CECILIA HO, NATUROPATHIC DOCTOR

CONFIDENTIAL PATIENT HEALTH RECORD

Pickering Chiropractic Health Centre

1154 Kingston Rd, Unit 1 Pickering, ON L1V 1B4

Dear Patient,

Congratulations for taking ownership of your health and making Naturopathic Medicine part of your health care program. Naturopathic Doctors use natural and individualized treatments to initiate your body's own healing strength. The result is a safe, effective and long lasting treatment that enhances your body's resistance to disease.

The word doctor comes from the Latin root *docere*, meaning teacher, and that is how I view my role as your Naturopath. In making your appointment you have implied that you are ready to make some changes in your life to experience better health. Taking time to fill out this intake form thoroughly will help me to understand what your goals and expectations are and together we will formulate a health care plan that works for you. The ultimate goal I see for you is taking responsibility for your own health and I am just one of the health care professionals you see to this end.

Under my care you can expect:

- Prevention-oriented medicine to help you maintain optimal health
- Find-out what is really going on with your body
- Treatment of the root cause, not just the symptoms
- Treatment of the whole person- physical, mental, emotional, and spiritual aspects that can impact your health are all taken into consideration

Together we will develop practical, effective and sustainable health solutions!

Yours in Health,

Cecilia Ho, ND

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Adult Intake Form

Date: _____ ☐ Female ☐ Male

Name: _____

Age: _____ Date of Birth: _____/_____/_____
MONTH DAY YEAR

Address: _____

_____

_____

Province: _____ Postal Code: _____

Telephone: ( ) _____ (Home)
( ) _____ (Work)
( ) _____ (Cell)

May we leave a message regarding your visit?

Yes No

Occupation: _____

Hours per week: _____ or ☐ Student ☐ Retired ☐ Unemployed

Marital Status:
☐ Married ☐ Partnership ☐ Separated
☐ Divorced ☐ Widowed ☐ Single

Live with:
☐ Spouse/Partner ☐ Parent(s) ☐ Children
☐ Friend(s) ☐ Pet(s) ☐ Other _____

What are your expectations from this visit/treatment?

_____

Emergency Contact:
Name: _____ Phone: _____

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Other Health Care Providers:

1._____ 2. _____ 3. _____

_____ _____ _____

_____ _____ _____

(____)_____ (_____)_____ (_____)_____

_____

What are your health concerns in order of importance to you?

1._____

2._____

3._____

4._____

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

_____

_____

_____

_____

_____

Do you frequently use any of the following? (circle)

Aspirin Laxatives Antacids Diet pills

Birth control pills/implants/injections

Alcohol—how much/day or week

_____

Tobacco—form and amount/day_____

Caffeine—form and amount/day_____

Recreational drugs—what and how often

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

_____

Please list past prescription medications.

_____

_____

_____

ALLERGIES

Are you hypersensitive or allergic to any of the following (please list):

Drugs?

_____

_____

ALLERGIES

Are you hypersensitive or allergic to any of the following (please list):
Foods?

_____

_____

Environmentals? (pollen, dust, etc.)

_____

_____

Vaccinations

Please indicate what immunizations you have had

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Tetanus booster; when?
- ☐ MMR (measles, mumps, rubella)
- ☐ Haemophilus influenza B
- ☐ "Flu"
- ☐ Polio
- ☐ Any adverse reactions to vaccinations? If so please indicate

_____

Diet

Do you have any food allergies or intolerances? Please list.

_____

_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

_____

Describe a typical day's diet

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Family history

Indicate if a close relative (parent, child, sibling) has had any of the following

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

☐ I don't know my family medical history

General

Weight: _____lbs Height _____ft _____in

Weight one year ago: _____ lbs

Max. Weight/ When:

_____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____

_____

_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?

_____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

_____

_____

_____

How would you describe the emotional climate of your home?

_____

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____
_____
_____

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

_____
_____
_____

WOMEN'S HEALTH

Are you pregnant? □ Yes □ No

Have you had a hysterectomy? □Yes□ No

Is your menstrual cycle regular? Yes□ No

Do you suffer from any pre-menstrual symptoms?
□ Yes □ No

If Yes, which ones? (ie. Breast tenderness, bloating, craving, mood swings)

_____
_____

When was your last menstrual cycle?

_____

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CONTEXT OF CARE

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from this visit to our clinic?
1)
2)
3)

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are **self-destructive** lifestyle habits: (please list)

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?

Clinic Policies

Payment Policy
All payments are due when services are rendered, or you may prepay in advance. Our clinic accepts cash, cheque, debit, Visa, and MasterCard as forms of payment.

Missed Appointments
Missed appointments will be charged the ***full 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 cancellation notice for a follow up appointment and 2 days for an initial consultation.

A missed appointment hurts three people: you, the practitioner and the person who could have came in your place. Please be considerate and notify us if you are unable to make your scheduled appointment and we would be happy to reschedule your appointment.

Insurance
Many of our patients have extended health care benefits with their own or another family member's employer, which covers naturopathic consultations. We recommend that you check your benefit plans and familiarize yourself with their procedures. Although we do not deal directly with benefit plan providers, we will gladly provide you with statements of account so that you can submit them for reimbursement.

By signing the consent form, you are agreeing to the above terms.
Please take this page for your records.