Adult Naturopathic Intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care.

<table>
<tr><th colspan="3">PATIENT INFORMATION</th></tr>
<tr><td colspan="3">Name: ______________________ ________________________
First Last</td></tr>
<tr><td>Age:</td><td>DOB: ______/______/______
MM DD YY</td><td>Gender:</td></tr>
<tr><td colspan="2">Occupation:</td><td>Marital Status:</td></tr>
<tr><th colspan="3">CONTACT INFORMATION</th></tr>
<tr><td colspan="3">Address:</td></tr>
<tr><td colspan="2">City:</td><td>Postal Code:</td></tr>
<tr><td>Home #:</td><td>Cell #:</td><td>Work #:</td></tr>
<tr><td colspan="3">Email Address:</td></tr>
<tr><td colspan="3">Preferred method of contact:</td></tr>
<tr><td colspan="3">Can we send you our seasonal newsletter and monthly calendar of events via email. Your email address will not be shared.
YES | NO</td></tr>
<tr><th colspan="3">EMERGENCY CONTACT</th></tr>
<tr><td colspan="2">Name:</td><td>Relationship:</td></tr>
<tr><td colspan="3">Contact #:</td></tr>
<tr><th colspan="3">OTHER HEALTHCARE PROVIDERS</th></tr>
<tr><td>Medical Doctor:</td><td>Address:</td><td>Phone:</td></tr>
<tr><td>Other:</td><td>Address:</td><td>Phone:</td></tr>
<tr><td>Other:</td><td>Address:</td><td>Phone:</td></tr>
<tr><th colspan="3">HEALTH CONCERNS</th></tr>
</table>

INKLEIN HEALTH KLINIC

Please list your main health concerns in order of importance.
1. 2. 3. 4. 5.
FAMILY HISTORY Does anyone in your family have a history of any of the following conditions? Please circle below and indicate your relationship of family member
Alcoholism Allergies Anemia Arthritis Asthma Cancer Diabetes Eczema Epilepsy Depression High blood pressure Heart disease Hepatitis Headaches Infertility Kidney disease Mental illness Stroke Tuberculosis Osteoporosis
ALLERGIES/SENSITIVITIES
Are you allergic or hypersensitive to: *Any drugs?* *Any foods?* *Any environmental allergens or chemicals?*
MEDICATIONS AND SUPPLEMENTS Please list any prescription medications, over-the-counter medications, as well as any vitamins or supplements you are taking. If possible, please include dosages and frequency.
LIFESTYLE

INKLEIN HEALTH KLINIC

Do you exercise regularly? YES | NO

What type of exercise? ____________________

How often? ____________________

Alcohol – how much consumed per day or week? ____________________

Tobacco – form and amount per day? ____________________

Caffeine – form and amount per day? ____________________

Recreational drugs – what and how often? ____________________

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

GENERAL

Have you taken antibiotics within the last 5 years? YES | NO

Are you up-to-date with vaccinations?

MMR (Measles, Mumps, Rubella):	YES | NO
DPT (Diphtheria, Pertussis, Tetanus):	YES | NO
Hib (Haemophilus Influenza B:	YES | NO
Varicella Zoster (Chicken Pox):	YES | NO
Rabies:	YES | NO
Hepatitis A:	YES | NO
Hepatitis B:	YES | NO
Tetanus:	YES | NO
Polio:	YES | NO
Flu:	YES | NO
Other: ________	

FEMALE

Are you currently or could you be pregnant? YES | NO How many weeks: __________

Have you ever been pregnant? YES | NO How many times: ___________

How many vaginal births? ___________ C-sections? ___________

How old were you when you had your first period? ____________

Have your periods been regular? ____________

REVIEW OF SYSTEMS

Inklein Health Klinic
10477 Islington Ave, Kleinburg ON L0J 1C0
905.552.1775

INKLEIN
HEALTH KLINIC

Please list conditions or concerns that involve the following systems:
SKIN *(eg. eczema, psoriasis, hives, rashes)* ____

HEAD *(eg. headaches)* ____

EYES *(eg. itching, pain, infection, corrective lenses)* ____________________________________

EARS *(eg. wax, discharge, hearing impairment)* _______________________________________

NOSE *(eg. sinus problems, pain, nose bleeds)* ____

MOUTH *(eg. difficult dentition, cavities, loss of taste, problems swallowing)* _________________

NECK *(eg. stiffness, tenderness, hoarseness, tonsillitis, swelling)* _________________________

HEART *(eg. rheumatic fever, murmurs, chest pain)* ____________________________________

LUNGS *(eg. cough, asthma, wheezing)* ____

GASTROINTESTINAL *(eg. vomiting, swallowing, diarrhea, constipation)* ___________________

URINARY *(eg. pain, increased frequency, blood)* ______________________________________

MALE *(eg. hernias, pain or masses in scrotum/testes)* __________________________________

FEMALE *(eg. urgency, menstruation/menarche, discharge, pain or masses in ovaries/uterus*
____

MUSCLE AND SKELETON *(eg. joint pain, stiffness, weakness, back pain, fractures)*
____

NEUROLOGICAL *(eg. seizures, paralysis, clumsiness, memory, vision changes, speech problems, sensation alteration)* ____

Informed Consent

Please note that this form must be signed prior to your first appointment.

Naturopathic medicine promotes wellness and aims to prevent disease by addressing the root cause of illness. Dr. Erica Arcuri, ND will take a detailed case history and perform any relevant physical examinations. It is very important that you inform Dr. Erica Arcuri, ND of any medical concerns, medications and/or supplements that you may be taking, as well as if you are pregnant, suspect you are pregnant or if you are breastfeeding. As a patient, you will receive information about your diagnosis and/or treatment, any alternative options available, associated costs, expected benefits and/or risks, side effects and in each case, the consequences of not having the diagnosis and/or treatment acted upon. As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine.

Possible health risks of naturopathic medical treatment include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, fainting or injury from acupuncture

I understand:

- An electronic medical record will be kept of the health services provided to me. This record will be kept in strict confidentiality and will not be released to others unless law requires it or I give my written consent.
- Dr. Erica Arcuri, ND will have to report me in the following instances: when I am in imminent danger of harming myself or others, when there is reasonable suspicion that I am neglecting and/or emotionally, physically or sexually abusing a minor, and if I engage in sexual relations with any of my healthcare providers.
- I may access my medical records at any time and can request a copy by paying the required fee.
- Dr. Erica Arcuri, ND does not guarantee treatment results. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and potential complications.

I recognize that this consent form covers the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I have read this statement and agree to work within its guidelines, including the limits of confidentiality.

Patient Name: (Please print): ____

Signature of Patient or Guardian: _____________________________ Date: _____________________

ND Signature: ____

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Naturopathic Fee Schedule

I understand that the fees are as follows:

Visit Type	Length	Fee
Adult Initial Visit	60 minutes	$180
Pediatric Initial Visit (12 or under)	60 minutes	$135
Follow up visits	45 minutes	$120
	30 minutes	$80
Telephone/Skype Consultation	30 minutes	$80
	15 minutes	$45

Payment
Payment is always due at the time of service. Naturopathic visits are not covered by OHIP; however naturopathic care is covered under most extended health benefit plans. We accept the following forms of payment: cash, debit card, Visa, Mastercard, cheque or direct billing to insurance companies. Naturopathic visits are exempt from HST. Laboratory testing and supplements are not in included in the fees above and are subject to HST.

Cancellation Policy
Please note that there is a 24-hour cancellation policy. Patients who give less than 24hr notice, or no shows, will be charged 50% of their original appointment fee.

Phone Consults
Phone consults can only be scheduled after the in-person initial consult.

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above.

Print Name: ____

Signature: ____

Date: ____

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Inklein Health Klinic is a multidisciplinary clinic, which offers a wide array of potential care for all of your health concerns. If you would like to find out more about what your personal health insurance covers, please let us know and our staff will call for you to find out.

Insurance Company: ____

Service	Coverage Amount	% Coverage	Max per Treatment	Dr. Note
Physiotherapy				
Acupuncture				
Chiropractic				
Naturopath				
Massage				
Psychotherapy				
Orthotics				
Compression Hosiery				

Year End: ________________

Spousal Secondary Coverage? ____