

**Adult Intake**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth (D/M/Y): \_\_\_\_\_

**Contact Information**

Address: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

E-mail address: \_\_\_\_\_

Can messages be left for you regarding changes in appointments? Y N

Place of employment and hours worked per week: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about Banff Naturopathic Medical Clinic? \_\_\_\_\_

Do you wish to be contacted via email for product sales, articles, and updates? Y N

**Family**

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Live with Partner [ ] Widowed

Do you have children? Y N

**Medical**

Name of Medical Doctor: \_\_\_\_\_ Date of last visit to MD: \_\_\_\_\_

Do you have regular physical exams? Y N

Do you have regular screening blood work? Y N

Are you under the care of any specialists? Y N Their specialty: \_\_\_\_\_

**Medical History**

Please list your health concerns in order of importance to you

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

How would you describe your general state of health? \_\_\_\_\_

Please list any major trauma, surgery or illness you have sustained

| Incident | Approximate date | Any long term effects? |
|----------|------------------|------------------------|
|          |                  |                        |
|          |                  |                        |
|          |                  |                        |
|          |                  |                        |

**Childhood Illnesses & Vaccinations**

Were you vaccinated as a child? Y N

Have you had any additional vaccinations as an adult (i.e. Flu shot, HPV)? Y N

Have you recently travelled to any high risk areas internationally? Y N Where to? \_\_\_\_\_

Please check all that apply:

- Chicken Pox             Measles             Mumps             Rubella (German Measles)             Roseola  
 Mononucleosis             Scarlet fever             Tuberculosis             Whooping cough             Impetigo  
 Ear Infections             Strep throat             Polio             Rheumatic Fever             Other

**Family History**

Please indicate if any of your first degree relatives (parents, siblings, grandparents, aunts and uncles) are affected by the following conditions. Leave blank if you do not know your family history:

| Condition                 | Family member | Condition                 | Family member |
|---------------------------|---------------|---------------------------|---------------|
| Alcoholism/drug addiction |               | Genetic disorders         |               |
| Asthma                    |               | Heart disease             |               |
| Allergies                 |               | High blood pressure       |               |
| Cancer                    |               | Kidney disease            |               |
| Diabetes                  |               | Liver disease             |               |
| Digestive disorders       |               | Mental illness/depression |               |
| Epilepsy                  |               | Thyroid disorders         |               |

**Medications and Natural Health Products**

Please list all current prescription or over the counter medications, herbal remedies, homeopathics, or nutritional supplements:

| Name | Used for? | For how long? | Dosage |
|------|-----------|---------------|--------|
|      |           |               |        |
|      |           |               |        |
|      |           |               |        |
|      |           |               |        |
|      |           |               |        |
|      |           |               |        |
|      |           |               |        |

How frequently do you take antibiotics? \_\_\_\_\_

Banff Naturopathic  Medical Clinic

Dr. Samantha Frey, ND, BSc

Please indicate if you use any of the following currently or re-currently

- Tobacco     Alcohol     Recreational drugs     Caffeine     Hormones     sleeping aids  
 Laxatives     Antacids     Anti-inflammatories     Steroids     Cortisone

Are you routinely exposed to environmental toxins in your work-place (i.e. hair salon, auto body shop) Y N

Please indicate if any of the following conditions have affected you in the past (P), or are current issues (C):

|            |  |                      |  |                           |  |
|------------|--|----------------------|--|---------------------------|--|
| Anemia     |  | Epilepsy             |  | Multiple sclerosis        |  |
| Arthritis  |  | Gallbladder disorder |  | Autoimmune disorder       |  |
| Asthma     |  | Heart disease        |  | STD                       |  |
| Cancer     |  | Hepatitis            |  | Thyroid disorder          |  |
| Crohn's    |  | HIV/AIDS             |  | Alcohol or drug addiction |  |
| Depression |  | Kidney disease       |  |                           |  |
| Diabetes   |  | Liver disease        |  |                           |  |

Do you have any particular food restrictions (i.e. religious, ethical)? \_\_\_\_\_

Have you ever had an eating disorder (anorexia, bulimia)? \_\_\_\_\_

What is your current weight? \_\_\_\_\_ One year ago? \_\_\_\_\_ Ideal? \_\_\_\_\_ Height? \_\_\_\_\_

Please check any **current** or **re-current** conditions:

**Skin and Hair**

- Rashes     Ulcerations     Hives     Itching     Eczema     Dandruff  
 pimples     Hair loss     New moles     Changing moles

Any concerning change in hair or skin texture? \_\_\_\_\_

**Head, eyes, ears, nose, throat**

- Dizziness     Concussions     Migraines     Headaches     Eye pain     Glasses or contacts  
 Cataracts     Blurry vision     Macular deg.     Ringing in ear     Earaches     Loss of hearing  
 Sinus issues     Nosebleeds     Sore throat     Grind teeth     TMJ     sores on lips/tongue  
 Dental issues     Facial pain

**Cardiovascular**

- High blood pressure     Low blood pressure     Irregular heartbeat  
 Swelling of hands/feet     Cold hands/feet     Blood clots  
 Chest pain     Fainting     Difficulty breathing

**Respiratory**

- Cough     Cough blood     Bronchitis     Pneumonia     Pain with deep breath     Difficult breathing while lying down

**Gastrointestinal**

- Nausea     Vomiting     Indigestion     Gas     Belching     Bad breath  
 Diarrhea     Constipation     Itchy rectum     Rectal pain     Hemorrhoids     Blood in stool  
 Whitish stool     Blackish stool     Fecal incontinence     Abdominal pain

**Genitourinary**

- Pain with urination     Frequent urination     Urinary incontinence  
 Genital sores     Urinary tract infections     Kidney stones  
 Impotence     Change in libido     Yeast infections  
 Change in flow or incomplete bladder emptying

**Musculoskeletal**

- Osteoporosis     Arthritis     Chronic pain (muscle/joint/bone)

Where? \_\_\_\_\_

**Neuropsychological**

- Seizures     Numb region     Lack of coordination     Loss of balance  
 Depression     Anxiety     Irritability     Inability to cope with stressors

Have you ever been treated for emotional problems? Y N

Have you ever considered or attempted suicide? Y N    If yes, when? \_\_\_\_\_

Any other neurological or psychological issues (i.e. schizophrenia, ADD)? \_\_\_\_\_

**Allergies & Sensitivities**

Please list any know allergies or sensitivities (drug, environmental, or food)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you consider yourself sensitive to medications (i.e. cannot handle full dosages)? Y N

**Female Health**

Age of first menses \_\_\_\_\_    Age at menopause \_\_\_\_\_

How long does your menstruation last? \_\_\_\_\_    How long is your cycle? \_\_\_\_\_

Day 1 of last menses? \_\_\_\_\_    Date of last PAP exam? \_\_\_\_\_

Any PMS symptoms? Describe: \_\_\_\_\_

Do you practice any form of birth control? Y N    What type? \_\_\_\_\_

Do you perform self breast exams? Y N    Last mammogram or thermography? \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_    Number of births \_\_\_\_\_

Any history of miscarriage, breech, c-section, or multiples?

Any previous complications during pregnancy or delivery?

Is there **any** chance you are pregnant now? Y N

Are you breast-feeding now? Y N

**Male Health**

Do you have screening digital rectal exams? Y N

Date of last exam: \_\_\_\_\_

Any change of flow, frequency, or incomplete urination? Y N

Any change in libido or erectile dysfunction? Y N

**Additions**

If you have any other concerns, be they physical or emotional, not addressed on this form, please indicate below:

Thank-you for completing this form. All information collected is strictly confidential and will be used only in accordance with our privacy policy.

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**Consent to Treatment**

As part of your care under a Naturopathic Doctor, the following procedures may be performed: health interview, physical exam, blood/urine or other laboratory investigations to assess health status. Treatments may include: nutritional supplementation, dietary counselling, acupuncture, herbal medicines, homeopathics, and/or intravenous therapies.

I, \_\_\_\_\_, as a patient of Dr. Samantha Frey, have read the above information and understand that my care will reflect the philosophy and practices of Naturopathic Medicine. I recognize that there is a potential for any therapy to have complications in certain physiological conditions, or certain patients. The information I have provided to Dr. Frey is complete and inclusive of all health conditions including risk of pregnancy, and all medications. The slight health risks of some Naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements, herbs, or intravenous solutions; and fainting, bruising, or injury from acupuncture or venipuncture. I also recognize the following:

- I understand that a medical file will be kept to record my consultations and treatments. This record will be kept confidential as per the clinic privacy policy, and will not be released in part or whole without the patient's signed consent.
- I am aware that I am responsible for payment at the time of services rendered.
- I am aware that I must give 24 hours for non-emergency appointment changes or cancellations. Failure to do so may result in a \$25 cancellation fee.
- I understand that Dr. Frey reserves the right to refer me to other practitioners if necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(parent or guardian please sign for those under 18 years of age)