Dr. Jill Kazuk
Naturopathic Doctor

1062 Portage Avenue
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P: (204) 774-5521
www.wolseleywellness.ca

ADULT INTAKE FORM

Date: _____

Name: _____
Address: _____
_____
City: _____ Province: _____
Postal code: _____
Birthplace: _____
Date of birth: _____
Name preference: _____

Gender / self-identity: _____
Telephone (Home) _____
(Cell) _____
(Work) _____
On which of the above may we leave confidential information (please circle): **Home** **Work** **Cell**

Email address: _____

How did you hear about us? _____
Emergency contact: _____ Relation: _____ Phone number: _____

HEALTH CONCERNS

Please list your most important health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

When were you last feeling really great? _____

Are you currently receiving medical care? Yes / No
Medical doctor: _____
Clinic Name: _____
Clinic Address: _____ Clinic Phone: _____

GENERAL

Height: _____ Weight _____ Weight one year ago: _____ Maximum Weight: _____
When in the day is your energy best? _____ Worst? _____

PAST MEDICAL HISTORY

Childhood illnesses *Please circle whether you had any of the following as a child:*

Scarlet fever	Diphtheria	Rheumatic fever	German Measles
Mumps	Measles	Chicken Pox	Whooping cough

Other: _____

Major Traumas / Surgeries / Injuries / Illnesses *Physical, mental, emotional, or spiritual*

Event _____ year _____ Outcome _____
Event _____ year _____ Outcome _____
Event _____ year _____ Outcome _____
Event _____ year _____ Outcome _____
Event _____ year _____ Outcome _____

Allergies

Please list any things you are allergic or sensitive to and what happens when you are exposed to it:

Drugs: _____
Foods: _____
Environmental/Chemical: _____

Current Medications

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Have you ever used antibiotics? Yes / No If so, how many times have you used antibiotics in your life: _____

SOCIAL HISTORY

Relationship status: *(please circle)* single / married / common-law / divorced / separated / widowed

Live with: *(please circle)* alone / spouse/partner / children / parent(s) / relative(s) / friend(s) / roommate(s)

Are you happy at home? _____
Do you feel supported? _____
Occupation: _____
Do you enjoy your work? _____
Do you exercise? If yes, what do you like to do?
_____
How often? _____

Difficulty falling/staying asleep? Yes / No
Wake rested? Yes / No
Are you currently pregnant? Yes / No
Are you currently breast feeding? Yes / No
Do you have a religious or spiritual practice? Yes / No
If so, what kind? _____

FAMILY MEDICAL HISTORY

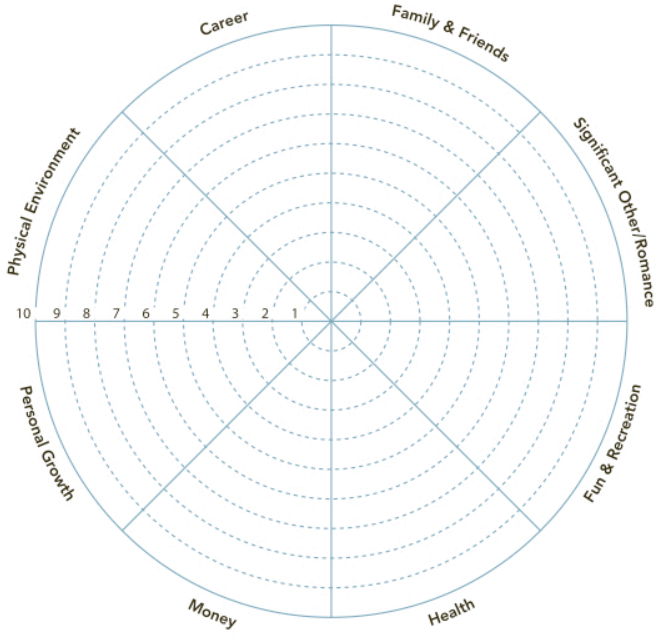
Please list if anyone in your biological family has or had any of the following. If you do not have information about your biological family's medical history, please skip.

Cancer _____ Thyroid Issues _____ Mental Illness _____
Diabetes _____ Asthma _____ Addiction _____
Heart Disease _____ Autoimmune _____ Glaucoma _____
High Blood Pressure _____ Kidney Disease _____ Epilepsy _____
Stroke _____ Osteoporosis _____ Alzheimer's _____

Any other relevant family medical history?_____

Wheel of Balance

Using the circle, shade the level of satisfaction in each area. For example, if you are 60% satisfied with your health, shade the first six levels of the Health slice. Do the same for each area, starting from the center point radiating outward.



GOALS AND MOTIVATION FOR TREATMENT

What is your present level of commitment to addressing your health concerns? (circle one):

LOW 1 2 3 4 5 6 7 8 9 10 **HIGH**

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?

_____

What are the major sources of stress in your life and how do you cope with them?

_____

What potential obstacles do you foresee in achieving your health goals?

_____

What long-term expectations do you have for working with your doctor?

_____

If there is anything else you would like to share at this time, please do so in the space below.

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Informed Consent for Treatment

Naturopathic medicine is the treatment and prevention of diseases and disorders by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Using a variety of treatment modalities, gentle, non-invasive techniques stimulate the body's inherent healing capacity.

Even the gentlest therapies have their complications. Certain conditions propose higher risk, such as: pregnancy, lactation, those on multiple medications or who have certain diseases such as diabetes, heart, liver or kidney disease, or are very young. To ensure your safety, it is very important that you inform Dr. Kazuk immediately of:

- any disease process that you are suffering from
- if you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or if you are breast-feeding

I understand that there are some potential health risks to treatment by Naturopathic Medicine. Although rare, these include but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, bruising or injury from venipuncture.

Cancellation Policy and Financial Responsibility Agreement

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 other applicable fees. I understand that **I must give 24 hours notice to change or cancel an appointment**. If I do not follow this cancellation policy, or simply do not show up for my appointment, I agree to pay the full cost of the appointment.

Privacy Disclosure and Policies

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless directed by myself or when law requires it. I understand that I may look at my medical record at any time and can request a copy or have a report drawn up by paying the appropriate fee.

I intend this consent form to cover my entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I DECLARE that I have received a full and complete explanation of the naturopathic medical treatment or services that I may receive at Wolseley Wellness Centre and hereby authorize and consent to treatment.

Patient's Full Name (printed): _____
Patient's signature: _____ Date: _____

Signature of patient or legal guardian:_____