

DR KATHERINE KEYES - ADULT INTAKE FORM
MAYA HEALTH CENTRE
 #2, 1922 9th Avenue SE, CALGARY, AB, T2G 0V2
 PH: 403-457-3393 FAX 403-288-4886
www.dr-keyes.com

PATIENT INFORMATION

Date (day/mo/yr): ____ / ____ / ____

Name: _____

Date of birth (day/mo/yr): ____ / ____ / ____ Sex: M / F

Email: _____

Address with postal code: _____

Tel (home): _____ (work): _____

Emergency contact: _____ Relationship: _____

Tel (home): _____ (work): _____

Medical doctor: _____ MD Tel: _____

Other healthcare providers: _____

How did you hear about the clinic? _____

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

When was your last physical exam? _____

Medications

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.		
4.			8.		

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? _____

Have you ever had a bad reaction to any medication? Y / N

Please circle any of the following that you use.

- | | | |
|-----------------------|--------------------|---------------|
| Alcohol | Diet pills | Tranquilizers |
| Antacids | Laxatives | Cortisone |
| Antibiotics | Pain relievers | Tobacco |
| Aspirin | Recreational drugs | Caffeine |
| Appetite suppressants | Sleeping pills | |
| Birth control pills | Thyroid medication | |

Medical history

Indicate if you had any of the following childhood illnesses (circle):

- | | | |
|----------------------------------|--------------------------|-----------------|
| Asthma | Measles | Rheumatic fever |
| Chickenpox | Mumps | Scarlet fever |
| Eczema | Polio | Whooping cough |
| Frequent ear infections or colds | Rubella (German measles) | Other: _____ |

Immunizations: (Check ✓)

- DPT Hemophilus influenza B Hepatitis A Hepatitis B
- Flu shot Tetanus Booster MMR Polio
- Smallpox Chicken Pox Other: _____

Any adverse reactions to vaccinations? Y / N. If yes, explain. _____
 Please list (with approximate dates) any serious conditions, illnesses or injuries, and any hospitalizations. _____

Family History

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

	Relative		Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	

Diet

Please describe your typical diet:

Breakfast _____
 Lunch _____
 Dinner _____

Water consumption/ day? _____glasses/d
 Coffee/caffeine consumption/day? _____cups, glasses of _____
 Alcohol consumption/ week? _____bottles, glasses of _____

Cravings/ Likes? _____
 Aversions? _____
 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? _____

Do you smoke/are you exposed to significant tobacco smoke? Y / N/Past use Recreational drug use? Y/ N/ Past use

Are you frequently exposed to animals? Y / N

Are you regularly exposed to toxins or other hazards? Y / N. If yes, explain. _____

Please list all allergies (food, environmental, or medications). _____

Occupation: _____

Marital status: _____

Rate your stress level (circle): Low High Unbearable
 Which factors most contribute to your stress? (circle)
 Health Work Money Family Marriage Other: _____

Number of children: _____
 Average High Unbearable

Women's health

Do you get regular screening tests done by another doctor (blood work, Pap)? Y / N

Date of last Pap? (month/yr) ____ / _____ Have you ever had an abnormal Pap? Y / N

Age of first period? _____ Is your period regular? Y / N

Length of monthly cycle (days)? ____ Length of period or flow (days)? ____ Amount of flow? (light, heavy)

Color of blood? (bright, light, dark red) Menstrual cramps? ____ Clots? _____

Do you use tampons? Y/ N Do you experience PMS? Y / N Low back pain with period? (before, during)

Are you menopausal? Y / N. If yes, age of last period ____ Vaginal dryness? Y/N Hotflashes? Y/N Night sweats? Y/N

Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N

Do you have any sexual problems or concerns? Y / N. _____

Current forms of contraception? (BCP, Condoms, Diaphragm, Other) _____

Have you ever had a sexually transmitted disease? Y / N

Number of pregnancies? ____ Births? ____ Miscarriages? ____ Abortions? ____

Have you had any of the following concerning your breasts? (circle)
 Pain Lumps Infections Cysts Nipple discharge

Do you experience vaginal infections? Never Rarely Frequently
 Do you experience bladder infections? Never Rarely Frequently

Men's health

Do you get regular screening tests done by another doctor (blood work, prostate examination)? Y / N
 Date of last prostate examination? (month/yr) ____ / ____
 Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N
 Do you have any sexual problems or concerns? Y / N _____
 Current forms of contraception? _____
 Do you have difficulty urinating completely? Y / N
 How many times do you get up from your sleep to go to the bathroom at night? ____
 Have you had any of the following? (circle)
 Testicular pain Hernia STDs Discharge Sores

REVIEW OF SYSTEMS

How do you rate your overall energy? Poor Fair Good Excellent
 Please check (✓) if you currently experience the following or write a P if you experienced it in the past:

General symptoms

Headache
 Head injury
 Fever
 Chills
 Sweats
 Dizziness
 Fainting
 Loss of sleep
 Fatigue
 Nervousness
 Loss of weight
 Numbness or pain in arms/legs/hands
 Allergy
 Convulsions

Eyes, Ears, Nose, Throat

Dental decay
 Gum trouble
 Frequent colds
 Enlarged thyroid
 Tonsillitis
 Sore throat
 Hoarseness
 Enlarged glands
 Glaucoma
 Failing vision
 Cataracts
 Eye pain
 Ear discharge
 Deafness
 Ear ache
 Nasal drainage
 Nose bleeds
 Nasal obstruction
 Sinus infection
 Hay fever
 Mercury tooth fillings

Cardiovascular

Low blood pressure
 High blood pressure
 Previous heart stroke
 Hardening of the arteries
 Swelling of the ankles
 Poor circulation
 Paralytic stroke
 Irregular heart beat
 Shortness of breath
 Chest pain

Skin

Hives or allergy
 Acne or skin eruptions
 Itching
 Bruises easily
 Dryness
 Boils
 Varicose veins
 Sensitive skin
 Change in mole

Gastrointestinal

Excessive thirst
 Excessive hunger
 Belching
 Gas (flatulence)
 Nausea
 Vomiting
 Vomiting of blood
 Abdominal cramps
 Constipation
 Diarrhea
 Colon trouble
 Hemorrhoids (piles)
 Intestinal worms
 Liver problems
 Gallbladder problems
 Jaundice
 Colitis

Kidneys & Reproduction

Inability to control urine
 Frequent urination
 Painful urination
 Blood in urine
 Pus in urine
 Kidney infection
 Kidney stones
 Prostate trouble
 Sores on genitals

Muscle & Joint

Stiff neck
 Back pain
 Muscle weakness
 Swollen joints
 Painful tailbone
 Foot trouble
 Pain in shoulders
 Hernia
 Spinal curvature
 Faulty posture
 Arthritis
 Fracture/dislocation

Respiratory

Asthma
 Chronic cough
 Spitting up phlegm
 Spitting up blood
 Difficult breathing

Is there anything else that you feel has not been covered? _____

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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 naturopath 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 doses 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 must 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.

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

Date of Consent: _____
Day Month Year

X _____
Signature of Patient (or legal guardian)

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

Your Naturopathic Doctor 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 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 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)