Adult Intake Forum

Personal Information

Full Name: _____

Date of Birth: _____ **Age**: _____ **Sex**: _____

Mailing Address: _____

Home# _____ **Mobile#** _____**Work#** _____

Email: _____

Emergency Contact:

Name:_____ **Relation**: _____

Home# _____ **Mobile#** _____**Work#** _____

Medical Doctor:

Name:_____ **Phone**: _____

Address:_____ **Fax**: _____

Personal Health Number (Care Card) _____

How did you hear about *Arc Integrated Medicine*?

_____

_____

Medical Information

Current Health Concerns and/or Goals

Please list your concerns in order of importance, when the symptoms began and any treatments that you have tried.

1. _____Onset: _____

   Treatments: _____

2. _____Onset: _____

   Treatments: _____

3. _____Onset: _____

   Treatments: _____

4. _____Onset: _____

   Treatments: _____

5. _____Onset: _____

   Treatments: _____

Allergies & Sensitivities

Please list any known drug or food reactions that you have experienced, use the back of the page if you require more space.

Drug Allergy: _____ Reaction: _____

Drug Allergy: _____ Reaction: _____

Environmental Allergy: _____ Reaction: _____

Environmental Allergy: _____ Reaction: _____

Food Allergy: _____ Reaction: _____

Food Allergy: _____ Reaction: _____

Food Sensitivity: _____ Reaction: _____

Food Sensitivity: _____ Reaction: _____

MEDICATIONS (Prescription drugs and over-the-counter preparations)

Please list all medications that you are currently taking, and any other information you can provide.

Drug	Dose	Reason for Taking	Year Started

SUPPLEMENTS (Vitamins, minerals, amino acids, herbal medicines, homeopathic preparations)

Please list all supplements that you are currently taking, and any other information you can provide.

Supplement *(Including brand if known)*	Dose	Reason for taking *(Including who prescribed this to you)*	Year Started

Past Medical History

Conditions

Please list any previous medical conditions, and when you suffered from them

1. _____

2. _____

3. _____

4. _____

Other Medical Events

Please list any hospitalizations, major injuries or surgeries you've experience and the year in which they occurred

1. Year: _____Condition: _____

2. Year: _____Condition: _____

3. Year: _____Condition: _____

4. Year: _____Condition: _____

Did you receive all general childhood vaccinations? YES NO

What other vaccines have you received?

- ○ Hepatitis A
- ○ Hepatitis B
- ○ Typhoid
- ○ Flu Shot
- ○ Chicken Pox
- ○ HPV (Gardasil)

Review of Symptoms

Please check all symptoms that you have experienced during the last 6 months

GENERAL
- ○ Weight gain
- ○ Weight loss
- ○ Heat/Cold Intolerance
- ○ Insomnia
- ○ Fatigue
- ○ Night sweats

Other: _____

HEAD, EYES, EARS, NOSE & THROAT
- ○ Headache
- ○ Migraine
- ○ Ear pain
- ○ Ringing in ears
- ○ Changes in hearing
- ○ Itching or watery eyes
- ○ Dry or red eyes
- ○ Eye pain
- ○ Changes in vision
- ○ Throat pain
- ○ Difficulty swallowing
- ○ Sinus infection/pain
- ○ Nasal congestion

Other: _____

CARDIOVASCULAR
- ○ Chest pain
- ○ Heart palpitations
- ○ High blood pressure
- ○ Easy bruising
- ○ Varicose veins
- ○ Swollen feet/ankles
- ○ Cold hands/feet

Other: _____

RESPIRATORY
- ○ Difficulty breathing
- ○ Exercise intolerance
- ○ Cough
- ○ Hoarseness of voice
- ○ Sleep apnea
- ○ Snoring
- ○ Asthma or wheezing

Other: _____

GASTROINTESTINAL
- ○ Bloating & Flatulence
- ○ Indigestion
- ○ Constipation
- ○ Diarrhea
- ○ Blood and/or mucous in stool
- ○ Pain during bowel movements
- ○ Belching
- ○ Acid reflux
- ○ Hemorrhoids
- ○ Anal fissures
- ○ Nausea

Other: _____

EATING & APPETITE
- ○ Difficulty gaining weight
- ○ Difficulty losing weight
- ○ Frequent dieting
- ○ Poor appetite
- ○ Always hungry
- ○ Emotional eating
- ○ Cravings

Specify _____
- ○ Binge eating
- ○ Anorexia or bulimia

Other: _____

PSYCHOLOGY & NERVOUS SYSTEM
- ○ Anxiety or panic attacks
- ○ Depression
- ○ Difficulty concentrating
- ○ Poor memory
- ○ Numbness or tingling
- ○ Difficulty with speech
- ○ Seizures

- ○ Trembling or tremor
- ○ Dizziness or vertigo
- ○ Fainting or feeling lightheaded
- ○ Loss of balance
- ○ Difficulty walking

Other: _____

MUSCULOSKELETAL

- ○ Joint pain, redness, or stiffness

Specify _____

- ○ Neck or back pain
- ○ Foot cramps or pain
- ○ Wrist or hand pain
- ○ Joint deformity
- ○ Muscle pain or cramps
- ○ Muscle weakness
- ○ Restless legs
- ○ Tendonitis
- ○ TMJ /Jaw pain

Other: _____

URINARY

- ○ Acute or Chronic UTI's
- ○ Incontinence or Dribbling
- ○ Pain or burning on urination
- ○ Frequent urination
- ○ Blood in urine

Other: _____

IMMUNE

- ○ Enlarged lymph nodes
- ○ Painful or tender lymph nodes
- ○ Frequent infections
- ○ Frequent colds or flu
- ○ Slow wound healing

SKIN & NAILS

- ○ Acne
- ○ Athlete's foot
- ○ Jock Itch
- ○ Dandruff
- ○ Dark circles under eyes
- ○ Profuse sweating
- ○ Rashes or hives
- ○ Dry or itchy skin
- ○ Bumps on the back of arms
- ○ Suspicious moles
- ○ Changes in pigment
- ○ Hair loss
- ○ Brittle or breaking nails
- ○ White spots or ridges on nails

Other: _____

MEN'S HEALTH

Please check all boxes that apply

- ○ Prostate enlargement
- ○ Change in libido
- ○ Hernia
- ○ Erectile dysfunction
- ○ Testicular mass or pain
- ○ Prostate or urinary infection
- ○ Urinary urgency, hesitancy or dribbling
- ○ Sexually transmitted infections

Other: _____

Date of most recent PSA test: _____ Normal/Abnormal?
Date of most recent Prostate Exam: _____ Normal/Abnormal?

WOMEN'S HEALTH

Please provide the numbers as they apply

- ○ Pregnancy _____
- ○ Miscarriage _____
- ○ Caesarean _____
- ○ Abortion _____
- ○ Vaginal Delivery _____
- ○ Living Children _____
- ○ Gestational Diabetes _____
- ○ Postpartum Depression _____
- ○ Breast Feeding _____

Date of last PAP test _____ Normal/Abnormal?
Date of last Mammogram _____ Normal/Abnormal?

MENSTRUAL HISTORY

Age at first period _____
Length of period _____
Length of cycle _____ Irregular Y N
Date of last period _____

- ○ Blood Clots
- ○ Menstrual Cramping
- ○ Breast Tenderness
- ○ Mood Swings/Irritability
- ○ Water retention
- ○ Depression

GYNECOLOGICAL CONDITIONS

- ○ Endometriosis
- ○ PCOS (Ovarian cysts)
- ○ Uterine Fibroids
- ○ Pain with Intercourse
- ○ Bleeding between periods
- ○ Infertility
- ○ Low libido
- ○ Fibrocystic breasts
- ○ Sexually transmitted infections
- ○ Cervical dysplasia
- ○ Menopause, since age _____
    - ○ Hot flashes
    - ○ Vaginal dryness
    - ○ Night sweats
    - ○ Mood swings
    - ○ Difficulty concentrating
    - ○ Depression
- ○ Perimenopause, since age _____
- ○ Use of Hormone replacement therapy

FAMILY MEDICAL HISTORY

Please check all boxes that apply, mark with a "D" if deceased

	Mother	Father	Sibling	Children	Maternal Grandparents	Paternal Grandparents	Aunts	Uncles
Cancer								
Genetic Disorders (e.g. MS, ALS, etc.)								
Cardiovascular Disease (e.g. stroke, high blood pressure)								
Diabetes								
Dementia								
Psychiatric or Mood Disorders								
Food/ Environmental Allergies								
Autoimmune Disease (e.g. Rheumatoid arthritis, Lupus, etc.)								

Social History

What is your occupation? _____

Do you smoke? YES NO If yes, how many packs per day _____ For how long? _____

How many alcoholic drinks do you consume per week? None 1-4 5-7 7-10 10+

Please list any recreational drug use: _____

How many cups of caffeine do you drink per week? None 0-6 7-9 10-14 14+

Many servings of sugar do you consume per week? 1-4 5-10 10-14 14-20 21+

Do you adhere to a specific diet (e.g. vegetarian, vegan, high-protein, gluten-free, paleolithic)?

_____

What foods do you avoid? _____

_____

Psychosocial

Please rate, on a scale from 0-10 (10=best) how satisfied you are with the following areas of your life

Work/School _____
Financial Situation _____
Social Life/Friends _____
Spirituality _____

Relationship _____
Sexual Life _____
Family _____

Informed Consent for Naturopathic Care

- I understand that the practice of naturopathic medicine requires taking a thorough case history, and may require a physical exam. In some cases, diagnostic testing including the collection of blood, urine and/or saliva may be required.

- I confirm that the information I have provided to *Arc Integrated Medicine* is complete and inclusive of all health concerns including the possibility of pregnancy and use of all current medications, including over-the-counter drugs.

- I understand that naturopathic medicine carries a risk of complications and that a resolution of symptoms is not guaranteed. Health risks of some naturopathic treatments include, but are not limited to:
    - Temporary aggravation of pre-existing symptoms
    - Allergic reactions and other adverse effects to botanical medicines or supplements
    - Pain, fainting, bruising or injury from venipuncture, acupuncture or cupping treatments
    - Muscle sprain, ligament strain, swelling and/or pain from spinal manipulation

- I confirm that I have the ability to accept or reject the recommended treatment at my own free will.

- I understand that I have the ability to seek and/or continue medical care from another qualified health care practitioner. I recognize that I am encouraged to speak freely regarding the treatments received and recommendations made at *Arc Integrated Medicine*.

- I understand that a record of my visits and medical history will be kept, that this record will be strictly confidential and will not be released to any persons without my written consent.

- I have read and understood the fee schedule and I acknowledge that these services are not covered by MSP and I am responsible for payment of goods and services in full at each visit.

- I understand the following return policy regarding products/supplements/herbal tinctures:

    - Unopened products can be returned for full refund up to 60 days after purchase.
    - Opened products CANNOT be returned unless there has been an adverse reaction, which must be reported to your naturopathic doctor within 30 days of occurrence. If the product has caused an adverse reaction, a full refund will be processed.

- I understand that there is a cancellation fee for appointments missed without notice or cancelled with less than 24 hours notice. I acknowledge that if I arrive late for my scheduled appointment, the visit will be shortened to ensure that other patient visits are kept on time.
    - No-Show fee – 75% of visit cost (Initial) _____
    - Less than 24 hour cancellation – 50% of visit cost (Initial) _____

- I understand that the doctors at *Arc Integrated Medicine* reserve the right to determine which cases fall outside their scope of practice, in which case an appropriate referral will be recommended.

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____