



ADULT NATUROPATHIC INTAKE FORM

Welcome to our clinic. Your health questionnaire provides valuable information on factors which influence your well being, and contribute to the underlying causes of your health concerns. Please fill out the questions to the best of your ability and bring the form to your first visit.

GENERAL CONTACT INFORMATION

Name: _____ Blood Type: _____
(last name) (first name) (middle initial)

Age: _____ Gender: Female Male Date of Birth: _____ / _____ / _____
DD MM YY

Address: _____
(street address) (city) (province) (postal code)

Telephone: Cell _____ Work _____ Home _____

Email: _____

Occupation: _____

How did you hear about Dr. Keyes? Word of mouth, Webpage, Tradeshow, Other _____

Emergency Contact: _____
(name) (relationship) (telephone)

Medical Doctor: _____ Last physical exam _____
(name) (telephone) (month) (year)

Other Health Care providers: _____
(name) (telephone)

HEALTH INFORMATION

What is your main health concern? _____

Please list any other health concerns (physical, emotional, or mental) in order of importance.

1. _____
2. _____
3. _____

What are your treatment goals and expectations? _____

How do you rate your overall health? Poor Fair Good Excellent

How committed are you in taking responsibility for your healing and in following through on treatment?
(low) 0 1 2 3 4 5 6 7 8 9 10 (high)

Medications/Supplements

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose/day	How long?	Medication	Dose/day	How long?
1.			5.		
2.			6.		
3.			7.		

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement	Dose/day	How long?	Supplement	Dose/day	How long?
1.			5.		
2.			6.		
3.			7.		
4.			8.		

How many courses of antibiotics have you had in the past 10 years? _____

Allergies (please list all known)

Allergy	Items	Reaction
Medication/ Food		
Environmental/ Animal		

Environmental Toxic Exposure

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, etc) while at work, home or travelling? Y N

Do you live near power lines or a refinery? Y N

Are your home and work environments **not** well-ventilated? Y N

Are you exposed to tobacco smoke (work, home, etc.)? Y N

Are you frequently exposed to animals (work, pets, etc.)? Y N

Do you have mercury dental fillings? Y N How many? ____

Have you had mercury dental fillings in the past? Y N How many? ____

Do you have surgical implants, body piercings (medical, cosmetic) Y N

Do you use fluoride toothpaste? Y N

Have you ever had any organ transplants/ blood transfusions? Y N

Do you have a history of drug or alcohol abuse? Y N

Medical history

Childhood illnesses (Check ✓)

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Eczema | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Ear infections/colds | <input type="checkbox"/> Rubella (German measles) | <input type="checkbox"/> Other: _____ |

Immunizations: (Check ✓)

- | | | | |
|-----------------------------------|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> DPT | <input type="checkbox"/> Hemophilus influenza B | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Flu shot | <input type="checkbox"/> Tetanus Booster | <input type="checkbox"/> MMR | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Other: _____ | |

Any adverse reactions to vaccinations? Y / N. If yes, explain. _____

Traumas/ Illnesses Timeline (please complete as this section is especially important)

Please list the **most** serious, trauma/injuries, illnesses, drug reactions, hospitalizations, from childhood to present

Date _____ event _____

Date _____ event _____

Date _____ event _____

Date _____ event _____

Date _____ event _____

Date _____ event _____

Date _____ event _____

Date _____ event _____

Family History (m=mother f=father b=brother s=sister a=aunt u=uncle gm-grandmother gf=grandfather)

Please indicate whether your family members have or had the following:

Condition	Relative	Condition	Relative
Alcoholism		Heart disease	
Allergies		Kidney disease	
Alzheimer's disease		Liver disease	
Arthritis		Mental Illness i.e. depression	
Asthma		Osteoporosis	
Autoimmune disease		Parkinson's	
Cancer (indicate type)		Seizure/ Epilepsy	
Crohn's or Colitis		Stroke Aneurysm	
Drug addiction		Thyroid condition	
Diabetes		Tuberculosis	
Eczema		Other	

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Cravings: sugar salty foods spicy foods (please list) _____

Aversions: _____

Glasses of **water** per day? Tap____ Filtered____ Distilled____ Reverse Osmosis____ Spring____

Cups/ glasses per day? Coffee____ Black tea____ Herbal tea____ Pop?____ Other____

Alcohol consumption/ week? _____ bottles/ glasses of _____

Please list any dietary restrictions? Vegan vegetarian Other _____

Lifestyle

Do you exercise? Y N. What type of exercise and how often? _____

What do you do for recreation and relaxation? _____

Rate your stress level: **(low)** 1 2 3 4 5 6 7 8 9 10 **(high)**

Which factors most contribute to your stress? Health Work Money Family Marriage Relationship Other

REVIEW OF SYSTEMS

Energy

Rate your energy level between: **(low)** 1 2 3 4 5 6 7 8 9 10 **(high)**.

When during the day is your energy the best? _____ the worst? _____

What makes your energy better? _____ worse? _____

Sleep

Time you retire _____ Time you rise _____ Average hours of sleep per night _____

Do you sleep in the dark? Y N

Wake unrefreshed Sleepy in the afternoon

Difficulty falling asleep

Difficulty staying asleep Nightmares

Wake to use washroom (# times) _____

Temperature (how do you tend feel most of the time?)

Warm Chilly Cold hands Cold feet Heat or Cold Intolerance

Thirst

Do you prefer hot Cold not thirsty

Perspiration

Excess Minimal

Please **check** (✓) if you currently experience the following or write a **P** if you experienced it in the past:

	Past	Now		Past	Now
<u>Skin, Hair Nails</u>					
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Dry/ rough skin	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Light/dark patches of skin	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Change in size/colour of mole	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Loss of hair	<input type="checkbox"/>	<input type="checkbox"/>
Cysts	<input type="checkbox"/>	<input type="checkbox"/>	Pits on nails	<input type="checkbox"/>	<input type="checkbox"/>
Warts	<input type="checkbox"/>	<input type="checkbox"/>	Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>
Scars	<input type="checkbox"/>	<input type="checkbox"/>	Nail colour change/ ridges	<input type="checkbox"/>	<input type="checkbox"/>

Head

Head Injury Dizziness or vertigo

Headaches

If yes, where? Forehead Temples Back of head Top of head Eyes Behind eyes

	Past	Now		Past	Now
<u>Eyes</u>					
Poor eyesight (near or far)	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Sudden change in vision	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Red, itching or painful	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ears</u>					
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears (Tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to noise	<input type="checkbox"/>	<input type="checkbox"/>	Itchiness	<input type="checkbox"/>	<input type="checkbox"/>
<u>Nose and Sinuses</u>					
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>
<u>Mouth and Throat</u>					
Frequent sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>
Tonsils removed	<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>
Persistent hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Gum problems/ bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
Jaw problems	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores	<input type="checkbox"/>	<input type="checkbox"/>
<u>Respiratory</u>					
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Pain on breathing	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
<u>Cardiovascular</u>					
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain when walking	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain when sitting/ lying	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling in arm	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in legs/ ankles	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
<u>Gastrointestinal</u>					
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Change in thirst	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	Irritable if miss a meal	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Tired after eating	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hiccups	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Belching/ gas/ bloating	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Fissures	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Black stool	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Distress from fatty foods	<input type="checkbox"/>	<input type="checkbox"/>	Undigested food in stool	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have a bowel movement? _____ Itchy rectum/ parasites? _____					
<u>Urinary</u>					
Pain on urination	<input type="checkbox"/>	<input type="checkbox"/>	Burning on urination	<input type="checkbox"/>	<input type="checkbox"/>
Increased frequency	<input type="checkbox"/>	<input type="checkbox"/>	Frequency at night	<input type="checkbox"/>	<input type="checkbox"/>
Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Incomplete urination	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>

	Past	Now		Past	Now
<u>Emotional</u>					
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety or nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
OCD	<input type="checkbox"/>	<input type="checkbox"/>	Anger	<input type="checkbox"/>	<input type="checkbox"/>
ADD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Restlessness	<input type="checkbox"/>	<input type="checkbox"/>

<u>Neurological</u>					
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance/coordination	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/ tingling	<input type="checkbox"/>	<input type="checkbox"/>	Burning sensation on soles of feet	<input type="checkbox"/>	<input type="checkbox"/>

<u>Musculoskeletal</u>					
Joint pain/ stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis/bursitis	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain/ stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasms/ cramps	<input type="checkbox"/>	<input type="checkbox"/>	Herniated/degenerated discs	<input type="checkbox"/>	<input type="checkbox"/>
Loss of muscle tone	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>

<u>Endocrine</u>					
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss/Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy upon standing	<input type="checkbox"/>	<input type="checkbox"/>

<u>Lymphatic/Immune</u>					
Chronic Infections	<input type="checkbox"/>	<input type="checkbox"/>	Chronic swollen glands	<input type="checkbox"/>	<input type="checkbox"/>
Slow wound healing	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Auto-immune _____	<input type="checkbox"/>	<input type="checkbox"/>

Female Health

Age of first period _____ Date of last period? _____
 Length of flow (days)? _____ Length of complete menstrual cycle (days)? _____
 Colour of blood? bright light dark red Do you use tampons? Yes No
 Do you experience?
 Heavy flow Yes No Light flow Yes No
 Clotting Yes No Bleeding between periods Yes No

Do you suffer from PMS? Yes No
 Menstrual cramps Mood Swings
 Bloating and/or water retention. Headaches
 Breast tenderness Cravings? salt sugar
 Low back pain before period Low back pain during period

Are you currently sexually active? Yes No Have you been sexually active in the past? Yes No
 Are you pregnant? Yes No
 Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____
 Have you ever used birth control? Yes No
 Current forms of contraception? BCP Condoms Diaphragm Other _____
 Do you have any sexual problems or concerns? Yes No _____
 Have you had a sexually transmitted disease? Yes No _____
 Are you postmenopausal (no period for 1 year) ? Yes No If yes, age of last period _____
 Have you had a hysterectomy? Yes No

Please indicate if the following applies to you

- | | |
|--|--|
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Vaginal Itching | <input type="checkbox"/> Low libido |
| <input type="checkbox"/> Vaginal odour | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Absent menstruation | <input type="checkbox"/> Pain during intercourse |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Breast pain | <input type="checkbox"/> Pelvic pain |

Last Pap test? _____ Have you had an abnormal Pap? Yes No Date: _____

Do you perform monthly self breast exams? Yes No

Do you have regular mammograms Yes No or breast thermograph? Yes No

Have you had an abnormal mammogram? Yes No or breast thermograph? Yes No Date: _____

Men's Health

Are you currently sexually active? Yes No Have you been sexually active in the past? Yes No

Current forms of contraception? BCP Condoms Diaphragm Other _____

Do you have any sexual problems or concerns? Yes No _____

Have you had a sexually transmitted disease? Yes No _____

Please indicate if the following applies to you

- | | | | | |
|--|--|--|---|------------------------------|
| <input type="checkbox"/> Hernia (type): _____ | <input type="checkbox"/> Impotence | <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Discharge or sores | <input type="checkbox"/> STD |
| <input type="checkbox"/> Testicular mass and or pain | <input type="checkbox"/> Prostate condition. | Year of last prostate exam? ____ | | |

Thank you for taking the time to fill out these forms.

Return to nature. Everything we need to heal is in nature.



Declaration and Consent to Treatment

Caution must be taken in physiological conditions such as pregnancy and lactation, in very young children, persons with diabetes, heart, liver or kidney impairment and/or in persons taking multiple medications.

It is important that you inform your Naturopathic Doctor, Dr. Katherine Keyes, immediately of:

- Any disease process from which you currently suffer
- If you are on any medications either prescribed or over-the-counter
- If you are pregnant, suspect you are pregnant, planning to become pregnant or are currently breast feeding

There are some slight health risks associated with treatment by Naturopathic Medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture
- Accidental burning of the skin from the use of moxa.
- Muscle strains and sprains, and disc injuries from spinal manipulation.
- The very small potential for stroke is a concern in neck manipulation. Patients are thoroughly screened prior to manipulating the neck.

Your Naturopathic Doctor is trained to handle emergencies should the need arise.

I understand that my Naturopathic Doctor, Dr. Katherine Keyes will answer any questions that I have to the best of her ability. I understand that results are not guaranteed. I do not expect the ND to anticipate and explain all risks and complications. I will rely on the naturopathic doctor to exercise judgment during the course of my treatment which she feels is in my best interest based on the facts which are known. I also understand that pharmaceutical grade supplements and herbal medicines prescribed and sold by my naturopathic doctor may be a part of my treatment protocol. This is to ensure that the appropriate dose and quality of medicine is administered and immediately available, in order to provide the most effective treatment possible. I also understand that there may be an additional cost for certain diagnostic procedures.

With this knowledge I voluntarily consent to the diagnostic and therapeutic procedures mentioned above. I intend for this consent to cover the course of my treatment. I am free to withdraw my consent and discontinue treatment at any time. I also testify that I am able to give legal consent or there is a parent or guardian able to sign on my behalf.

If I am unable to make a scheduled appointment I will provide 24 hours advance notice to avoid being charged a missed appointment fee of 100%. I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as any other applicable fees. I understand that all supplements, labs and naturopathic fees are non-refundable.

Patient's Full Name (please print): _____
First Middle Last

Date of Consent: _____
Day Month Year

X _____
Signature of Patient (or legal guardian)



Dr. Katherine Keyes BA, B.Ed, ND
DOCTOR of NATUROPATHIC MEDICINE

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dr-keyes.com • info@dr-keyes.com

Patient Consent Form for Collection, Use and Disclosure of Personal Information

Your Naturopathic Doctor, Dr Katherine Keyes, understands the importance of protecting your personal information.

To help you understand how she does that, here is an outline of how your Naturopathic Doctor may use and disclose this information:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To inform you of change of location/moving
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with your other treating health-care providers i.e. MDs, NDs, Osteopaths
- To allow your Naturopathic Doctor to efficiently follow-up for treatment, care and billing
- To invoice for goods and services
- To process payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others
- To be used for research purposes. Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

I have reviewed the above information that explains how my Naturopathic Doctor, Dr Katherine Keyes, will use my personal information, and the steps that she is taking to protect my information.

I agree that my Naturopathic Doctor can collect, use and disclose personal information about _____ as set out above in the information about my

(Patient Name)

Naturopathic Doctor's privacy policies.

Patient's Full Name (please print): _____
First Middle Last

Date of Consent: _____
Day Month Year

X _____

Signature of Patient (or legal guardian)