Mardian Natural Medicine

347 Old Chicopee Trail, Kitchener, Ontario, N2A 4G5
Telephone: (519) 896-4800 Fax: (519) 896-4806
Email: info@MNM.ca Website: MNM.ca

Adult Intake Form

First Name: _____ Last Name: _____

Age: _____ Birth Date: _____ Sex: Male ☐ Female ☐

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

E-Mail Address: _____

Occupation & Employer: _____

Single ☐ Married ☐ Divorced ☐ Separated ☐ Common Law ☐ Widowed ☐

Number of Children: ___ Emergency Contact Name : _____

Relation: _____ Phone: _____

How did you hear about our clinic? _____

What is your **main** reason for coming in today? _____

_____

List **other health problems** that are troubling you:

1) _____ When did it start? _____
2) _____ When did it start?_____
3) _____ When did it start?_____
4) _____ When did it start?_____

Health History

What is your general **state of wellbeing** from 1-10? (10 is the highest) _____
What is your **level of commitment** to your wellbeing & Health? (10 is the highest) _____
On average, how would you **rate your energy** level from 1-10 (10 is the highest) _____

Please list previous **surgeries** (include dates if possible) _____
_____

Please list any **allergies** to **drugs, plants, foods, animal** or other? _____
_____

Please check if you consume: ☐ Alcohol ☐ Artificial Sweeteners ☐ Coffee/caffeine
☐ Recreational Drugs ☐ Soda Pop ☐Tobacco

Please list current **supplements** and/or **medicines**_____
_____
_____

Which of the following have you had and indicate **Now (N)** or **Past (P)**:

	N	P		N	P		N	P		N	P
Allergies			Weight problems			Stroke			Venereal disease		
Asthma			Gallstones			Cancer			Syphilis		
Eczema			Gout			Epilepsy			Miscarriage		
Psoriasis			Arthritis			Migraine			Headache		
Ear infection			Thyroid problems			Pneumonia			Varicose veins		
Strep throat			Anemia			Diabetes			Broken bone		
Hay fever			High Blood pressure			Bladder Infections			Numbness/tingling		
Measles			Rheumatic fever			Tuberculosis			Cold hands/feet		
Mumps			Fainting			Small pox			Visual problems		
Chicken pox			Poor memory			Malaria			Warts		
Whooping cough			Balance problems			Yeast Infections			Mono		
Diphtheria			Speech problems			Gas/bloating			Depression		
Scarlet fever			Ringing in ears			Hemorrhoids			Child abuse		
Sinusitis			Jaundice			Parasites			Physical abuse		
Canker sores			Hepatitis			Rectal bleeding			Sexual abuse		
Acne			Heart disease			Herpes			Emotional abuse		
Tonsillitis			Alcoholism			Mental illness			Rape		

Other : _____

Family History

	Age if living	Age at Death	Cause of death	Health Concerns
Mother				
Father				
Brother(s)				
Sister(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Personal Habits/Lifestyle

Do you **exercise**? **Y/N** Do you have **sleep problems**? **Y/N** Do you **wake refreshed**? **Y/N**
How many **hours of sleep** do you get per night? _____ Do you **sweat** at night? **Y/N**

How is your **body temperature** in general? **Warmer** □ **Cooler** □ **Average** □
How much **water** do you drink per day? _____ Do you use a **microwave oven**? Y/N
Is your home **damp** or **moldy**? **Y/N** Do you work with **toxic fumes** or **materials**? **Y/N**

Female Reproduction ♀

Age of first period _____ Have your periods stopped? **Y/N** At what age? _____
Are your cycles regular? **Y/N** Are there any clots? **Y/N**
Do you have any spotting or bleeding between your periods? **Y/N**
Do you have any premenstrual symptoms **(PMS)**?

Water retention □ **Breast tenderness** □ **Irritability** □ **Depression** □ **Headaches** □

Anger □ **Mood swings** □ **Crying** □ **Bloating** □ **Acne** □ **Cravings** □
Other: _____
Number of pregnancies _____ Number of abortions_____ Number of miscarriages_____
Do you, or did you, have any problems getting pregnant? _____
Do you get **yearly PAP smears**? **Y/N** Any abnormal PAP's? **Y/N**
Breast lumps? **Y/N** Do you do monthly breast examinations? **Y/N**
Are you currently sexually active? **Y/N** Do you use birth control? **Y/N**
What type of birth control? _____ Any problems with sex drive? **Y/N**

Male Reproduction ♂

Do you get up in the night to urinate? Y/N Have you ever had any prostate problems? **Y/N**
Ever had your prostate checked? **Y/N** Any sores on genitals? Y/N
Any problems with sex drive? Y/N Any problems getting or maintaining an erection? **Y/N**
Are you currently sexually active? **Y/N** Do you use birth control? **Y/N**

Other

What long term **expectations** do you have from **working with our clinic**? _____

_____

What **expectations** do you have of me personally as your naturopathic doctor? _____

_____

Thank-you for filling in this questionnaire.
It is a valuable tool in assessing your health care needs.

MNM

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Consent to Treatment / Office Policy

Each person must sign this document before any treatment will be rendered.

Each person seeking care in this clinic should understand that the practitioner is a naturopathic doctor. If a medical diagnosis is required, it must be obtained from a licensed medical doctor.

By signing this document you are acknowledging the following:

1. The methods utilized in this clinic have a proven clinical foundation yet may not be accepted by standard (allopathic) medicine.
2. Naturopathic Doctors are required by their licensing board to perform a physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is accepted by the attending practitioner.
3. Naturopathy uses non-invasive methods for the assessment of bodily dysfunction and natural therapeutics for its correction. The therapeutics used in this clinic include: nutrition, homeopathy, botanical medicine, hydrotherapy, detoxification techniques, acupuncture, Bowen therapy, and lifestyle modification techniques.
4. The practitioner reserves the right to determine which cases fall outside of their scope of practice, in which event an appropriate referral will be recommended.
5. As a client, you are accepting or rejecting this care of your own free will.
6. The ultimate responsibility of your health care is your own and we are here to support you in this. We reserve the right to discontinue our service where it is apparent that your expectations and what we provide are not in agreement.
7. As a client, I confirm that none of the Naturopathic Doctors, nor anyone else at this clinic has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.
8. I agree to pay my full account for each visit or treatment, including fees for services, cost of supplements and remedies, cost of lab tests and any other fees. I am aware that these fees are not covered by OHIP.
9. I am aware that any phone call to the naturopathic doctor greater than 2 minutes will require an appointment or a charge for a phone consultation will be applied.
10. I am aware that if I do not show up on time for my appointment that there will be no extensions and I will be charged the regular fee.

I _____ (Please print your name here), have read and understood, and acknowledge the above statements.

_____ Date: _____
(Patient's signature)