Val Cremanaru, ND
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NATUROPATHIC INTAKE FORM

CONTACT INFORMATION

Name _____ Age ____ Birthdate (D/M/Y) _____

Address _____ City_____ Postal Code _____

Phone (Home) _____ Cell _____

Is it okay to leave a message? Yes/No E-mail _____

Occupation _____

Emergency Contact _____ Contact Number _____

How did you find out about us? _____

YOUR CURRENT HEALTH CONCERNS

What is your <u>main reason</u> for coming in today?_____

_____

Please list, in order of importance, any other health concerns that you may have:

1. _____
2. _____
3. _____

What kind of treatment have you received for the above? _____

None _____

Which of the following do you currently use? Please indicate how much, and how often.

Alcohol		**Tobacco**	
Hormones		**Coffee**	
Cortisone		**Laxatives**	
Sedatives		**Antacids**	
Recreational drugs		**Aspirin or Tylenol**	

List all medications you are currently taking (please give the name, dose and length of time on the medication):

_____ _____

_____ _____

_____ _____

List all supplements you are currently taking (please include all vitamins, herbs and homeopathics):

_____ _____

Do you have any allergies (medications, herbs, foods, animals, environmental)? If so, please specify:

_____

Do you feel that your general state of health is: **excellent** **good** **average** **fair** **poor**

What is your current level of energy from 1 to 10 (where 10 is the highest)? _____

What is your current approximate weight? _____ Height? _____

What is your current level of commitment to improving your health (1-10, 10 highest)? _____

Are there any foods you exclude or restrict from your diet? _____ Yes / No _____

If **Yes**, please explain Why? _____

Do you have any issues with digestion? (heartburn, gas, bloating, indigestion etc) ____ Yes / No _____

How often do yo have a bowel movement? _____

Is this normal for you? _____

Do you have any of the following right now: _____ Constipation _____ Diarrhea _____ Yo-yo between the two?

____ None

YOUR HEALTH HISTORY

Which of the following conditions apply to you? Please indicate if **now (N)** or in the **past (P).**

	Now	Past		Now	Past		Now	Past		Now	Past
Allergies			**Weight problems**			**Stroke**			**Venereal disease**		
Asthma			**Gallstones**			**Cancer**			**Syphilis**		
Eczema			**Gout**			**Epilepsy**			**Gonorrhea**		
Psoriasis			**Arthritis**			**Migraine**			**Miscarriage**		
Ear infections			**Thyroid problems**			**Pneumonia**			**Varicose veins**		
Strep throat			**Anemia**			**Diabetes**			**Broken bones**		
Hay fever			**High blood press.**			**Malaria**			**Numbness/tingling**		
Measles			**Rheumatic fever**			**Tuberculosis**			**Cold hands/feet**		
Mumps			**Fainting**			**Yeast infection**			**Suicidal thoughts**		
Chicken pox			**Poor memory**			**Eating disorder**			**Anxiety**		
Whooping cough			**Balance problems**			**Gas/bloating**			**Depression**		
Diphtheria			**Speech problems**			**Hemorrhoids**			**Self-mutilation**		
Scarlet fever			**Ringing in ears**			**Parasites**			**Mental illness**		
Sinusitis			**Jaundice**			**Rectal bleeding**			**Child abuse**		
Canker sores			**Hepatitis**			**Herpes**			**Physical abuse**		
Acne			**Heart disease**			**Headaches**			**Sexual abuse**		
Tonsilitis			**Alcoholism**			**Visual problems**			**Emotional abuse**		

Have you ever had suicidal thoughts? _____ Yes / No _____ If Yes, was there ever a Plan? _____Yes / No _____

Are there any of these conditions from which you feel you have never been well since?

_____

Have you had any major injuries? If so, what happened and when?

_____

Please list any previous surgeries and hospitalizations including dates.

_____

Have you had any **diagnostic tests** done in the **past year?** (i.e. EKG, ultrasound, x-ray, MRI, CT scan, mammogram, bone mineral density, PAP test etc.)

_____ Yes / No _____ If YES, which one(s)? _____

FAMILY HEALTH HISTORY

	Mother	Father	Sibling	Grandparent	Other blood relative
Cancer (type)					
Drug Abuse/Alcoholism					
Heart disease					
Arthritis					
Diabetes					
High blood pressure					
Asthma					
Kidney disease					
Depression					
Anemia					
Mental Illness					
Other					

LIFESTYLE FACTORS

Are you currently living with: **Spouse** **Partner** **Parents** **Friends** **Children** **Alone**

How many children do you have? (names and ages) _____ _____ _____ _____

Do you exercise? **____Yes/No_____** If **Yes**, what and how often? _____

What is your current level of stress? **Very High** **High** **Moderate** **Low** **None**

How much sleep on average do you get each night? ____ Hrs

On a scale of 1-10, how would you rate the quality of your sleep (0 horrible - 10 being great)? _____

How is your body temperature, compared to others? **Warmer** **Cooler** **Average**

Is there anything else you feel is relevant that I should know about you?

_____

Thank you for taking the time to fill out this lengthy questionnaire.

We are more than a collection of symptoms.

It will be a valuable resource in helping me understanding your health.

I'm looking forward to working with you.

Family Naturopathic Clinic
Val Cremanaru, ND

DECLARATION AND CONSENT TO TREATMENT

Naturopathic medicine is the treatment and prevention of illness using natural substances and therapies such as nutritional and lifestyle counseling, herbal medicine, Chinese medicine and acupuncture, homeopathy, vitamin & mineral supplementation, and hydrotherapy. Naturopathic doctors assess and treat the whole person, taking into consideration physical, mental, and emotional aspects of the individual. Therapy is aimed at treating the cause of illness, and to stimulate the body's inherent healing capacity. Naturopathic treatment and conventional medical treatment are not mutually exclusive, and therefore, you are free to seek or continue medical care from a physician.

Your first visit will be approximately 60 minutes long and will be spent exploring your major health concerns, health history, and may include a complaint-oriented physical exam. A treatment plan will be discussed. Subsequent visits will occur as necessary for treatment.

Certain health conditions require caution and your naturopath must be aware of them to be able to treat safely and effectively. It is imperative that you inform your naturopathic doctor immediately of any illness from which you are suffering, if you are taking any medications, if you are or suspect you may be pregnant, are planning to become pregnant, or if you are breastfeeding. Some of the health risks associated with naturopathic medicine include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, and pain or bruising from acupuncture.

PROTECTION/DISCLOSURE OF PERSONAL HEALTH INFORMATION

The privacy protocols of Val Cremanaru, ND comply with the Personal Health Information Protection Act (PHIPA), the Personal Information Protection and Electronic Documents Act (PIPEDA), and the standards of our regulatory body. Your information may be accessed by regulatory authorities under the terms of the Drugless Practitioners Act, for the purpose of fulfilling our regulatory body's mandate or by the law. Any type of disclosure otherwise will require a consent form signed by you.

CANCELLING OR RESCHEDULING APPOINTMENTS

We ask that you give us at least 24 hours notice when cancelling an appointment. A missed appointment, without proper notice, may result in a cancellation charge to be paid before another appointment is booked.

Payment for all services is due at the end of the visit. Though the Ontario Health Insurance Plan (OHIP) does not cover naturopathic services, several insurance companies offer partial or complete coverage for visits. Official receipts will be issued at the end of each visit so that you may obtain reimbursement directly from your insurance company. Lab tests are tax deductible.

I acknowledge that I am aware and agree to the above. Date: _____

Name (printed):_____ Signature: _____