PURE HEALTH
ADULT INTAKE FORM

Dr. Julia Sung Gill, Bsc. (Hon), ND
Naturopathic Doctor

PATIENT INFORMATION

Name: ____ Today's Date:____/____/____ (D/M/Y)
Age: ______ Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ (D/M/Y)
Address:____
City:___________________________ Province:________________________ Postal Code:__________________
Cell Phone: ___________________ Home Phone:___________________ Other/Fax:____________________
Occupation:___________________________ Email:____
How did you hear about our Clinic?____

Emergency Contact

Name:_______________________ Relationship:____________________ Phone Number:________________
Do you have extended health care insurance for Naturopathic Medicine? Y / N
Are you: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership
Live with: ☐ Spouse ☐ Partner ☐ Alone ☐ Friends ☐ Children ☐ Parents

PLEASE COMPLETE THE FOLLOWING QUESTIONS

Please list your current health concerns (In the order of importance):

1. ____
2. ____
3. ____
4. ____
5. ____

Please list all accidents, surgeries or hospitalizations and the year they occurred:

1. ____
2. ____
3. ____

Family Doctor's Name:________________________ Phone Number:_________________________________
Last physical exam:____________________________ Last blood test:________________________________
Please list all medications and supplements that you are currently taking:

	Medication/Supplement	Dosage	Reason for use
1.			
2.			
3.			
4.			
5.			

Please list all allergies: ____
____

Alcohol: amount per day or week ______________________________________
Tobacco: form and amount per day ____________________________________
Caffeine: form and amount per day ____________________________________
Recreational Drugs: what and how often ______________________________

FAMILY HISTORY

Please indicate if a close relative (Parent, Child, Sibling) has had any of the following:

	Who?		Who?
Allergies		High blood pressure	
Alcoholism		Kidney disease	
Asthma		Mental illness	
Arthritis		Mononucleosis	
Cancer (type?)		Multiple Sclerosis	
Chronic Bronchitis		Osteoporosis	
Diabetes		Rheumatic Fever	
Depression		Skin disease	
Drug abuse		Strep throat	
Emphysema		Stroke	
Hepatitis		Tuberculosis	
Heart disease		Other	

☐ I don't know my family medical history

TYPICAL DIET

Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Beverages (and total quantity): ____
Cravings: ____
Aversions: ____
Do you have any dietary restrictions (religious, vegetarian, etc)? ________________

Do you experience any of the following? (Please circle)

Unusual fatigue | Decreased motivation | Decreased libido
Excessive stress | Decreased self-esteem | Decreased satisfaction

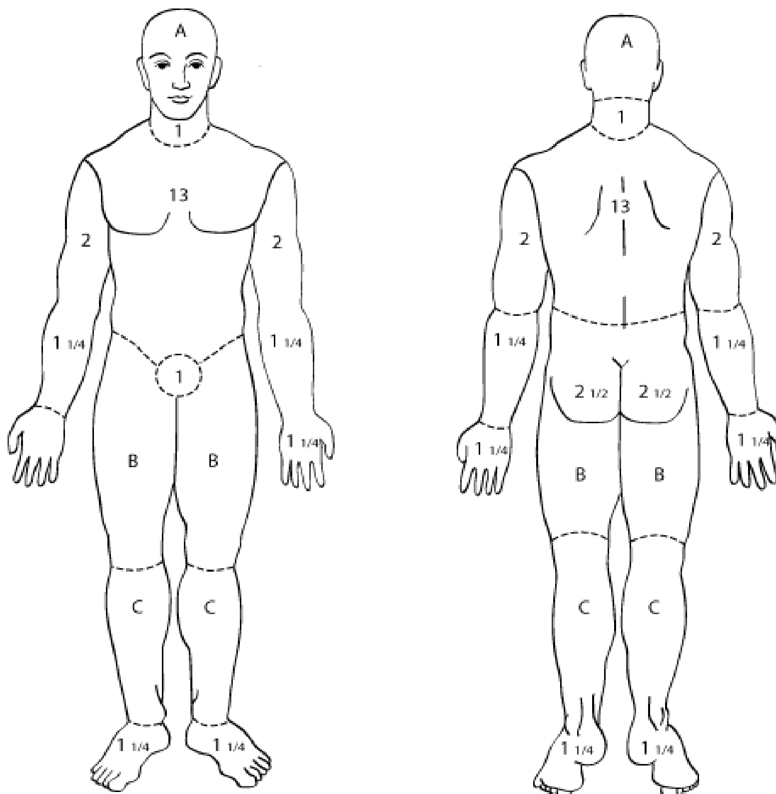
Do you consider yourself a happy person? Y / N

ENVIRONMENT

How many hours do you sleep per night? ____________ Do you sleep well? Y / N
Do you exercise regularly? Y / N What do you do for exercise, how much, how often? ______________________________
Number of bowel movements in a day: ______________ Gas Y / N Bloating Y / N
Are you exposed to significant tobacco smoke at home or at work? Y / N
Are you frequently exposed to animals (work, pets, etc)? Y / N
Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc)? Please indicate: ______________________________
What are your interests and hobbies? ______________________________
Describe the emotional climate at home and at work: ______________________________
Is there anything that you feel is important that has not been covered? ______________
____

PAIN LOCATION

Please circle, shade or otherwise indicate painful location or any affected area. Use descriptive words where possible.



Thank you for taking the time to complete this form!

WHOLSOME WELLNESS NATUROPATHICS
CONSENT TO TREATMENT

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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. Your ND will take a thorough case history, perform a physical examination that may include a breast exam and take blood and urine samples. Therefore, it is very important that you inform your ND immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise your ND immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

(*Initials*)______ I understand that although all therapies are natural and non-invasive, there may be potential health risks and complications including but not limited to: aggravation of current symptoms; Allergic reactions to the supplements or herbs; Bruising from Biopuncture, B12 Injections or Acupuncture; Fainting from needling or at a sight of blood; Accidental burning of the skin from the use of Moxa; and Muscle strains and sprains, disc injuries from spinal manipulation.

(*Initials*)______ I understand that charges are to be paid in full at the time of the visit. Payment for all dispensary items is due at the time of the visit.

(*Initials*)______ I understand that a $50 fee will be charged for any missed appointments or late cancellation (less than 24 hours).

As the patient, I am responsible for the total charges incurred for each visit including costs of supplements. If I have coverage for naturopathic medicine, it is my responsibility to bill my insurance company. I understand that most insurance companies do not cover the cost of supplements. I have read and understood the above stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (Please Print): ______________________________

Signature of Patient or Guardian: ___________________________ Date: _________________________

"The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease"

-Thomas Edison –