

Adult Patient
CONSENT TO NATUROPATHIC TREATMENT

Naturopathic treatment at **Pura Vida Health Care** is wellness-based, founded on individual treatment, financial accessibility, informed consent, and integrative complementary medicine, in an atmosphere that is supportive and healing to both clients, practitioners and our environment.

Naturopathic treatment at **Pura Vida Health Care** may include the following modalities and diagnostic procedures:

- botanical medicine
- homeopathy
- clinical nutrition
- Traditional Chinese Medicine including acupuncture
- hydrotherapy
- bodywork
- lifestyle counseling
- physical examination
- urinalysis
- blood tests (finger prick)

Not all of the above modalities and diagnostic services will necessarily be appropriate in your case at all times and may or may not be implemented by your Naturopath. All procedures and treatments will be fully explained to you, including the expected cost of the procedures and treatments, expected length of treatment, any adverse effects of or alternative choices to a specific treatment, and consequences of not obtaining treatment, before your treatment plan is undertaken. All information exchanged between you and your naturopath is confidential, and your privacy is assured.

I, _____, consent to treatment by my licensed Naturopathic Doctor, **Pascaline Phillips ND**, and have been fully informed of the nature of all therapeutic procedures, services, diagnostic tests.

signature

date



Naturopath - Adult Intake form

Name: _____ today's date: _____

Date of birth: _____ age: _____ sex/gender: _____

Home address: _____ city: _____

Postal code: _____ home telephone: () _____
Work telephone: () _____

E-mail address: _____ Other numbers: _____

How did you find out about our clinic? _____

Health Care Team:

Family physician: _____ phone: () _____

Other health care providers: _____ phone: () _____

_____ phone: () _____

CHIEF HEALTH CONCERNS: What are your health concerns, in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? Please list approximate dates and reasons:

ENVIRONMENT & LIFESTYLE

Occupation / employer: _____

Do you exercise regularly? Y N

- what types of exercise: how much and how often?

What is your social support network? _____

Do you: live alone live with a partner: male or female? live with friends other

Are you exposed to any air fresheners/artificial scents or chemicals? Y N

How would you describe the emotional climate of your home? _____

How stressful is your work or other aspects of your life?

How do you manage stress?

HEALTH HISTORY:

Do you have any allergies (foods, environmental, medications)? please list:

Please list all current medications: prescription, over-the-counter, vitamins, herbs, homeopathics:

- How many times have you been treated with antibiotics?
- Do you frequently use any of the following?
 - laxatives
 - antacids
 - diet pills
 - aspirin/Tylenol/Advil/ibuprofen
 - caffeine – form and amount per day _____
 - tobacco/cigarettes – how much or how many/day? _____
 - alcohol – how much per day or week? _____
 - recreational drugs – what and how much? _____
- Do you get regular screening tests done by a doctor? (Pap, blood tests, etc) Y N
- Do you have any dietary restrictions (religious, vegetarian, vegan, etc)?

Describe a typical day's diet:

- breakfast: _____
- lunch: _____
- dinner: _____
- snacks: _____
- beverages (and amount consumed): _____

FAMILY HEALTH HISTORY: (√ for present or "p" for in the past)

Please indicate if a close relative (parent, grandparent, sibling) has had any of the following:

- allergies
- arthritis
- asthma
- auto immune disease: type: _____
- cancer: type: _____
- diabetes
- heart disease
- high blood pressure
- mental illness: type: _____
- multiple sclerosis
- stroke
- tuberculosis
- any other medical conditions? _____

Is there any other information that has not been covered which you feel is important regarding your health care?

GENERAL HISTORY: For the following list of symptoms, indicate with a "c" for those that you currently experience, or "p" for those that you've had in the past:

SKIN:

- rashes
- eczema
- psoriasis
- vitiligo
- dryness
- hives
- boils
- acne
- warts

HEAD:

- head injury
- headaches/migraines
- vertigo/dizziness
- hair loss
- dandruff

EYES:

- redness
- excessive tearing
- double/blurred vision
- spots/floaters
- flashing lights
- glaucoma
- cataracts
- discharge/infection

EARS:

- infection
- ringing in ears (tinnitus)
- hearing loss

NOSE & SINUSES:

- frequent colds
- nasal stuffiness
- loss of smell
- nose bleeds
- chronic runny nose
- sinus infections
- nasal polyps

MOUTH & THROAT:

- bleeding gums/gingivitis
- sores in mouth
- periodontal disease
- thrush
- sore throat
- enlarged lymph glands
- torticollis/stiff neck

RESPIRATORY:

- cough
- wheezing
- asthma
- central chest pain
- bronchitis

- pneumonia
- emphysema
- coughing up blood
- tuberculosis

CARDIOVASCULAR:

- rapid heart beat
- high blood pressure
- chest pain
- palpitations
- heart murmurs
- difficult breathing
- leg cramps
- deep leg pain/
thrombophlebitis
- edema/swollen ankles
- cold hands/feet
- hot flashes

GASTROINTESTINAL:

- trouble swallowing
- nausea
- vomiting
- regurgitation/heartburn
- indigestion
- bloating
- abdominal pain
- excessive passing of gas
- ulcer
- hypoglycemia
- diabetes
- jaundice
- hepatitis
- colitis / Crohn's disease

GENITO-URINARY:

- constipation
- blood in stool
- diarrhea
- hemorrhoids
- eating disorder
- urgency
- dribbling / leaking
- frequency
- incontinence
- burning/pain on urination
- urinary tract infections
- kidney infection
- kidney stones
- sexually transmitted diseases
(HPV, etc)

GENERALS:

- noticeable weight loss
- noticeable weight gain
- fatigue
- night sweats
- profuse perspiration
- weakness

FEMALE:

- PMS
- menopause
- low libido
- yeast infection/vaginitis
- vaginal dryness
- painful periods
- irregular periods
- excessive discharge
- miscarriage(s)
- pregnancy(s)
- abortion
- endometriosis
- uterine fibroids
- cervical dysplasia
- fibrocystic/breast problems

MALE:

- BPH/enlarged prostate
- prostatitis
- discharge
- low libido/erectile dysfunction

HAEMATOLOGICAL:

- anemia
- easy bleeding
- easy bruising
- varicose veins/spider veins
- any past transfusions
- hepatitis A, B or C
- HIV

MUSCULOSKELETAL:

- muscle pains
- joint pains
- osteoarthritis
- back pain
- muscle spasms/cramps
- joint swelling
- gout

NEUROLOGICAL:

- fainting/black outs
- numbness/loss of sensation
- tremors/involuntary movements
- tingling/"pins & needles"
- loss of balance
- paralysis
- speech problems
- memory loss
- loss of sleep
- nervousness/tension
- irritability
- depression