



NATUROPATHIC INTAKE FORM – ADULT

SECTION #1 ~ GENERAL INFORMATION:

Name: _____
 Age: _____ Date of Birth (mm/dd/yy): _____ Male Female
 Address: _____
 City: _____ Province: _____ Postal Code: _____
 Telephone (home): _____
 Telephone (cell/work): _____
 Email address: _____
 Occupation: _____

How did you hear about Dr. Ruth?
 referral _____ www.ruthshuster.com clinic website other _____

Have you ever seen a naturopathic doctor before? NO YES
 If so, Name of previous ND: _____
 Date of last visit: _____

SECTION #2 ~ CURRENT MEDICAL INFORMATION:

Your Health Concerns:

Please list the health concerns that you wish to address with the naturopathic doctor:

Health Concern:	How long have you had this condition?
1)	
2)	
3)	
4)	

If you have any severe allergies or medical conditions (eg. Anaphylaxis, Epilepsy) please list here:

Emergency Contact: _____
 Relationship: _____ Telephone: _____

Your Health Care Team:

Please list other professional healthcare providers you see currently. (eg. Family doctor, Physiotherapist, Chiropractor)

Name:	Type of practitioner:	Phone number:

Current Medications: Please list all prescribed medications that you are currently taking.

Name/Brand:	Dose:	For what Condition?	Since When?

Current Natural Health Products: Please list all natural products that you are currently taking.

Name/Brand:	Dose:	For what Condition?	Since When?

Do you:

- NO YES Have any known contagious diseases/infections at this time? If yes, what? _____
- NO YES Smoke? If yes, # per day & how long? _____
- NO YES Exercise? If yes, please describe: _____

SECTION #3 ~ PAST MEDICAL INFORMATION:

Please describe any major illnesses, medical diagnoses, hospitalizations, surgeries, imaging, etc. (Including the date of occurrence).

SECTION #4 ~ FAMILY MEDICAL INFORMATION:

Please indicate whether anyone in your family (grandparents, parents, siblings) has had any of the following conditions?

- Heart disease
- Diabetes
- Allergies
- Digestive problems
- Nervous System problems
- Mental/Emotional problems
- Other _____
- Hypertension
- Asthma
- Kidney problems
- Arthritis
- Hormonal problems
- Cancer

PRIVACY POLICY:

The collection of the above information is designed to provide the ND with all relevant information necessary to establish a baseline assessment of your health status. It will be used to: assess your health care needs, advise you of naturopathic treatment options, deliver safe and effective patient care, and establish appropriate follow-up measures. The ND will keep your medical information confidential; however the multi disciplinary nature of the clinic files may not guarantee absolute confidentiality from other clinic practitioners. A copy of your file can be released only with a signed "Release of Records Consent Form", or unless the disclosure is required by law. Please be advised that ND's must comply with legal requirements for reporting such situations as, but not limited to, child abuse or neglect, adverse reactions to medications or natural products, contagious diseases or infections specified by the Ministry of Public Health. All original documents will be kept by Dr. Shuster, ND for the length of your active care with her and for ten years after your last appointment.

INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES:

Naturopathic Medicine is the prevention and treatment of health concerns by natural means. ND's assess the whole person – taking into consideration physical, mental and emotional aspects of the individual. It is very important that you inform Dr. Shuster, ND of your complete health history and all medications (including natural supplements) that you are taking. If you are (or become) pregnant, if you are breast feeding, or if your health status changes, please advise the ND immediately. Any medical treatment has the possibility of health risks. In Naturopathic Medicine these may include, but are not limited to: aggravation of a pre-existing condition; adverse reaction to supplements or herbs; pain, bruising, or injury from acupuncture or injections. No results are guaranteed, and not all risks/complications can be anticipated.

I, _____, do hereby acknowledge that I have been informed of and understand the naturopathic therapeutic procedures and privacy policy as listed above. I do hereby acknowledge that the information I have provided is true and complete to the best of my knowledge. I understand that the ND will answer my questions, to the best of her ability, regarding all therapeutic procedures with respect to financial costs, expected benefits, potential risks and side effects, the likely consequences of not receiving treatment, and what alternative course(s) of action are available to me. I understand that I may withdraw my consent at any time and in doing so I understand that I will not continue to receive naturopathic treatment.

Signature: _____

Date: _____