Dr. Gerann Murphy N.D.
Naturopathic Medicine

736 Arlington Park Pl., Kingston, ON K7M 8H9
T: 613.545.0454 E: ArlingtonParkHealth@gmail.com
F: 613.545.2493 W: NaturopathicDoctorKingston.com

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 Practioners:

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: _____

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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: _____

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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

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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.

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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)					

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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: _____

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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 $200 and does *not* include the cost of laboratory testing or prescription items. Follow-up consultation fees are prorated at $200 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 **100% cancellation fee if providing less than 24-hour weekday notice for cancelling appointments** _____ (please initial).

_____	_____	_____
Signature	Date	Witness

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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 _____