EAST COAST
NATUROPATHIC CLINIC

PATIENT INTAKE FORM

All information is confidential. Please print.

PERSONAL

Name _____ Date _____

Age _____ Date of Birth (m/d/y) _____ Gender _____

Occupation _____ Number of work hours per week _____

Mailing Address _____

Phone: h. _____ c. _____ w. _____

Email _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about our clinic? _____

Please follow us on Facebook for clinic and health information (East Coast Naturopathic Clinic)

MEDICAL

Family Medical Doctor _____ Address _____ Phone _____

Date of last blood work (m/d/y) _____ Blood Type _____

Permission to consult with your health care providers? Please initial if yes. Y / N _____ (*initial*)

What is your chief health concern? _____

_____

Please list any prescription medications you are **currently** taking:

Medication	Prescribed for	Dosage

Please list any supplements (vitamins, herbs, homeopathics, etc.) you are **currently** taking:

Supplement	Taking for	Dosage

Please list any over the counter medications you are taking _____

_____

If you are currently under the care of another physician or healthcare practitioner, what treatments are you receiving? _____

_____

Please list major injuries, illnesses or surgery (with approximate dates) _____

_____

_____

Please list all allergies _____

_____

ENVIRONMENTAL

Do you react to strong scents (perfume, gasoline, tobacco, etc.)? _____

How many mercury ("silver") fillings do you have? _____ Number of root canals? _____

Have you reacted to a medication in the past? _____

Please list any toxic substances you are exposed to _____

Have you lived or worked in a building that is/was: Water-damaged? ____ Moldy? ____ Musty? ____

LIFESTYLE

Sleep (hours/night) _____ Quality? _____ Do you feel rested on waking? _____

Exercise (type, duration, frequency) _____

Water (glasses/day) _____ Coffee (cups/day) _____ Tea (cups/day) _____

Alcohol (drinks per day/week – circle one) _____ Pop (glasses/day) _____

Tobacco (type, # per day) _____ Recreational drugs _____

Hobbies _____

What are the significant stressors in your life? _____

_____

DIET

Do you have any dietary restrictions? _____

How many cups of vegetables do you consume each day? _____

Please list the typical meals that you consume:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

OVERVIEW OF BODY SYSTEMS

Please check ***at least one*** of the following that applies to you

Y condition that you have **NOW**

N condition that you **NEVER HAD**

P condition that you had in the **PAST**

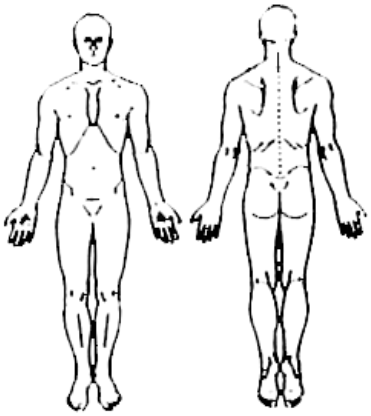
1. GENERAL	**Y**	**N**	**P**
Height			
Weight			
High blood pressure			
Low blood pressure			
Fatigue/weakness			
Fever/chills			
2. SKIN	**Y**	**N**	**P**
Rashes			
Eczema			
Acne			
Psoriasis			
Itching			
Nail changes			
3. HEAD	**Y**	**N**	**P**
Headache/migraine (please circle)			
Head Injury			
Dizziness			
4. EYES	**Y**	**N**	**P**
Impaired vision			
Watery/dry (please circle)			
Itching			
Blurring			
5. EARS	**Y**	**N**	**P**
Earache			
Discharge			
Infection			
Tinnitus (ringing in ears)			
6. NOSE & SINUS	**Y**	**N**	**P**
Congestion			
Runny nose			
Loss of smell			
7. MOUTH & THROAT	**Y**	**N**	**P**
Frequent sore throat			
Bleeding gums			
Canker sores			
Swollen glands			
Tonsil issues			
8. CARDIOVASCULAR	**Y**	**N**	**P**
Heart disease			
Chest pain/angina			
Heart flutters/palpitations			
Murmurs			
9. RESPIRATORY	**Y**	**N**	**P**
Cough			
Asthma			
Bronchitis/pneumonia			
Shortness of breath			
COPD			

10. BREASTS	**Y**	**N**	**P**
Lumps			
Fibrocystic breasts			
Pain			
11. URINARY	**Y**	**N**	**P**
Pain			
Increased/decreased frequency			
Frequency at night			
Inability to hold urine			
Frequent infections			
Kidney stones			
Blood in urine			
Urgency			
Hesitancy			
12. GASTROINTESTINAL	**Y**	**N**	**P**
Heartburn/reflux			
Nausea/vomiting			
Regular bowel movements			
Frequency: per day per week			
Blood in stool/black stool			
Undigested food in stool			
Excess gas/bloating			
Gallbladder disease			
Liver disease			
Ulcer			
Abdominal pain			
Hemorrhoids			
Rectal itchiness			
13. MALE REPRODUCTIVE	**Y**	**N**	**P**
Testicular masses			
Testicular pain			
Are you sexually active?			
Sexual difficulties			
Low libido			
Sexually transmitted infection			
Discharge or sores			
Prostate issues			
Date of last prostate exam:			
14. FEMALE REPRODUCTIVE	**Y**	**N**	**P**
Age menses began			
Regular cycles			
Duration of menstrual flow days			
Length of entire menstrual cycle days			
Bleeding/spotting between periods			
Excessive flow			
PMS symptoms			
Are you sexually active?			
Sexual difficulties			

Low libido			
Sexually transmitted infection			
Vaginal discharge			
Vaginal itching			
Number of yeast infections			
Abnormal cells on Pap test			
Difficulty conceiving			
Number of pregnancies			
Number of miscarriages			
Number of abortions			
15. MUSCULOSKELETAL	**Y**	**N**	**P**
Joint pain/stiffness			
Arthritis			
Muscle spasms/cramps			
Restless legs			
Weakness			
Back pain/neck pain			
Motor vehicle accident			
16. PERIPHERAL VASCULAR	**Y**	**N**	**P**
Cold hands/feet			
Varicose veins			
Easy bleeding/bruising			
Anemia			
Swollen ankles			
17. ENDOCRINE	**Y**	**N**	**P**
Heat/cold intolerance			
Thyroid issues			
Excessive sweating			
Diabetes			
Hypoglycemia (low blood sugar)			
Difficulty gaining/losing weight			
18. NEUROLOGICAL	**Y**	**N**	**P**
Fainting			
Stroke			
Seizures/convulsions			
Numbness/tingling			
Brain fog			
Memory issues			
Balance issues			
Sleep problems			
19. EMOTIONAL	**Y**	**N**	**P**
Depression			
Anxiety			
ADD/ADHD			
Alcohol/drug abuse/addiction			
Child abuse			
Physical abuse			
Emotional abuse			
Sexual abuse			
Excess stress			
Do you enjoy your job? Y / N			
20. IMMUNITY	**Y**	**N**	**P**
Serious infection			
Warts			
Hepatitis			
Parasites			
Yeast overgrowth			
Fungal infections			
Cancer			
Frequent Colds			
Autoimmune disease			
Lifetime # of antibiotic treatments			

PAIN

Please indicate on the diagram any areas where you are currently experiencing pain or discomfort.



Please use the space below to add any information that has not been covered in this questionnaire.

EAST COAST
NATUROPATHIC CLINIC

Informed Consent to Naturopathic Treatment with Dr. Cheryl Karthaus, ND

Naturopathic medicine is practiced by naturopathic doctors (NDs) and is complementary to other regulated forms of healthcare in Nova Scotia. Consultations with a ND include taking a detailed case history, performing a relevant physical exam, and following up on treatment results and symptom progression. NDs employ a range of therapeutic techniques including botanical medicine, Traditional Asian Medicine (including Asian herbs and acupuncture), nutritional counseling, homeopathic medicine, physical medicine (including soft tissue massage and other forms of bodywork), and lifestyle counseling. While the best course of action is continually sought for the patient there always exists the possibility of side effects, adverse reactions or inefficacy of treatment. Dr. Cheryl Karthaus, ND holds your safety and well-being as her top priority in the management of your case and welcomes all questions or concerns you may have.

In signing below I, _____, acknowledge that:

1. Dr. Cheryl Karthaus has in no way suggested that my being under her medical care should prevent me from seeking treatment from any other healthcare practitioner.
2. Dr. Cheryl Karthaus will strive to deliver the safest and most effective treatments for my case, however there is still the possibility that side effects or adverse reactions might occur, or that therapeutic benefit may not be achieved.
3. Should my treatment under Dr. Cheryl Karthaus involve acupuncture, injection or blood draw, there is risk of bleeding, bruising, fainting, or tissue damage secondary to needle insertion.
4. I will inform Dr. Cheryl Karthaus of all medical conditions I have been diagnosed with, symptoms I am experiencing, and medications I am taking/have taken in the past. I will also inform her of any new medical conditions or symptoms or medications should they arise.
5. I will inform Dr. Cheryl Karthaus if I am pregnant or breastfeeding. I will immediately inform her should I become, or plan to become pregnant or if I begin, or plan to begin to breastfeed.
6. I will inform Dr. Cheryl Karthaus if I do not understand any given part of my diagnosis or treatment or if I am uncomfortable with any aspect of my care.
7. All of the information I provide to Dr. Cheryl Karthaus is confidential unless required by law.
8. My case information may be used for the publication of case reports or case studies. Any information concerning my identity will be excluded from publication, thus maintaining my anonymity.
9. I am free to purchase any products recommended by Dr. Cheryl Karthaus for my treatment from a vendor of my choosing, being under no obligation to purchase products from her directly.
10. I have read and understand Dr. Cheryl Karthaus's naturopathic visit fee schedule.

I, the undersigned, declare that I have read and understood the information presented above and that I authorize and consent to my present and future naturopathic treatment by Dr. Cheryl Karthaus, ND. I understand that I may withdraw this consent at any time.

_____ _____

Patient Name (Print) Date

_____ _____

Patient Signature Cheryl Karthaus, ND Signature

EAST COAST
NATUROPATHIC CLINIC

Naturopathic Consultation Fee Schedule*

Initial Visit	-	$185.00
Follow-up Visit – 60 minutes	-	$170.00
Follow-up Visit – 45 minutes	-	$135.00
Follow-up Visit – 30 minutes	-	$90.00
Acute Visit	-	$50.00

Child (17 years of age or younger) Initial Visit	-	$170.00
Child (17 years of age or younger) Follow-up Visit – 60 minutes	-	$150.00
Child (17 years of age or younger) Follow-up Visit – 45 minutes	-	$120.00
Child (17 years of age or younger) Follow-up Visit – 30 minutes	-	$85.00
Child (17 years of age or younger) Acute Visit	-	$45.00

**** HST is not charged on naturopathic services.***

Please note that naturopathic visits are not covered under provincial healthcare, although most extended insurance plans offer coverage. Please note that 24 business day hours are required to reschedule an appointment, lest a missed visit charge of $40 per half hour missed will apply.

Scent Free Policy

As part of our commitment to provide a safe environment for our patients, clients, health care practitioners, and employees, East Coast Naturopathic Clinic has a scent free policy. Please refrain from wearing perfume, scented hairspray, cologne, scented deodorant, aftershave, or any other scented products when you come to our Centre. Scented products contain chemicals which can cause migraines, nausea, and breathing problems for people with asthma, allergies, and environmental illness. Thank you.