PATIENT INTAKE FORM

INFORMED CONSENT:

At Prairie Sky Health we 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. We will take a thorough case history, perform a physical exam and may employ specific diagnostic testing, if it is deemed necessary, which will be discussed in your visit. It is very important that you inform the doctor of any disease process that you are suffering from, and 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 Naturopathic Doctor immediately.

Statement of Acknowledgement

As a patient of Dr Laura Stark ND, I _____ have read the information and understand that 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 in writing 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.

The information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs.

With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for:
_____.
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.

I also confirm that I have the ability to accept or reject this care of my own free will and choice.

I accept full responsibility for any fees incurred during care and treatment.

Patient Name (Please Print): _____

Signature: _____ Date: _____

SASKATCHEWAN eHEALTH ACCESS CONSENT:

With your permission, your Saskatchewan eHealth record containing bloodwork, imaging and prescription information can be reviewed for the purpose of reviewing recent labwork and imaging.

Your signature below indicates your consent to access your private health information through eHealth for safe treatment.

Signature: _____ Health Card #: _____

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INTEGRATIVE HEALTH

PATIENT INTAKE FORM

PERSONAL INFORMATION

First Name:	**Last Name:**	**Date of Birth:** **M/F:**
Full Address:		
Home Phone:	**Cell Phone:**	**Fax:**
Email:		

EMERGENCY CONTACTS

In the event of an emergency, please contact:

Name:	**Name:**
Relationship:	**Relationship:**
Contact Numbers: **Cell:** **Home:** **Work:**	**Contact Numbers:** **Cell:** **Home:** **Work:**

CANCER DIAGNOSIS

How was your cancer discovered? Date of Diagnosis:	
Primary Cancer Type:	
Organs Involved:	
Your Doctors:	
How are you monitored? CT/MRI/Cancer marker labs:	
Surgery? Type and Dates:	
Chemotherapy? Types and Dates:	
Radiation Therapy? Dates:	
Any Complications/Side Effects?	

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INTEGRATIVE HEALTH

PATIENT INTAKE FORM

OTHER MEDICAL CONDITIONS:
(Ex: High blood pressure, heart trouble, diabetes, depression, breathing problems, or other)

Condition:	Year Diagnosed:	Treatment:

INJURIES – HOSPITALIZATIONS – SURGERIES:

Injury/Illness/Surgery:	Date:	Hospital	Outcome:

ALLERGIES/SENSITIVITIES:
(Ex: Medications, food, and/or other substances; hay-fever, skin reactions, etc.)

Allergy:	Reaction (What symptoms develop?):

PRESCRIPTION MEDICATIONS:

Medication:	Dosage:	Reason for taking/any side effects:	Date Started:	Prescribed By:

OTHER MEDICATIONS:
Please include any over the counter (OTC) medicine you take (Vitamins, herbs, pain relievers, supplements, etc.)

Other Medication:	Dosage:	Reason for taking/any side effects:	Date Started:

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INTEGRATIVE HEALTH

PATIENT INTAKE FORM

HEALTH AND LIFESTYLE HABITS:

Please indicate your consumption of the following:

Water: ☐ Never ☐ Occasionally ☐ _____ /day

Coffee: ☐ Never ☐ Occasionally ☐ _____ /day or wk

Soda pop: ☐ Never ☐ Occasionally ☐ _____ /day or wk

Juice: ☐ Never ☐ Occasionally ☐ _____ /day or wk

Alcohol: ☐ Never ☐ Occasionally ☐ _____ /day or wk

Tobacco: ☐ Never ☐ Occasionally ☐ _____ /day or wk Have you ever been a smoker? _____

Recreational drugs: ☐ Never ☐ Occasionally ☐ _____ /day or wk What kind(s)? _____

Do you have a regular exercise program? _____

Type(s): _____ Amount per week: _____

What do you do for recreation? _____

DIET:

What do you typically eat for…

Breakfast?	Lunch?	Dinner?
What do you snack on (and when)?		
Cravings? For what and when?		
Any foods you avoid out of your diet? (and why?)		
How often do you eat out per week?	What type of restaurants?	

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INTEGRATIVE HEALTH

PATIENT INTAKE FORM

PSYCHOSOCIAL HISTORY:

Relationship Status: □ single □ dating □ common-law □ married □ separated/divorced □ widowed

Number of children & ages? _____

Where do you live? □ city □ small town □ rural/farm AND □ house □ apartment/condo □ care home

Who do you live with (pets too)? _____

Occupation: _____

Please list any important life experiences in chronological order, especially traumatic events:

Age	Event	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has there been a significant event in your life that changed you forever? _____

Have you ever had a nervous breakdown? □ yes □ no If yes, please describe the circumstance: _____

_____

_____

What do you do to cope with stress? _____

_____

Religious or spiritual beliefs: _____

_____

What is your view of the present and your outlook for the future? _____

_____

How do you feel about yourself? _____

Do you have a supportive environment (work/home) for making lifestyle changes? _____

What are your short-term health goals? _____

_____

What are your long-term health goals? _____

_____

What is your realistic monthly budget for health spending? _____

Would you like to be included in our online donation program to gain financial support for your care?

□ I would like an application/more information

REVIEW OF BODY SYSTEMS:

On the following two pages, please place a "**X**" by any symptoms you have **currently**.

Place a "**P**" by any you have had in the **past.**

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PATIENT INTAKE FORM

	General:		Skin:		Head & Hair:
	Fatigue		Acne		Headaches
	Night sweats		Open sore/ ulcer		Migraines
	Hot person		Hives/ Itching		Hair loss (excessive)
	Chilly person		Rashes		Hair growth (excessive)
	Trouble falling asleep		Warts		Head injury/ Concussion
	Trouble staying asleep		Eczema/ Dermatitis		Dizziness/ Vertigo
	Recent weight gain/ loss		Psoriasis		**Mouth & Throat:**
	Infections:		Nail problems		Tooth Problems
	HIV/AIDS		Skin colour changes		Cavities/ fillings
	Hepatitis		Changes in moles		Dentures
	Tuberculosis		**Eyes:**		Gum problems/ bleeding
	Chicken pox		Vision problems		Cold/ Canker sores
	Mononucleosis		Floaters		Hoarse voice
	Whooping cough		Cataracts		Frequent sore throat
	Scarlet fever		Glaucoma		Tonsils removed
	Mumps		Glasses/ Contacts		Loss of taste/Bad taste in mouth
	Measles		Sensitivity to light/ sun		**Ears:**
	Malaria		Eye infections		Hearing loss
	Rheumatic fever		Excess tearing/ Dry eyes		Ringing in ears/ Tinnitus
	Typhoid fever		**Nose & Sinuses:**		Excess wax
	Other:		Frequent colds		Frequent infections/ ear aches
	Exposures:		Hay fever/Allergies		**Respiratory:**
	Pesticides/Herbicides		Frequent nose bleeds		Chronic cough
	Gas Fumes		Congestion		Sputum/ excess mucous
	Solvents		**Blood:**		Asthma
	Asbestos		Bleeding disorder		Frequent lung infections
	Cigarette smoke		Easy bruising		COPD/ Emphysema
	Mercury Dental Fillings		Anemia		Pneumonia
	Other:		Iron deficiency/ excess		**Gastrointestinal:**
	Musculoskeletal:		**Urinary:**		difficulty swallowing
	Chronic pain		wake up to urinate ____x/night		heartburn/acid reflux
	Joint Problems		kidney stones		nausea
	Arthritis		bladder infections		appetite up or down
	Gout		frequent urination		persistent vomiting
	Muscle Pain/ Spasms		urgency		indigestion
	Jaw pain/ Clicking		incontinence		excess bloating
	Osteoporosis		**Circulatory:**		excess belching
	Nervous System:		High or low blood pressure		excess passing gas
	Seizures		High or low cholesterol		abdominal pain
	Stroke/ TIAs		Heart murmur		stomach ulcer
	Paralysis		Chest pain		jaundice
	Tremors		Cold hands/feet		gallstones
	Numbness/ Tingling		Swollen ankles/edema		gallbladder removed
	Fainting/ Blackouts		bruise/bleed easily		constipation
	Memory problems		Wounds slow to heal		diarrhea
	Learning difficulties		Varicose veins		blood in stool
	ADD/ ADHD		Hemorrhoids		irritable bowel syndrome

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INTEGRATIVE HEALTH

PATIENT INTAKE FORM

REVIEW OF BODY SYSTEMS Continued:

Please place a "**X**" by any symptoms you have **currently**. Place a "**P**" by any you have had in the **past.**

	Mind & Mood:		Breast (male & female):		Female Reproductive (cont):
	diagnosed mental illness		breast tenderness		birth control pill?
	depression/excess sadness		breast lumps		bleeding after intercourse
	seasonal depression		fibrocystic breasts		vaginal discharge
	anxiety/nervousness		nipple discharge		itch
	panic attacks		Inverted nipple		yeast infections
	mania/hyperactivity		**Male Reproductive:**		endometriosis
	tension		enlarged prostate		fibroids
	mood swings		hernia		ovarian cysts
	excess anger/irritability		testicular pain		cervical dysplasia
	difficulty expressing emotions		testicular lump		difficulty conceiving
	lack of concentration		sores on penis		# of pregnancies
	foggy thinking		discharge from penis		# of deliveries
	Sexual:		jock itch		# of miscarriages
	sexually active		infertility		# of abortions
	increased libido		**Female Reproductive:**		Problems during pregnancy
	decreased libido		age of first period?		problems during delivery
	painful intercourse		irregular cycles		tubal ligation
	sexual difficulties		excessive flow/clots		hysterectomy
	sexually transmitted infection		bleeding between periods		menopause
	birth control methods?		cramping/painful periods		vaginal dryness
	_____		PMS mood changes		hot flashes

Are there specific types of treatments that you are interested in?

__ Dietary Guidance __ IV Therapies __ Supplement Recommendations
__ Mind-Body Support __ Other: _____

OTHER INFORMATION TO SHARE WITH THE HEALTHCARE TEAM:

I have read, understand and completed this health history form with accuracy and to the best of my knowledge/ Any questions I had were answered to my satisfaction.

_____ _____ _____
Name (first, last) **Signature** **Date**

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