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## NATUROPATHIC INTAKE FORM

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### CONTACT INFORMATION

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate (D/M/Y) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

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

Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Contact Number \_\_\_\_\_

Physician Name \_\_\_\_\_ Physician Number \_\_\_\_\_

Last physician or health practitioner seen? \_\_\_\_\_ When? \_\_\_\_\_

How did you find out about us? \_\_\_\_\_

### YOUR CURRENT HEALTH CONCERNS

What is your main reason for coming in today? \_\_\_\_\_

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

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

What kind of treatment have you received for the above? \_\_\_\_\_

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

<b>Alcohol</b>		<b>Tobacco</b>	
<b>Hormones</b>		<b>Coffee</b>	
<b>Cortisone</b>		<b>Laxatives</b>	
<b>Sedatives</b>		<b>Antacids</b>	
<b>Recreational drugs</b>		<b>Aspirin or Tylenol</b>	

**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):

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

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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)? \_\_\_\_\_

## 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			Small pox			Warts		
Chicken pox			Poor memory			Polio			Mono		
Whooping cough			Balance problems			Gas/bloating			Depression		
Diphtheria			Speech problems			Hemorrhoids			Yeast infection		
Scarlet fever			Ringling 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		

Other: \_\_\_\_\_

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

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

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Please list any previous surgeries and hospitalizations including dates.

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Were you vaccinated?   Yes/No   Any adverse reactions (e.g. fever, skin rash, etc.)   Yes/No

## 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 (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.  
It will be a valuable resource in helping to understand your health.  
I'm looking forward to working with you.**

# Family Naturopathic Clinic

## Val Cremanaru, ND

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### DECLARATION AND CONSENT TO TREATMENT

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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 60-90 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.

**I acknowledge that I am aware and agree to the above.**

**Date:** \_\_\_\_\_

**Name (printed):** \_\_\_\_\_ **Signature:** \_\_\_\_\_