Sage Naturopathic Clinic
Feel Better - We Can Help
585 Queen St. S. Suite:101, Kitchener, ON N2G4S4 519.573.6700 info@thesageclinic.com www.thesageclinic.com @thesageclinic

ADULT INTAKE FORM

First Name: _____ Last Name: _____

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

Street Address: _____

City: _____ Province: _____ Postal Code: _____

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

Would you like to receive reminder emails before

E-Mail Address: _____

Would you like to receive our electronic quarterly newsletters: **Yes No**

Occupation: _____ Employer: _____

Marital Status:

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

Number of Children: _____

Medical Doctor's Name: _____

Medical Doctor's Phone Number: _____

Date of last Physical Exam and bloodwork: _____

Emergency Contact Name : _____

Relation: _____ Phone: _____

How did you hear about our clinic? _____

OFFICE USE ONLY: Vital Statistics

Height:	Weight:	BP:	Pulse

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?_____

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				

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? 1-10? (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 list current **supplements** and/or **medications**:_____

_____

Were you vaccinated? If so, any adverse reactions? Please list:_____

_____

Please check if you consume: Alcohol ☐Artificial Sweeteners ☐ Coffee/caffeine ☐

Recreational Drugs ☐ Soda Pop ☐ Tobacco ☐

Please indicate which, if any, of the following you have had either **Now (N)** or in the **Past (P)**:

Allergies		Ear Infection		Malaria		Sexual abuse	
Abscesses		Eczema		Measles		Sleeping Problems	
Alcoholism		Emotional abuse		Mental illness		Small pox	
Anemia		Epilepsy		Migraine		Strep throat	
Arthritis		Fainting		Miscarriage		Stroke	
Asthma		Fatigue		Mono		Syphilis	
Balance issues		Fungal Infections		Mumps		Thyroid issues	
Bladder infections		Gallstones		Numbness or tingling		Tonsillitis	
Broken bone		Gas/bloating		Parasites		Tuberculosis	
Bronchitis		Gout		Pelvic Inflammatory Disease		Varicose veins	
Cancer		Hay fever		Physical abuse		Venereal disease	
Chicken pox		Headache		Pneumonia		Vision issues	
Child abuse		Heart disease		Poor memory		Warts	
Chronic Sore Throats		Hemorrhoids		Rape		Weight issues	
Cold hands/feet		Hepatitis		Rectal bleeding		Whooping cough	
Depression		Herpes		Rheumatic fever		Worms	
Diabetes		High blood pressure		Ringing in ears		Other:	
Diphtheria		Jaundice		Scarlet fever			

PERSONAL HABITS/LIFESTYLE:

Do you **exercise**? **Y/N** What forms? _____

Do you have **sleep problems**? **Y/N** Please describe _____

_____

How many **hours of sleep** do you get per night? _____ Do you **wake refreshed**? **Y/N**

Do you **sweat** at night? **Y/N** How is your general **body temperature**? **Warmer Cooler Average**

How much **water** do you drink per day? _____ Is your home **damp** or **moldy** at all? **Y/N**

Do you work in the presence of **toxic fumes** or **materials**? **Y/N** Do you use a **microwave**? **Y/N**

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

OTHER:

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

_____

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

_____

Is there any other information you think is important for me to know? _____

_____

Thank-you for filling in this questionnaire.

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It is a valuable tool in assessing your health care needs.

Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for: □ Past 30 days □ Past 48 hours

Point Scale

0- Never or almost never have the symptoms
1- Occasionally have it, effect is not severe
2- Occasionally have it, effect is severe
3- Frequently have it, effect is not severe
4- Frequently have it, effect is severe

Head	_____ Headaches _____ Faintness _____ Dizziness _____ Insomnia **Total** _____
Eyes	_____Watery or Itchy eyes _____ Swollen, reddened or sticky eyelids _____ Bags or dark circles under eyes _____Blurred or tunnel vision (does not include near or farsightedness) **Total** _____
Ears	_____ Itchy ears _____ Earaches, ear infections _____ Drainage from ear _____ Ringing in ears, hearing loss **Total** _____
Nose	_____ Stuffy nose _____ Sinus problems _____ Hay fever _____ Sneezing attacks _____Excessive mucus formation **Total** _____
Mouth/ Throat	_____ Chronic coughing _____ Gagging, frequent need to clear throat _____ Sore throat, hoarseness, loss of voice _____ Swollen or discoloured tongue, gums, or lips _____ Cancker sores **Total** _____
Skin	_____ Acne _____ Hives, rashes, dry skin _____ Hair loss _____ Flushing, hot flashes _____ Excessive sweating **Total** _____
Heart	_____Irregular or skipped heartbeat _____ Rapid or pounding heartbeat _____ Chest pain **Total** _____
Lungs	_____ Chest congestion _____ Asthma, bronchitis _____ Shortness of breath _____ Difficulty breathing **Total** _____

Digestive Tract	_____ Nausea, vomiting _____ Diarrhea _____ Constipation _____ Bloated feeling _____ Belching, passing gas _____Heartburn _____ Intestinal/ Stomach pain **Total** _____
Joints/ Muscles	_____ Pain or aches in joints _____ Arthritis _____Stiffness or limitation of movement _____ Pain or aches in muscles _____Feeling of weakness or tiredness **Total** _____
Weight	_____ Binge eating/ drinking _____ Craving certain foods _____ Excessive weight _____ Compulsive eating _____ Water retention _____ Underweight **Total** _____
Energy/ Activity	_____ Fatigue, sluggishness _____ Apathy, lethargy _____ Hyperactivity _____ Restlessness **Total** _____
Mind	_____ Poor memory _____ Confusion, poor comprehension _____ Poor concentration _____ Poor physical coordination _____ Difficulty making decisions _____ Suffering or stammering _____ Slurred speech _____ Learning disabilities **Total** _____
Emotions	_____ Mood swings _____ Anxiety, fear, nervousness _____ Anger, irritability, aggressiveness _____Depression **Total** _____
Other	_____ Frequent illness _____ Frequent or urgent urination _____ Genital itch or discharge **Total** _____

Welcome to Sage Naturopathic Clinic!

About Us

At Sage Naturopathic Clinic, we want people to feel better. Our vision is to create a safe space for all our patients in which they can strive for their optimum health. We know that in today's world, striving for optimum health is not easy – it's incredibly challenging. At Sage, we work to empower our patients to feel the best they can feel. We aim to educate our patients so that they can make the most informed decisions about their care.

Informed Consent

Naturopathic Medicine

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration the physical, mental, emotional and spiritual aspects of the individual. Gentle, noninvasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Initial Visit(s) and Fees

During your initial one-hour visit, your Naturopathic Doctor will take a thorough case history and may perform a basic/complaint-oriented physical examination. Second visits are 45 minutes in length and include a complete physical exam as well as follow up on your concerns, it may also include urine sampling. Subsequent visits are typically 45-30 minutes in length.

As primary care physicians, we recommend basic screening lab exams. If you have had lab work done with your medical doctor in the last 6 months, please bring a copy of these results with you to the appointment. If you have not had any lab work done recently, your Naturopathic Doctor may prescribe certain lab tests which are an additional fee. Lab fees vary depending on which tests are recommended, for more information please call the clinic at 519-573-6700.

Some therapies must be used with caution in certain conditions or diseases such as diabetes, heart/liver/kidney disease, or in young children, those taking multiple medication or pregnancy/lactation. Therefore, it is very important that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, as well as, any medications (prescription or over-the counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breastfeeding, please advise your Naturopathic doctor immediately.

The fees for Naturopathic Medicine are as follows:

First Visit (Aprox. 60 minutes): $175.00
Follow Up (Aprox. 45 minutes): $110.00
Return Appointment (Aprox. 30 minutes): $80.00
Mini Visit (Aprox. 15 minutes): $50.00
Full Urine Analysis: $30.00

Fees for Naturopathic Medicine are not covered by OHIP however, most extended healthcare plans provide some coverage. It is best to check your individual plan for more information.

TREATMENT OPTIONS

A number of different approaches may be used throughout the course of treatment. Your Naturopathic Doctor will discuss with you the most appropriate treatments as they are recommended. Treatment modalities include dietary modification and nutritional supplementation, lifestyle counseling, botanical medicine, homeopathy, traditional Chinese medicine & acupuncture, hydrotherapy, and physical medicine. Both our Naturopathic Doctors have additional training and are certified in parenteral therapy (IV therapy) as well as First Line Therapy (a diet and lifestyle management therapy). Further information about any of these modalities can be discussed with your Naturopathic Doctor.

The Naturopathic Doctor may prescribe supplements that can be purchased at the clinic or at other local options i.e. health food stores. Most insurance companies do not cover the supplements that we prescribe and dispense.

PRIVACY POLICY

Privacy of your personal information is an important part of what we offer at Sage Naturopathic Clinic, and protecting your personal information is something we take very seriously. We are committed to collecting, using and disclosing your personal information responsibly.

- Only necessary information is collected about you;
- Only with your consent do we share information with others outside the clinic;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy
- protection protocols;
- Sage Naturopathic Clinic's privacy policy conforms to privacy legislation and standards of the
- Board of Directors of Drugless Therapy – Naturopathy.

Personal information is collected in order to:

- Assess your health;
- Provide health care;
- Advise you of treatment options;
- Establish and maintain contact with you regarding appointments, invoicing and follow-up care;
- Send you pertinent information and mailings;
- Facilitate your insurance claims;
- Allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale;
- Comply with the legal and regulatory requirements of the Drugless Practitioners Act.

WAIVER

By signing below, you have agreed that you have reviewed the above information that explains the benefits and possible risks of Naturopathic treatment. You understand that the results are not guaranteed. You do not expect the naturopathic doctors to be able to anticipate and explain all risks and complications. With this knowledge, you voluntarily consent to Naturopathic care and intend this consent form to cover the entire course of treatment. You understand that you are free to withdraw your consent at any time.
You also agree that you have reviewed the above information that explains how the clinic will use your personal information, and the steps Sage Naturopathic Clinic is taking to protect your information. You agree that the clinic can collect, use and disclose personal information as set out above in the information about the clinic's privacy policies.

Signature:_____Date:_____

Witness:_____Date:_____

Print parent/guardian's name:_____
(if under 18 years of age)

Signature of Parent/guardian:_____

Collaborative Team:
At Sage, out healthcare team works to provide the best care possible for our patients. We recognize that in some cases, providing the best healthcare means utilizing the skills of multiple practitioners. In such cases allowing for professional, open dialogue, regarding your case, between members of your healthcare team at Sage Naturopathic Clinic can allow for optimal treatment strategies and improvement in your health.
I welcome professional dialogue regarding my case between members of my healthcare team at Sage Naturopathic Clinic:

Yes No

Signature: _____