WELCOME to Naturopathic Medicine at Vivo!

What You Can Expect:

1st Appointment: Your first appointment is up to 1 hour and 30 minutes; this includes a detailed patient intake, a complete health history, a physical exam and initiation of a treatment plan. The initial visit provides information to create appropriate treatment plans.

2nd Appointment: Your second appointment is up to 45 minutes; a customized treatment plan is presented (and optimized). Reaching your health goal(s) will depend on how well you follow your treatment plan.

Follow up visits: Follow up visits will vary in length (20-45 minutes) and in frequency. They are beneficial to monitor your progress and if needed, make modifications to the treatment plan.

What We Would Like:

Please bring in the following on your initial visit:

- Completed **Adult Intake** form
- Completed and signed **Informed Consent** form
- All prescription and non-prescription **medications**
- All **natural health product** or supplement information
- Recent (within 6 month period) **lab tests** if possible

Thank-you, I look forward to working with you and meeting you soon.

To better health,

Amy de Oliveira BSc, ND

Naturopathic Treatment INFORMED CONSENT

Naturopathic medicine and care is a unique primary health care system that combines standard medical diagnostics and knowledge with traditional, natural and gentle therapies. The goal is to understand the individual, address the underlying cause and improve health and well-being.

I, _____ [print name] understand that the form of medical care is based on naturopathic principles and practices.

I will completely disclose and inform my Naturopathic Doctor of all my health concerns and conditions, allergies, medications, supplements and medical interventions.

I will inform my naturopathic doctor if I suspect or become pregnant and/or if I am breastfeeding.

I understand that my identity will be protected and kept confidential.

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 without my consent, unless required by law.

I understand that I may look at my medical records and can request a copy by paying a fee

I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications.

I understand that although naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to:

- Aggravation of pre-existing conditions and symptoms
- Allergic reactions to supplements or botanical prescriptions
- Pain, bruising, fainting or puncturing of an organ with acupuncture needles

I understand that fees and supplements are to be paid for at the time of the consultation period.

I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours notice

PATIENT CONSENT

- I have read and understand the above-stated policies, information, missed appointment fee
- 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 (written or verbal format).

Patient Name: _____ Date: _____

Patient Signature: _____

Naturopathic Doctor: _____

ADULT INTAKE FORM – Naturopathic Medicine

GENERAL PATIENT INFORMATION Date:_____

Name: _____ Age: _____ Birth Date: ___ dd/mm/yy___ Sex: F M

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell or other phone: _____

May we leave messages relating to your visits? Y / N Which Phone #? _____

Profession: _____ Employed: Full or Part-time

How did you find out about naturopathic services at the centre? If referred, please indicate from whom
_____

E-mail Address:_____
Would you like to receive our electronic health newsletter: Yes No

Person to notify in case of emergency: _____
Phone Number: _____ Relationship: _____

Other health care providers (name and phone number);

1. _____ Phone _____
2. _____ Phone _____
3. _____ Phone _____

HEALTH CONCERNS

What is the main reason that you are here today? _____

What are your health concerns or health goals, in order of importance to you:

1. _____When did it start _____
2. _____When did it start _____
3. _____When did it start _____
4. _____When did it start _____

How would you describe your general state of health? Poor Fair Good Excellent

If you are female are you currently pregnant? Yes No (Please circle one)

Please list any allergies to drugs, plants, foods, animal, other? _____

List Any Treatments and Practitioners you have visited for your chief concerns:

1._____

2._____

3._____

MEDICAL HEALTH HISTORY

Current Medications (prescription, over the counter, birth control)

Medication	Dose per day	What purpose	Date when Started

Current Supplements or Herbs

Supplement or Herbs	Dose per day	What purpose	Date when Started

Check if you have used any of the following?

☐ Anti-depressants	☐ Chemotherapy	☐ Epidural	☐ Pain relievers (aspirin)
☐ Antacids	☐ Cortisone (other steroids)	☐ Flu vaccines	☐ Sleeping pills
☐ Anti-histamines	☐ Diuretics	☐ Hormone therapy	☐ Thyroid medication
☐ Blood thinners	☐ Drugs for arthritis	☐ Laxatives	☐ Vaccination for foreign travel

Any adverse events or allergic reactions to any of the above? Yes No _____

List all hospitalizations, surgeries, and accidents

Description	Year	Outcome

Date of last antibiotic use: _____ Date of last physical exam: _____

FAMILY HEALTH HISTORY (Grandparents, parents, siblings, children – insert where applicable)

	Who & Age		**Who & Age**
Allergies		High blood pressure	
Arthritis		High cholesterol	
Asthma		Heart disease	
Cancer		Mental illness	
Depression		Osteoporosis	
Drug abuse or alcoholism		Stroke	
Diabetes		Thyroid problems	

REVIEW OF SYSTEMS: Circle **N** for conditions you have NOW; **P** for conditions you had in PAST

SKIN

Rash	N P	Color Change	N P
Hives	N P	Lump	N P
Psoriasis/eczema	N P	Itchy	N P
Dry	N P	Warts/moles	N P
Cancer	N P	Excess Perspiration	N P

HEAD

Headache	N P	Migraine	N P
Dandruff	N P	Head Injury	N P
Oil/dry hair	N P	Hair loss	N P

NOSE

Frequent Colds:	N P	Nosebleeds	N P
Congestion:	N P	Post Nasal Drip	N P
Polyps:	N P	Seasonal Allergies	N P

EYES

Dry	N P	Blurry Vision	N P
Double Vision	N P	Cataracts	N P
Glaucoma	N P	Styes	N P
Strain	N P	Discharge	N P
Itchy	N P	Dark under Eyelid	N P

MOUTH

Canker sores:	N P	Cold sores:	N P
Sore Throat:	N P	Gum disease:	N P
Dentures:	N P	Cavities:	N P
Loss of taste:	N P	Hoarseness:	N P

RESPIRATORY

Cough	N P	TB	N P
Shortness of breath w/ exertion	N P	Bronchitis	N P
Shortness of breath sitting	N P	Pneumonia	N P
Shortness of breath lying	N P	Asthma	N P
Wheezing	N P	Painful breathing	N P

CARDIOVASCULAR

High Blood Pressure	N P	Rheumatic Fever	N P
Low Blood Pressure	N P	Murmur	N P
Arrhythmias	N P	Palpitations	N P
Edema (socks leave imprint)	N P	Chest Pain	N P

URINARY TRACT

Incontinence	N P	Pain w/ Urination	N P
Frequent Infections	N P	Kidney Stones	N P
Urgency (wake up at night)	N P	Discharge/Blood	N P

GASTROINTESTINAL

Heartburn	N P	Bowel Movement Freq	
Indigestion	N P	Recent BM Change	N P
Bloating	N P	Diarrhea/Constipation	N P
Nausea or vomiting	N P	Hemorrhoids	N P
Blood or mucous in stool	N P	Gall Bladder Disease	N P
Change in Appetite	N P	Liver Disease	N P
Itching around anus	N P	Ulcer	N P

MUSCULOSKELETAL

Weakness	N P	Arthritis	N P
Stiffness	N P	Leg Cramps	N P
Tremors	N P	Pain	N P

NERVOUS

Paralysis:	N P	Sciatica	N P
Tingling/numbness	N P	Carpal tunnel syndrome	N P
Seizures	N P	Fainting	N P

MENTAL, EMOTIONAL

Depression	N P	Anger/irritability	N P
Suicidal	N P	High-strung/tense	N P
Anxiety/Fear/Panic	N P	Eating disorder	N P

MALE SYSTEM

Testicular pain/swelling	N P	Sexually Active	N P
Hernia	N P	S.T.D.	N P
Discharge	N P	Prostate Disease/Symptoms	N P
Impotency	N P	Last prostate exam	

FEMALE SYSTEM

Age Period Began		How Often Period Occurs	
How long period lasts		Heavy menstrual bleeding	N P
Menstrual cramping	N P	Blood clots	N P
PMS	N P	Food cravings	N P
Times Pregnant		How many births	
Miscarriages		Abortions	
Last Pap Smear			
Any abnormal Pap Smear	N P	When was abnormal	
Menopausal since what age		Use of hormones	N P
Type of hormones used		Healthy libido	N P
Dry vagina	N P	Sexually Active	N P
Pain w/ Intercourse	N P	Vaginitis	N P
S.T.D.	N P	Mammography	N P
Bone Density Test	N P	Self-breast examinations	N P

Do you feel there is anything else important that has not been covered?