

Adult Intake Form

Please bring this completed form to your first appointment, along with any relevant blood work or health reports.
The details you provide will remain confidential.

Contact Details

Personal Information:

Name: _____ Date: _____

Date of birth (dd/mm/yy): _____ Age: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Home Tel: _____ Work Tel: _____

Email: _____

What is the best way for us to contact you? _____

May we leave messages at home or work? _____

How did you hear about Dr. Murphy's naturopathic medical practice? _____

Emergency Contact Information:

Name: _____

Relationship: _____ Tel: _____

History

Healthcare Practitioners:

Please list all other healthcare practitioners you are seeing:

1. _____ Tel: _____

2. _____ Tel: _____

3. _____ Tel: _____

Health Concerns:

Please list your primary health concerns, in order of importance:

1. _____ Date of onset: _____

2. _____ Date of onset: _____

3. _____ Date of onset: _____

4. _____ Date of onset: _____

Medical History

Please list any hospitalizations, surgeries, traumas (including emotional traumas) or major illnesses:

1. _____ Date started: _____ Date resolved: _____
2. _____ Date started: _____ Date resolved: _____
3. _____ Date started: _____ Date resolved: _____
4. _____ Date started: _____ Date resolved: _____
5. _____ Date started: _____ Date resolved: _____

Please list all prescription and over the counter medications you are taking:

1. _____ Date started: _____ Dose: _____
2. _____ Date started: _____ Dose: _____
3. _____ Date started: _____ Dose: _____
4. _____ Date started: _____ Dose: _____

Please list all supplements you are taking (e.g. vitamins, herbal medicines, etc.):

1. _____ Date started: _____ Dose: _____
2. _____ Date started: _____ Dose: _____
3. _____ Date started: _____ Dose: _____
4. _____ Date started: _____ Dose: _____

Approximately how many times have you been treated with antibiotics? _____

Please list any allergies, sensitivities or adverse reactions (e.g. to medications, immunizations, foods, chemicals, scents, pets):

Lifestyle

Diet:

Please describe a **typical** day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

How much and how often do you consume the following:

Water: _____ Pop: _____ Fruit Juice: _____
 Caffeine: _____ Alcohol: _____ Tobacco: _____
 Desserts / sweets: _____ Recreational Drugs: _____

Exercise:

Please describe what forms of exercise you participate in, and how often:

Sleep:

On average, how many hours of sleep do you get each night? _____
 Do you have difficulty falling asleep? _____
 Do you have difficulty staying asleep? _____
 On average, what time do you go to bed? _____
 On average, what time do you get up? _____
 Do you wake rested in the morning? _____

Personal:

What is your occupation? _____
 Please list some of your hobbies: _____
 Do you have a religious or spiritual practice? _____
 Do you have any children or elderly living in your home? _____
 Please briefly describe your travel history: _____

Emotional Health

On a scale of 1 (low) to 10 (high), please rate the following:

Your overall level of stress: _____
 Your overall energy level: _____
 How happy you are: _____
 How would you describe the emotional climate of your home? _____
 Do you feel your home is a safe space? _____
 Have you ever felt sad or depressed for two weeks or more at a time in the past year? Yes No

Do you have any concerns regarding your emotional or mental health (please describe)?

Environment

Are you **regularly** exposed to any of the following at home or work?

Tobacco smoke Chemicals / toxins Animals Radiation Well water

Please describe: _____

Have you ever been exposed to a constant source of heavy metals or environmental contaminants (e.g. welding, stained glass making, farming, manufacturing)? Yes No

Please describe: _____

Family Health History

Please indicate whether the following health conditions **pertain to any of your family members**:

| Condition | Relative | Age of Onset | Details |
|--|----------|--------------|---------|
| Heart Problems (e.g. high blood pressure) | | | |
| Lung Problems (e.g. asthma) | | | |
| Nervous System Problems (e.g. seizures) | | | |
| Digestion Problems (e.g. Crohn's disease) | | | |
| Allergies (moderate / severe) | | | |
| Skin Problems | | | |
| Cancer | | | |
| Diabetes | | | |
| Autoimmune Disease | | | |
| Mental Illness (e.g. depression) | | | |
| Drugs / Alcohol Difficulties | | | |
| Other | | | |

Is there anything else you would like to include on this form? _____

Thank you.

Review of Systems

Please indicate with a checkmark (✓) whether you are currently experiencing the following concerns (C), or if you have experienced them in the past (P).

| Condition | C | P | Condition | C | P |
|---|---|---|---------------------------------------|---|---|
| Skin | | | | | |
| Rash, eczema, hives | | | Excessive sweating / Night sweats | | |
| Acne | | | Warts, lipomas, or other masses | | |
| Colour change or change in a mole | | | Nail or hair changes | | |
| Boils | | | Excessive dry skin | | |
| Head, Nose & Sinus | | | | | |
| Headache or migraine | | | Hair loss | | |
| Head injury | | | Dandruff | | |
| Nose bleeds | | | Sinus infections | | |
| Nose stuffiness | | | Loss of smell | | |
| Ears | | | | | |
| Impaired hearing or ringing | | | Ear pain or infections | | |
| Eyes | | | | | |
| Eye pain | | | Glaucoma or cataracts | | |
| Tearing, dryness, itching, redness | | | Spots or "floaters" | | |
| Discharge | | | Double or blurred vision | | |
| Mouth, Throat & Neck | | | | | |
| Frequent sore throat or throat dryness | | | Hoarseness | | |
| Sore tongue or mouth sores | | | Dental cavities or teeth problems | | |
| Cold sores | | | TMJ or jaw pain | | |
| Gums bleeding or receding | | | Loss of taste | | |
| Swollen lymph nodes in neck | | | Thyroid problems | | |
| Musculoskeletal | | | | | |
| Joint pain or stiffness; arthritis | | | Muscle soreness | | |
| Neck, back, or foot pain | | | Muscle spasms or cramps | | |
| Broken bones | | | Muscle weakness | | |
| Respiratory | | | | | |
| Prolonged cough or phlegm | | | Difficulty or pain breathing | | |
| Asthma, emphysema | | | Shortness of breath at night | | |
| Frequent colds, bronchitis, or pneumonia | | | Tuberculosis | | |
| Cardiovascular | | | | | |
| Heart disease | | | High cholesterol | | |
| High or low blood pressure | | | Sensation of blood rushing in ears | | |
| Murmurs | | | Palpitations (can feel heart beating) | | |
| Chest pain | | | Rapid, slow, or irregular heart rate | | |
| Peripheral Vascular, Hematological & Lymphatic | | | | | |
| Deep leg pain | | | Anemia | | |
| Cold or numb hands / feet | | | Easy bleeding or bruising | | |
| Varicose veins or spider veins | | | Lymph node swelling | | |
| Swelling ankles | | | Swelling wrists | | |
| Ascites (fluid gain in abdomen) | | | | | |

| Condition | C | P | Condition | C | P |
|--|---|---|--|---|---|
| Gastrointestinal | | | | | |
| Heartburn or reflux | | | Diarrhea or loose stool | | |
| Ulcer | | | Constipation | | |
| Indigestion, bloating after eating | | | Blood in stool or rectal bleeding | | |
| Sensation of heaviness after eating | | | Black or clay (grey) coloured stool | | |
| Belching or passing gas | | | Floating stool | | |
| Recurrent nausea or vomiting | | | Undigested food in stool | | |
| Change in thirst or appetite | | | Rectal or anal itching | | |
| Excessive thirst or appetite | | | Change in bowel habits | | |
| Abdominal pain | | | Liver disease, such as hepatitis | | |
| Hemorrhoids or hernia | | | Gall bladder stones and/or disease | | |
| Urinary System | | | | | |
| Pain during urination | | | Frequent infections | | |
| Increased frequency or excessive urination | | | Kidney or bladder stones | | |
| Hesitancy or urgent urination | | | Dark coloured urine | | |
| Neurologic | | | | | |
| Fainting / Loss of consciousness | | | Loss of memory or confusion | | |
| Dizziness / Loss of balance | | | Speech or swallowing difficulty | | |
| Seizures / Convulsions | | | Numbness or tingling | | |
| Paralysis | | | Involuntary movement | | |
| Mental & Emotional Health | | | | | |
| Depression, anxiety, or nervousness | | | Difficulty concentrating | | |
| Episodes of extreme energy / mood swings | | | Phobias | | |
| Female System | | | | | |
| Breast pain, tenderness, or lumps | | | Menstrual cycle pain or other difficulty | | |
| Breast discharge | | | Menopausal symptoms | | |
| Vaginal infection or discharge | | | Syphilis, chlamydia, or gonorrhea | | |
| Male System | | | | | |
| Prostate problems | | | Testicular lumps, sores, or pain | | |
| Syphilis, chlamydia, or gonorrhea | | | Penile sores or discharge | | |
| General | | | | | |
| Unexplained or excessive fatigue | | | Allergies (environmental, food) | | |
| Unintentional weight loss or gain | | | Insomnia or sleep difficulties | | |
| Blood sugar problems (high or low) | | | Dizziness or vertigo | | |

Exam History

Please indicate when you most recently (if ever) had the following tests / procedures performed:

Tuberculin (TB) test: _____ Hearing test: _____
 Chest x-ray: _____ PAP smear / gynecological exam: _____
 CT, MRI, or ultrasound: _____ Prostate exam: _____
 ECG: _____ Blood or urine tests: _____
 Eye exam: _____ Full physical exam: _____

Informed Consent for Treatment

Naturopathic medicine is a distinct system of primary care that addresses the whole body and root cause of illness and disease. It promotes health by assisting the body's own healing mechanisms according to current medical research and ancient healing knowledge. Naturopathic doctors are primary care providers who integrate standard medical diagnostics with a broad range of natural therapies, including clinical nutrition, herbal medicine, acupuncture, homeopathy and counseling. They work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

Your first naturopathic appointment will generally last 60-90 minutes and may include a physical exam and referral for laboratory tests. Follow-up appointments may range from 15-60 minutes each according to individual health requirements. The first consultation fee is generally \$175 to \$200 and does *not* include the cost of laboratory testing or prescription items. Follow-up consultation fees are prorated at \$150 per hour. OHIP does *not* cover the fees of a naturopathic doctor, however many extended healthcare insurance providers do.

Statement of Acknowledgement:

I, _____, as a patient of Dr. Gerann Murphy (N.D.), understand that this form of medical care is based on naturopathic principles and practices. I will inform Dr. Murphy of all health concerns, medications and medical interventions, including over-the-counter drugs and supplements, because safe care requires that I truthfully and completely disclose this information. I will also inform Dr. Murphy if I am pregnant or breastfeeding.

I understand that I am entitled to know about my diagnosis and treatment, including costs, benefits, risks and potential side-effects. I am entitled to know the consequences of *not* accepting treatment and of alternative courses of action. I am encouraged to request more information as needed, and to take an active role in my care. I am aware that I am always at liberty to seek or continue care from another healthcare provider.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs and bruising or injury during acupuncture.

I understand that Dr. Murphy is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at any time. I accept full responsibility for any fees incurred during care and treatment, including a **50% cancellation fee if providing less than 24-hour weekday notice for cancelling appointments** _____ (please initial).

Signature

Date

Witness

Consent for Collection, Use and Disclosure of Personal Health Information

Your health privacy is a primary concern. The personal health information you disclose to Dr. Gerann Murphy (N.D.) during your appointments will be handled in accordance with current privacy legislation and standards determined by the naturopathic regulatory body, the College of Naturopaths of Ontario. Personal health information includes identifiable information such as age, gender, family status and health history.

Dr. Murphy and administrative staff of Arlington Park Health Professionals will collect, use and disclose information about you for the following purposes:

- To assess your health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Administrative staff of Arlington Park Health Professionals will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. They will collect, use and disclose your personal health information so as to protect your privacy and the confidentiality of your information.

I have reviewed the above information and authorize Dr. Gerann Murphy (N.D.) and administrative staff of Arlington Park Health Professionals to collect, use and disclose my personal health information as outlined above.

Name

Date

Signature

Witness