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# ADULT INTAKE FORM

***Please note that all information disclosed is confidential and will not be released without your permission.***

DATE: ___________________________

Name: _________________________________________ Date of Birth: __/__/___
Last, First d m y

Address:

_______________________________________________________________________________
Street City Province Postal Code

Telephone Home: (___) __________Work Phone: (___) _________ Mobile: (___) __________________

Email: ______________________________ preference for method of contact? ________________

Would you like to receive email reminders about your future appointments? ______

**Emergency Contact:**

Name _________________________ Relationship ____________ Phone (___)____________

How did you hear about this office? ________________________________________________

**HEALTH CONCERNS IN ORDER OF IMPORTANCE TO YOU:**

| CONCERN | SINCE | CAUSES |
|---|---|---|
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| | | |
| | | |

**GENERAL STATE OF HEALTH AS:** (good, fair, poor)

Child ______________________________

Adolescent ______________________________

Adult ______________________________

**PLEASE CIRCLE ANY CONDITIONS THAT YOU HAVE HAD.**

| | | | | |
|---|---|---|---|---|
| Heart Disease | Thyroid Disease | Diabetes | Sexual Abuse | Asthma |
| High Blood Pressure | Cancer | Kidney Disease | Epilepsy | Sinusitis |
| STI's | Arthritis | Tuberculosis | | Hay Fever |
| Alcoholism | Stroke | Hepatitis | Cold Sores | |
| Psychiatric Disorders | Familial Disorders | Gall Stones | Herpes | Mononucleosis |
| Depression | Gout | Rubella | Diphtheria | Polio |
| Scarlet Fever | Measles | Mumps | Chicken Pox | Whooping Cough |

**IMMUNIZATIONS**

Have you had childhood vaccines? ______________ Do you get the flu vaccine? _____________

Have you had any unusual reactions to vaccinations? ______________________________________
_____________________________________________________________________________________

**LIST ANY ACCIDENTS, INJURIES OR HOSPITALIZATIONS** ______________________
_____________________________________________________________________________________

**PLEASE CIRCLE THE FOLLOWING CONDITIONS THAT HAVE AFFECTED YOUR RELATIVES (i.e. children, siblings, parents, grandparents).**

| | | | |
|---|---|---|---|
| Liver disease<br>Heart disease<br>Psychiatric Disorders<br>High Blood Pressure | Respiratory<br>Asthma<br>Allergies<br>Tuberculosis<br>Autoimmune | Thyroid<br>Alzheimer's<br>Osteoporosis<br>Stroke<br>Arthritis | Blood Diseases<br>Cancer<br>Kidney disease<br>Diabetes<br>Bowel disease |

**CURRENT HEALTH HISTORY: (Circle and date of most recent)**

SCREENING TESTS:

Pap smear
Breast exam
Mammogram

Colonoscopy
Bone density
Prostate exam

**ALLERGIES:** Medications: ______________________________________________________
Food: ______________________________________________________
Environment: ________________________________________________
Other: _____________________________________________________

**DIET**
Diet Restrictions: _______________________________________________________

Intolerances: __________________________________________________________

Any symptoms experienced after eating: ____________________________________________
______________________________________________________________________

Recent Weight Gain or Loss? _______________________________________________

**Environmental Hazards**? At Home ________________ At Work ______________________

**MEDICATIONS and SUPPLEMENTS:**
MEDICATIONS: Current use: _________________________________________________
______________________________________________________________________

Over the counter medications: ______________________________________________

Supplements, Herbal remedies and Homeopathic remedies: ____________________________
______________________________________________________________________

Tobacco, Alcohol, Caffeine: _________________________________________________

Recreational Drug use: _____________________________________________________

**EXERCISE AND LEISURE ACTIVITIES:** _____________________________________
______________________________________________________________________

**SLEEP PATTERN:**

1. Hours per night _________
2. Quality: Excellent ( ), Good ( ), Fair ( ), Poor ( )

**PERSONAL / SOCIAL HISTORY**
(Occupation, family structure and relationships, stresses and outlook on life)
______________________________________________________________________

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**ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN OR HEALTH CARE PRACTITIONER(S)?**

| Physician/Health Care Practitioner | For what condition? | Treatment(s) |
|---|---|---|
| | | |
| | | |
| | | |

**Consent Form**

In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your cooperation in signing this statement of acknowledgement. In doing so you understand that:

- You are at liberty to seek or continue medical care from a physician or surgeon or other healthcare provider.
- Cathleen MacDonald ND is not suggesting or recommending that you refrain from seeking or following the advice of another licensed healthcare provider.
- The treatment and therapies rendered or recommended by this office may be different than those usually offered by a medical doctor or other licensed healthcare provider.
- The ultimate responsibility for your health care is your own, and Cathleen MacDonald, ND is here to support you in this.
- While changes in dietary habits are not an absolute pre-requisite for treatment, failure to follow sound nutritional, exercise and lifestyle programs could undermine the expected results.
- If any explanation of proposed treatment or therapy is not clearly understood, you are responsible to seek clarification.
- All information you give regarding your health history is true to the best of your knowledge.
- The office privacy policy is available on the website and on the bulletin board at the office.
- Payment is made either by cash, debit, cheque visa or mastercard at the time of the visit.
    - The initial consultation is 60 – 90 minutes and is $175
    - Subsequent consultations are 30-45 minutes and are $90
    - $50 fee for NSF cheques.
    - Phone consultations are rounded to the nearest 15 minutes and based on $175/hour
- Notice of 24 hours is required for appointment cancellation.

***I have read, understood and acknowledged the above consent to treatment. I hereby authorize and consent to naturopathic treatment by Cathleen MacDonald, N.D.***

______________________________________________ Date ____________________

Signed