CLEARHEALTHINN

# PATIENT INTAKE FORM

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 Naturopathic Doctor 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. If your case requires, the physical may include more specific examinations such as breast, gynecological, rectal, prostate or genital exams. It is very important that you inform your Naturopathic 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.

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

- Possible 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
- Muscle strains and sprains, disc injures from spinal manipulation

*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: ________________________



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# PATIENT INTAKE FORM

## PERSONAL INFORMATION

| First Name: | Last Name: | Date of Birth:<br>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:**<br>**Cell:**<br>**Home:**<br>**Work:** | **Contact Numbers:**<br>**Cell:**<br>**Home:**<br>**Work:** |

## CANCER DIAGNOSIS

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

# 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?): |
| --- | --- |
| | |
| | |
| | |
| | |
| | |

Are you allergic to? Baking soda: Yes / No White Vinegar: Yes / No Hydrogen Peroxide: Yes / No

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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# PATIENT INTAKE FORM

SAFETY SCREENING - Please check any of the following that currently apply to you:

__ Active Liver (not in remission) undergoing treatment

__ Liver disease

__ Kidney failure OR Kidney damage

__ Eye or ear trauma in last 30 days

__ Body Implants

__ Pace maker

__ Pregnant or trying to get pregnant

__ Organ Transplant

__ Intracranial bleeding

__ Undergoing dialysis treatment

__ Claustrophobia

__ Metallic implants (superficial)

__ Electrical Implants (battery operated)

__ Seizures

__ Acute illness, please specify: ____________________________________________________________

HEALTH AND LIFESTYLE HABITS:

Please indicate your use of the following:

Water: ☐ Never ☐ Occasionally ☐ __________ /day

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

Soda pop: ☐ 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: __________________________

DIET:

What do you typically eat for…

| Breakfast? | Lunch? | Dinner? |
|---|---|---|
| | | |
| What do you snack on (and when)? | | |
| How often do you eat out per week? | What type of restaurants? | |



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# 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: ____________

___________________________________________________________________________________________

___________________________________________________________________________________________

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? __________________________________________

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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# 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?**

__ Hyperbaric Oxygen
__ Salt Chamber
__ Colour/Light Therapy
__ Detoxification Salt Bath
__ Ionic Foot Bath
__ Infrared Heat Therapy (Sauna)
__ Myopulse Therapy
__ Cold Laser Therapy
__ Mind-Body Support
__ Other: ________________________________________________________________
__ IV Therapies
__ Supplement Recommendations
__ Dietary Guidance
__ Ketogenic Meal Delivery

***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. ___ I understand that I will be required to physically sign this document once I come to the facility.*

__________________________________ __________________________________ __________________________________

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



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