Shifra Centre for Wellness

Dr. Carrie Mitchell & Dr. Andrea Clarke, ND
Naturopathic Doctors
403.932.3176

NATUROPATHIC INTAKE FORM - ADULT

Name	Sex	**DOB:** Age:
Address	**Phone Number**	
Emergency Contact	**Emergency contact Number**	

PERSONAL HEALTH HISTORY

Past medical history (hospitalizations, chronic disease, accidents etc)	
Family medical history (parents, siblings, overall family trends)	
Current medications, supplements, vitamins and botanicals	

	Health Concerns (in order of importance)	**Onset**
1		
2		
3		
4		
5		

Allergies, Food sensitivities

FOUNDATIONS			
Exercise	Type Frequency		
Diet	Breakfast		
	Lunch		
	Dinner		
	Snacks		
	Water		
	Current weight ______ Ideal weight ______		
Caffeine		Alcohol	
Smoking		Drugs	

System Overview					
Please check all that apply - Add any notes needed, and circle when necessary					
Ear, Eyes Nose, Throat, Immune		Head		Lung, Heart	
☐	Hearing changes	☐	Headaches	☐	Shortness of breath
☐	Ear pain	☐	Dizziness	☐	Difficulty breathing
☐	Ringing in ears	☐	Lightheadedness	☐	Chronic cough, mucous, or phlegm
☐	Nasal discharge	☐	Memory changes	☐	Bronchitis / Asthma
☐	Eye pain or itching	☐	Sinus congestion	☐	Palpitation or Irregular heart beat
☐	Vision changes	☐	Fainting	☐	Swelling in hands or feet
☐	Frequent coughs, colds	☐	Difficulty concentrating	☐	Blood clots
☐	Loss of smell	☐	Difficulty falling asleep	☐	High or low blood pressure
☐	Recent antibiotic use	☐	Difficulty staying asleep	☐	Chest pain

Gastro-Intestinal		Urinary		Skin, hair, nails	
☐	Nausea / Vomiting	☐	Pain on urination	☐	Rashes / Itching / Eczema
☐	Constipation /Diarrhea / Both	☐	Frequent urination	☐	Acne
☐	Abdominal pain	☐	Kidney stones	☐	Hives
☐	Bloating	☐	Inability to hold urine	☐	Moles
☐	Indigestion	☐	Blood in urine	☐	Poor wound healing
☐	Heartburn	☐	Irregular flow	☐	Hair loss / Change in hair texture
☐	Mucous / Blood in stool	☐	History of urinary tract infections	☐	Dandruff / Dry skin
☐	High / Low appetite	☐		☐	
☐	# Bowel movements daily _______	☐		☐	

Female		Male		Miscellaneous	
☐	Currently pregnant? Weeks gestation _____	☐	Sexual dysfunction Erectile dysfuntion	☐	Depression / Low moods / Irritability Anxiety
☐	History miscarriage	☐	Pain on urination	☐	Stress level (__ / 10)
☐	Past pregnancies	☐	Prostate pain / discomfort	☐	Stressors in life ________________________
☐	Menstruation length ___	☐	Weak urinary stream	☐	Energy Levels (___ / 10)
☐	Days of flow ___	☐	Urge to urinate several times nightly	☐	Chronic worrying
☐	PMS – Bloating / Cramping / Mood	☐	High / Low Libido	☐	Feels warmer / colder than others
☐	Fertility struggles	☐	History STI	☐	**Any other concerns not addressed:**
☐	History STI	☐		☐	
☐	High / Low Libido	☐		☐	

Informed Consent

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Dr. Carrie and/or Dr. Andrea will take a thorough case history, perform a complaint-oriented physical examination, and if required, take a urine sample and request blood work.

It is very important that you inform Dr. Carrie Mitchell and/or Dr. Andrea Clarke of any condition or disease that you currently have and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast- feeding, please advise your Naturopathic Doctor immediately.

There are some health risks to treatment by naturopathic medicine. These include but are not limited to:

-Aggravation of pre-existing symptoms

-Allergic reactions to supplements or herbs

-Pain, bruising or injury from acupuncture or intramuscular injections

-Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.

I understand that a record will be kept of the health services provided. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. I understand that I can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (please print clearly)____

Signature of Patient/Guardian: ____

Date of Initial Appointment: ____

Dr. Carrie Mitchell, ND: ____

Dr. Andrea Clarke, ND:____