

## New Adult Intake Form – History of Cancer

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive 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: (\_\_\_\_\_) \_\_\_\_\_

Where did you learn about this clinic?

- Google
- OAND/CAND
- Seminar
- Social Media
- Other
- Referral from: \_\_\_\_\_

**Please complete this to the best of your knowledge:**

Cancer Type/Stage: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Any Metastasis? Where? \_\_\_\_\_

**\*\*\*It will be of great assistance if you bring copies or original reports from diagnostic tests you have had i.e. biopsy report, CT, MRI, etc. You may also ask your doctors to fax them directly to us at (905)592-0106**

Health Priorities/ Chief Concerns

List your main health priorities/concerns in order of importance

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

For the purposes of integrating your care and communicating with other healthcare practitioners, please list name of treating your treating doctors. **We will not contact your doctors without your consent.**

	Name	Address and/or Location and/or Phone number	Permission to Contact	
Family Physician			Yes <input type="checkbox"/>	No <input type="checkbox"/>
Medical Oncologist			Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgeon			Yes <input type="checkbox"/>	No <input type="checkbox"/>
Radiation Oncologist			Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other:			Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please list dates of your cancer surgeries:

Date of Surgery	Purpose of Surgery	Complications

Please list dates for your radiation therapy:

Site of Radiation	Start Date	End Date	Complications

Please list the dates and type of chemotherapy received:

Type of Chemotherapy	Start Date	End Date	Complications

Other than the cancer diagnosis, please list any other medical conditions, illnesses, surgeries, complications, or reasons for past hospitalizations

Other Medical Conditions	Date of Diagnosis	Is the condition still present?	Symptoms or Complications

Please list all **current** medications/supplements

Medications/Supplements	Dose	Prescribing Physician	Length of use

Please list all significant previous medications/supplements you were on in the last 5 years

Medications/Supplements	Dose	Prescribing Physician	Length of use

Please indicate any allergies and/or food sensitivities

Allergy/Food sensitivity	Symptoms

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

Have you had any adverse reactions to an antibiotics? \_\_\_\_\_

Have you had any adverse reactions from any vaccinations? \_\_\_\_\_

Do you use any of the following?

Type	Circle one	How much/How often/Form
Alcohol	Yes No	
Tobacco	Yes No	
Caffeine	Yes No	
Recreational Drugs	Yes No	
Aspirin	Yes No	
Laxatives	Yes No	
Antacids	Yes No	
Diet pills	Yes No	
Birth control	Yes No	

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

Test	Circle one	How often/Recent date
Breast exam	Yes No Never	
Mammogram	Yes No Never	
Bone Density scan	Yes No Never	
PAP test (women)	Yes No Never	
Digital rectal exam (men)	Yes No Never	
PSA (men)	Yes No Never	
Cholesterol	Yes No Never	
Blood Glucose	Yes No Never	
Other (X-Ray, ultrasound, EEG, ECG, CT scan, MRI etc.)	Yes No Never	

**Family History:**

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, ↑ or ↓? and how much \_\_\_\_\_?

Hobbies: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

**Review of Symptoms**

Current Previous

Current Previous

Current Previous

<p><b><u>General Symptoms</u></b></p> <p>Loss of consciousness <input type="checkbox"/> <input type="checkbox"/></p> <p>Numbness / tingling <input type="checkbox"/> <input type="checkbox"/></p> <p>Fever <input type="checkbox"/> <input type="checkbox"/></p> <p>Sweats <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting <input type="checkbox"/> <input type="checkbox"/></p> <p>Dizziness <input type="checkbox"/> <input type="checkbox"/></p> <p>Loss of sleep <input type="checkbox"/> <input type="checkbox"/></p> <p>Frequent colds / flus <input type="checkbox"/> <input type="checkbox"/></p> <p>Loss of weight <input type="checkbox"/> <input type="checkbox"/></p> <p><b><u>Head / Neck</u></b></p> <p>Headaches <input type="checkbox"/> <input type="checkbox"/></p> <p>Type _____</p> <p>Vision problems <input type="checkbox"/> <input type="checkbox"/></p> <p>TMJ concerns <input type="checkbox"/> <input type="checkbox"/></p> <p>Earaches <input type="checkbox"/> <input type="checkbox"/></p> <p>Decreased hearing <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty swallowing <input type="checkbox"/> <input type="checkbox"/></p> <p><b><u>Skin</u></b></p> <p>Rashes / Eczema <input type="checkbox"/> <input type="checkbox"/></p> <p>Itching <input type="checkbox"/> <input type="checkbox"/></p> <p>Bruise easily <input type="checkbox"/> <input type="checkbox"/></p> <p>Dryness <input type="checkbox"/> <input type="checkbox"/></p> <p>Boils / Hives <input type="checkbox"/> <input type="checkbox"/></p> <p>Contagious disease <input type="checkbox"/> <input type="checkbox"/></p> <p><b><u>Respiratory</u></b></p> <p>Chronic cough <input type="checkbox"/> <input type="checkbox"/></p> <p>Shortness of breath <input type="checkbox"/> <input type="checkbox"/></p> <p>Smoking <input type="checkbox"/> <input type="checkbox"/></p> <p>Breathing problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma / Bronchitis <input type="checkbox"/> <input type="checkbox"/></p>	<p><b><u>Cardiovascular</u></b></p> <p>High blood pressure <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure <input type="checkbox"/> <input type="checkbox"/></p> <p>Bleeding disorders <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke <input type="checkbox"/> <input type="checkbox"/></p> <p>Artery hardening <input type="checkbox"/> <input type="checkbox"/></p> <p>Varicose veins <input type="checkbox"/> <input type="checkbox"/></p> <p>Swelling of ankles <input type="checkbox"/> <input type="checkbox"/></p> <p>Poor circulation <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart disease <input type="checkbox"/> <input type="checkbox"/></p> <p><b><u>Genitorurinary</u></b></p> <p>Trouble urinating <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood in the urine <input type="checkbox"/> <input type="checkbox"/></p> <p>Kidney infections <input type="checkbox"/> <input type="checkbox"/></p> <p>Bed wetting <input type="checkbox"/> <input type="checkbox"/></p> <p>Prostate trouble <input type="checkbox"/> <input type="checkbox"/></p> <p><b><u>Gastrointestinal</u></b></p> <p>Poor digestion <input type="checkbox"/> <input type="checkbox"/></p> <p>Indigestion <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive hunger <input type="checkbox"/> <input type="checkbox"/></p> <p>Belching or gas <input type="checkbox"/> <input type="checkbox"/></p> <p>Nausea / Vomiting <input type="checkbox"/> <input type="checkbox"/></p> <p>Abdominal pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Constipation <input type="checkbox"/> <input type="checkbox"/></p> <p>Diarrhea <input type="checkbox"/> <input type="checkbox"/></p> <p>Hemorrhoids <input type="checkbox"/> <input type="checkbox"/></p> <p>Liver concerns <input type="checkbox"/> <input type="checkbox"/></p> <p>Gall bladder trouble <input type="checkbox"/> <input type="checkbox"/></p> <p>Bladder concerns <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcer <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes <input type="checkbox"/> <input type="checkbox"/></p>	<p><b><u>Infections / Illnesses</u></b></p> <p>Herpes <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis <input type="checkbox"/> <input type="checkbox"/></p> <p>Plantar warts <input type="checkbox"/> <input type="checkbox"/></p> <p>TB <input type="checkbox"/> <input type="checkbox"/></p> <p>HIV / AIDs <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer <input type="checkbox"/> <input type="checkbox"/></p> <p>Allergies <input type="checkbox"/> <input type="checkbox"/></p> <p><b><u>Muscles and Joints</u></b></p> <p>Stiff neck <input type="checkbox"/> <input type="checkbox"/></p> <p>Backache <input type="checkbox"/> <input type="checkbox"/></p> <p>Swollen joints <input type="checkbox"/> <input type="checkbox"/></p> <p>Painful tail bone <input type="checkbox"/> <input type="checkbox"/></p> <p>Foot trouble L / R <input type="checkbox"/> <input type="checkbox"/></p> <p>Shoulder pain L / R <input type="checkbox"/> <input type="checkbox"/></p> <p>Elbow pain L / R <input type="checkbox"/> <input type="checkbox"/></p> <p>Wrist pain L / R <input type="checkbox"/> <input type="checkbox"/></p> <p>Hip pain L / R <input type="checkbox"/> <input type="checkbox"/></p> <p>Knee pain L / R <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis <input type="checkbox"/> <input type="checkbox"/></p> <p>Weakness/loss strength <input type="checkbox"/> <input type="checkbox"/></p> <p><b><u>Women's Health</u></b></p> <p>Painful menstruation <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive flow <input type="checkbox"/> <input type="checkbox"/></p> <p>Irregular cycle <input type="checkbox"/> <input type="checkbox"/></p> <p>Hot flushes <input type="checkbox"/> <input type="checkbox"/></p> <p>Cramps or backache <input type="checkbox"/> <input type="checkbox"/></p> <p>Vaginal discharge <input type="checkbox"/> <input type="checkbox"/></p> <p>Swollen breasts <input type="checkbox"/> <input type="checkbox"/></p> <p>Lumps in the breast <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you pregnant Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>On birth control Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p># of pregnancies _____</p> <p># of children _____</p>
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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 \_\_\_\_\_

**7 Day Diet Diary**

Name: \_\_\_\_\_

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

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