT-FREE CLINIC. PLEASE REFRAIN FROM WEARING ANY SCENTED PRODUCTS THE DAY OF YOUR APPOINTMENT.