NOVA HEALTH - Located in the Core Link Wellness Centre
2238 Caroline St., Burlington ON L7R1M6
Tel: 905. 592.0095 Fax. 905.592.0106

New Adult Intake Form

Please complete the following form to provide us with information we require to give you the best care.

Name:_____ Today's Date:_____

Age:_____ Date of Birth (m/d/y):_____

Address:_____City:_____

Province:_____ Postal Code:_____

Phone: H:(_____)_____C: (_____)_____W:(_____)_____

May we leave voicemails at the above phone numbers? If so, select which ones. □ Home □ Cell □ Work

Email address:_____

Occupation:_____Employer:_____

Gender: _____ Marital Status : _____

Do you have a health benefit plan? □Yes □No If Yes, which company? _____

Emergency Contact:

Name:_____

Relationship: _____ Phone: (_____)_____

Medical Providers:

Name of family doctor:_____

Phone Number: (_____)_____

Address:_____

Other Medical Providers: _____

Where did you learn about this clinic?

□ Google
□ OAND/CAND
□ Seminar
□ Social Media
□ Other
□ Referral from: _____

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Reason for your appointment:

List your main health concerns in order of importance

1)_____

_____

2)_____

_____

3)_____

_____

Please indicate any serious illnesses, conditions, or reasons for hospitalizations

Medical Condition/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

Please list all current medications/supplements

Medications/Supplements	Dose	Prescribing Physician	Length of Use

Please indicate any allergies or sensitivities to foods, drugs, herbs, vitamins, etc…

Allergy/Sensitivity	Symptoms

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Please indicate which of the following screening tests you receive (if known):

Test	Circle One	How Often/Recent Date
Breast exam	Yes No	
Mammogram	Yes No	
Bone Density Scan	Yes No	
PAP test (women)	Yes No	
Digital rectal exam (men)	Yes No	
PSA (men)	Yes No	
Cholesterol	Yes No	
Blood Glucose	Yes No	
Other (X-Ray, ultrasound, EEG, ECG, CT scan, MRI etc.)	Yes No	

Please indicate if any family member has had any of the following

Illness	Circle One	Family Member
Allergies	Yes No	
Asthma	Yes No	
Diabetes	Yes No	
Heart Disease	Yes No	
High Blood Pressure	Yes No	
Kidney Disease	Yes No	
Cancer	Yes No	
Depression	Yes No	
Other mental illness	Yes No	
Infertility	Yes No	
Other	Yes No	

Lifestyle:

Do you exercise?_____ How often? _____

Have you recently had a change in weight? □ Yes □ No If Yes, was it ↑ or ↓ and how much? _____

Hobbies: _____

Have you ever been infected with a Methicillin Resistant Organism (including MRSA)? _____

Is there anything that you feel is important that has not been covered?

_____

_____

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Check the conditions that you are currently experiencing, or have experienced often in the past. If more space is required please use the reverse side of this sheet.

	Current	Previous
General Symptoms:		
Loss of consciousness	☐	☐
Numbness / tingling	☐	☐
Fever	☐	☐
Sweats	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Loss of sleep/insomnia	☐	☐
Frequent colds / flus	☐	☐
Loss of weight	☐	☐
Head/Neck:		
Headaches	☐	☐
Type:_____		
Vision problems	☐	☐
TMJ concerns	☐	☐
Earaches	☐	☐
Decreased hearing	☐	☐
Sinus problems	☐	☐
Difficulty swallowing	☐	☐
Skin		
Rashes / Eczema	☐	☐
Itching	☐	☐
Bruise easily	☐	☐
Dryness	☐	☐
Boil / Hives	☐	☐
Contagious skin disease	☐	☐
Respiratory		
Chronic cough	☐	☐
Shortness of breath	☐	☐
Smoking	☐	☐
Breathing problems	☐	☐
Asthma / Bronchitis	☐	☐

	Current	Previous
Cardiovascular :		
High blood pressure	☐	☐
Low blood pressure	☐	☐
Bleeding disorders	☐	☐
Chest pain	☐	☐
Stroke	☐	☐
Artery hardening	☐	☐
Varicose veins	☐	☐
Swelling of the ankles	☐	☐
Poor circulation	☐	☐
Angina	☐	☐
Heart disease	☐	☐
Genitorurinary:		
Trouble urinating	☐	☐
Blood in the urine	☐	☐
Kidney infections	☐	☐
Bed wetting	☐	☐
Prostate trouble	☐	☐
Gastrointestional:		
Poor digestion	☐	☐
Indigestion	☐	☐
Excessive hunger	☐	☐
Belching or gas	☐	☐
Nausea / Vomiting	☐	☐
Abdominal pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Hemorrhoids	☐	☐
Liver concerns	☐	☐
Gall bladder trouble	☐	☐
Bladder concerns	☐	☐
Ulcer	☐	☐
Diabetes	☐	☐

	Current	Previous
Infections / Illnesses:		
Herpes	☐	☐
Hepatitis	☐	☐
Plantar warts	☐	☐
TB	☐	☐
HIV / AIDs	☐	☐
Cancer	☐	☐
Allergies	☐	☐
Muscles and Joints:		
Stiff neck	☐	☐
Backache	☐	☐
Swollen joints	☐	☐
Painful tail bone	☐	☐
Foot trouble L / R	☐	☐
Shoulder pain L / R	☐	☐
Elbow pain L / R	☐	☐
Wrist pain L / R	☐	☐
Hip pain L / R	☐	☐
Knee pain L / R	☐	☐
Arthritis	☐	☐
Weakness / loss strength	☐	☐
Women's Health:		
Painful menstruation	☐	☐
Excessive flow	☐	☐
Irregular cycle	☐	☐
Hot flushes	☐	☐
Cramps or backache	☐	☐
Vaginal discharge	☐	☐
Swollen breasts	☐	☐
Lumps in the breast	☐	☐
Are you pregnant ?	Yes	No
On birth control	Yes	No
# of pregnancies	_____	
# of children	_____	

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PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.
Our privacy policy states that: only necessary information is collected about you; storage, retention and destruction of your personal information complies with existing legislation and the privacy protection protocols of our regulatory body, the College of Naturopaths of Ontario.

This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns, provide health care, and advise you of treatment options
- To establish and maintain contact with you and follow-up with you for appointments
- To invoice goods and services, process payments including necessary credit card information and complete claims for insurance purposes when indicated
- To send you newsletters and other clinic updates as per your preference
- To communicate with other treating health-care providers when necessary with your consent
- To allow potential purchasers, practice brokers or advisors to conduct an audit

INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES

I, _____ acknowledge that I will be informed of the recommended therapeutic procedure(s)/ plan and will discuss any questions or concerns that may come up with the naturopathic doctor named below. I further acknowledge and confirm that I will be informed of and understand the therapeutic procedure(s)/plan with respect to the financial costs, expected benefits, potential risks and side effects, consequences of not having/following the procedure(s)/plan, and what alternative course(s) of action are available to me. As a result I do hereby voluntarily give my informed consent for the recommended therapeutic procedure(s)/plan and understand that I can change the status of my voluntary consent at any time.

PATIENT CONSENT

I have read and understand this form and consent to therapeutic care with a Naturopathic Doctor and the disclosure of my personal information as outlined above.

Signature:_____ Print Name:_____
Date:_____

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	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Breakfast							
Lunch							
Dinner							
Snacks							
Fluids							
Comments							