

# CECILIA HO, NATUROPATHIC DOCTOR

## CONFIDENTIAL PATIENT HEALTH RECORD

Pickering Chiropractic Health Centre

1154 Kingston Rd, Unit 1 Pickering, ON L1V 1B4



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Dear Patient,

Congratulations for taking ownership of your health and making Naturopathic Medicine part of your health care program. Naturopathic Doctors use natural and individualized treatments to initiate your body's own healing strength. The result is a safe, effective and long lasting treatment that enhances your body's resistance to disease.

The word doctor comes from the Latin root *docere*, meaning teacher, and that is how I view my role as your Naturopath. In making your appointment you have implied that you are ready to make some changes in your life to experience better health. Taking time to fill out this intake form thoroughly will help me to understand what your goals and expectations are and together we will formulate a health care plan that works for you. The ultimate goal I see for you is taking responsibility for your own health and I am just one of the health care professionals you see to this end.

Under my care you can expect:

- Prevention-oriented medicine to help you maintain optimal health
- Find-out what is really going on with your body
- Treatment of the root cause, not just the symptoms
- Treatment of the whole person- physical, mental, emotional, and spiritual aspects that can impact your health are all taken into consideration

Together we will develop practical, effective and sustainable health solutions!

Yours in Health,

Cecilia Ho, ND

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**Adult Intake Form**

Date: \_\_\_\_\_  Female  Male

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MONTH DAY YEAR

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (     ) \_\_\_\_\_ (Home)     May we leave a message  
(     ) \_\_\_\_\_ (Work)                 regarding your visit?  
(     ) \_\_\_\_\_ (Cell)                         Yes    No

Occupation: \_\_\_\_\_

Hours per week: \_\_\_\_\_ or  Student  Retired  Unemployed

Marital Status:  
 Married                                  Partnership                                  Separated  
 Divorced                                  Widowed    Single

Live with:  
 Spouse/Partner                                  Parent(s)                                  Children  
 Friend(s)    Pet(s)    Other \_\_\_\_\_

What are your expectations from this visit/treatment?  
\_\_\_\_\_

Emergency Contact:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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### Other Health Care Providers:

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
(____) _____	(____) _____	(____) _____

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What are your health concerns in order of importance to you?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Tobacco—form and amount/day \_\_\_\_\_

Caffeine—form and amount/day \_\_\_\_\_

Recreational drugs—what and how often \_\_\_\_\_

### Medical History

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

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

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Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

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Please list past prescription medications.

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Do you frequently use any of the following? (circle)

Aspirin Laxatives Antacids Diet pills  
Birth control pills/implants/injections  
Alcohol—how much/day or week

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### ALLERGIES

Are you hypersensitive or allergic to any of the following (please list):

Drugs?

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### ALLERGIES

Are you hypersensitive or allergic to any of the following (please list):

Foods?

\_\_\_\_\_  
\_\_\_\_\_

Environmentals? (pollen, dust, etc.)

\_\_\_\_\_  
\_\_\_\_\_

### Vaccinations

Please indicate what immunizations you have had

- |   |  |
|---|--|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus)                         | <input type="checkbox"/> Haemophilus influenza B |
| <input type="checkbox"/> Tetanus booster; when?                                       | <input type="checkbox"/> "Flu"                   |
| <input type="checkbox"/> MMR (measles, mumps, rubella)                                | <input type="checkbox"/> Polio                   |
| <input type="checkbox"/> Any adverse reactions to vaccinations? If so please indicate |  |

\_\_\_\_\_

### Diet

Do you have any food allergies or intolerances? Please list.

\_\_\_\_\_  
\_\_\_\_\_

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

\_\_\_\_\_  
\_\_\_\_\_

Describe a typical day's diet

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Beverages (and total quantity) \_\_\_\_\_

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### Family history

Indicate if a close relative (parent, child, sibling) has had any of the following

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

I don't know my family medical history

### General

Weight: \_\_\_\_\_ lbs Height \_\_\_\_\_ ft \_\_\_\_\_ in

Weight one year ago: \_\_\_\_\_ lbs

Max. Weight/ When:

\_\_\_\_\_

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

\_\_\_\_\_

\_\_\_\_\_

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?

\_\_\_\_\_

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How would you describe the emotional climate of your home?

\_\_\_\_\_

\_\_\_\_\_

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How stressful is your work, or other aspects of your life? How well do you handle these stresses?

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

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### WOMEN'S HEALTH

Are you pregnant?  Yes  No

Have you had a hysterectomy?  Yes  No

Is your menstrual cycle regular? Yes  No

Do you suffer from any pre-menstrual symptoms?

Yes  No

If Yes, which ones? (ie. Breast tenderness, bloating, craving, mood swings)

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When was your last menstrual cycle?

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### CONTEXT OF CARE

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from this visit to our clinic?

- 1)
- 2)
- 3)

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1    2    3    4    5    6    7    8    9    10

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are **self-destructive** lifestyle habits: (please list)

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?

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**Clinic Policies**

**Payment Policy**

All payments are due when services are rendered, or you may prepay in advance. Our clinic accepts cash, cheque, debit, Visa, and MasterCard as forms of payment.

**Missed Appointments**

Missed appointments will be charged the *full appointment fee* if prior notice of cancellation is not given. We often have patients on standby lists that may need that appointment time.

Please allow 24 hours cancellation notice for a follow up appointment and 2 days for an initial consultation.

*A missed appointment hurts three people: you, the practitioner and the person who could have come in your place. Please be considerate and notify us if you are unable to make your scheduled appointment and we would be happy to reschedule your appointment.*

**Insurance**

Many of our patients have extended health care benefits with their own or another family member's employer, which covers naturopathic consultations. We recommend that you check your benefit plans and familiarize yourself with their procedures. Although we do not deal directly with benefit plan providers, we will gladly provide you with statements of account so that you can submit them for reimbursement.

**By signing the consent form, you are agreeing to the above terms.  
Please take this page for your records.**