Selkirk Clinic

Initial Intake Form

PATIENT INFORMATION

Name: _____ ☐ Male ☐ Female Birthday (M/D/Y): _____

Age: _____ Health card #: _____ Do you have extended health coverage? Y/N

Address: _____

(Street) (City) (Postal Code)

Home Ph. #: _____ Cell: _____ Email: _____

Marital status: _____ # of Children: _____ Occupation: _____

Do you wish to receive our seasonal E-Newsletter full of health tips and blog posts, recipes, and clinic updates? Y / N

Do we have permission to use your email address to contact you concerning your care? Y / N

How did you hear about this clinic: ☐ Walk by ☐ Website ☐ Ad ☐ Google Search

☐ Friend/Referral: _____ ☐ Other: _____

Name of Medical Doctor: _____ Permission to contact for labs? Y / N

MAIN HEALTH CONCERNS

My usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list, in order of importance, your chief concerns:

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

FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

Cancer:	Autoimmune disease:
Eczema:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma:
High blood pressure:	Addictions:
Stroke:	Liver disease:
Thyroid disease:	Mental illness:

Initial Intake Form

List any major childhood illnesses: (ear infections, strep throat, tonsillitis, chicken pox, measles, etc.)

_____

Vaccinations: ☐ I have been fully vaccinated ☐ I get the flu shot regularly ☐ I have had some vaccines
☐ I haven't been vaccinated ☐ I have had travel vaccines (ie. Hepatitis) ☐ I don't know/don't remember

Successful health care and preventive medicine are only possible when we have a complete understanding of you – including your expectations and obstacles to cure. The nature of your responses to the following questions will go a long way in assisting how we can best help you. Your time, thoughtfulness and honesty in completing this overview are appreciated.

1. What do you know about the naturopathic approach?

2. What expectations do you have from **this** visit to our clinic?

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

4. What expectations do you have **of me personally** as your health care provider?

5. What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? Circle level of commitment:

   0% 1 2 3 4 5 6 7 8 9 10 (100%)

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

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

8. What potential **obstacles** do you foresee in adhering to the therapeutic protocols that I will be sharing with you?

9. Do you feel you are fulfilling your purpose in life? If no, what is standing in your way?

Initial Intake Form

Please list any hospitalizations, surgeries, major accidents/injuries, x-rays, CT scans, MRIs, EKGs, ultrasounds, etc.

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Major mental/emotional traumas: (childhood, bullying, loss of loved one/s, divorce, career change, miscarriage, major disease, etc.) _____

List any real or suspected allergies, sensitivities, or intolerances to drugs, food, alcohol, caffeine, chemicals, perfume, smoke, dust, dander, pollen, etc. _____

_____

Please list supplements **and** medications you are currently taking, including brand, daily dose, and approximate length of time you've been taking it:

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

DIET & LIFESTYLE

Please list your typical:

Breakfast _____ Lunch _____

Dinner _____ Snacks _____

What foods do you crave (salty, fatty, carbs, sweets, etc.)? _____

Water intake/day (in cups or liters) _____ Alcohol intake/day or week _____

Caffeine intake/day (soda, coffee, tea) _____

Do you smoke? Y / N If yes, how many cigarettes or packs/day and for how long? _____

Initial Intake Form

Please describe the following about your sleep: # of hours/night, bed & wake times, any difficulty falling/staying asleep, waking rested/unrefreshed _____

_____

Please describe your average energy level on a scale of 1 – 10 (10 = best energy): _____

Does your energy fluctuate throughout the day? Y / N If yes, at what times (ie. before/after meals, midafternoon, evening, etc.)? _____

Do you depend on caffeine to get yourself up or keep yourself going? _____

How many times in a typical week do you exercise and what do you do? _____

_____

Please describe your level of stress on a scale of 1-10 (10 = highest): _____

What are you biggest stressors (ie. past events, relationships, work, financial, health, lack of joy/purpose)? _____

_____

Do you typically work over 40 hours per week? Y / N What is your height? _____ Weight? _____

Please describe your religious or spiritual practice (if any)? _____

Informed Consent and Request for Naturopathic Medical Care, Acupuncture, and Intravenous Therapies

As a patient, I have the right to be informed about my health condition (s) and the recommended treatments. My naturopathic physician will discuss with me the potential benefits, risks and hazards involved. After signing this consent form, I understand I can withdraw consent at any time.

I recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs.

I give my written consent for naturopathic evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

_____	_____	_____
Printed Name	Signature	Date

Initial Intake Form

REVIEW OF SYSTEMS:

Read the following questions and circle the number that applies:

0 = Do not experience
1 = Minor or mild symptom, or it rarely occurs (once a month or less)
2 = Moderate symptom or it occasionally occurs (weekly)
3 = Severe symptom or it frequently occurs (daily or almost daily)

UPPER GASTROINTESTINAL SYSTEM

Belching or gas within 1 hr. of a meal	0	1	2	3	Do you feel better if you don't eat?	0	1	2	3
Heartburn or acid reflux	0	1	2	3	Sleepy after meals	0	1	2	3
Bloating shortly after eating	0	1	2	3	Fingernails chip, peel or break easily	0	1	2	3
Are you a vegan	No			Yes	Anemia unresponsive to iron	0	1	2	3
Bad breath	0	1	2	3	Stomach pains or cramps	0	1	2	3
Loss of taste for meat	0	1	2	3	Diarrhea, chronic	0	1	2	3
Sweat has a strong odor	0	1	2	3	Diarrhea shortly after meals	0	1	2	3
Nausea from taking vitamins	0	1	2	3	Black or tarry stools	0	1	2	3
Sense of excess fullness after meals	0	1	2	3	Undigested food in stool	0	1	2	3
Do you feel like skipping breakfast?	0	1	2	3					

LIVER/GALLBLADDER

Pain between shoulder blades	0	1	2	3	Alcoholic beverages per week	0	1	2	3
Stomach upset by greasy foods	0	1	2	3	Recovering alcoholic	No			Yes
Greasy or shiny stools	0	1	2	3	Hangovers after drinking alcohol	0	1	2	3
Nausea	0	1	2	3	History of drug or alcohol abuse	No			Yes
Motion sickness (air, car, boat)	0	1	2	3	History of hepatitis	No			Yes
History of morning sickness (pregnancy)	No			Yes	Long term use of Rx medications	No			Yes
Light or clay colored stools	0	1	2	3	Sensitive to chemicals (perfume, etc.)	0	1	2	3
Dry skin, itchy feet or skin peels on feet	0	1	2	3	Sensitive to tobacco smoke	0	1	2	3
Headache over the eye	0	1	2	3	Exposure to diesel fumes	0	1	2	3
Gallbladder attacks (past or present)	0	1	2	3	Pain under right side of rib cage	0	1	2	3
Gallbladder removed	No			Yes	Hemorrhoids or varicose veins	0	1	2	3
Bitter taste in mouth, esp. after meals	0	1	2	3	Artificial sweetener consumption	0	1	2	3
Become sick if drinking wine	0	1	2	3	Bothered by aspartame	0	1	2	3
If drinking alcohol, easily intoxicated	0	1	2	3	Chronic fatigue syndrome or fibromyalgia	0	1	2	3

SMALL INTESTINE

Food allergies	0	1	2	3	Crohn's disease	No			Yes
Abdominal bloating 1-2 hrs after eating	0	1	2	3	Wheat or grain sensitivity	0	1	2	3
Specific foods cause fatigue or bloating	0	1	2	3	Dairy sensitivity	0	1	2	3
Pulse speeds after eating	0	1	2	3	Are there foods you could not give up?	No			Yes
Airborne allergies	0	1	2	3	Asthma, sinus infections, stuffy nose	0	1	2	3
Experience hives	0	1	2	3	Bizarre, vivid or nightmarish dreams	0	1	2	3
Sinus congestion, "stuffy head"	0	1	2	3	Use over-the-counter pain medications	0	1	2	3
Crave bread or pasta	0	1	2	3	Feel spacey or unreal	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3					

Initial Intake Form

LARGE INTESTINE

Anus itches	0	1	2	3	Less than one bowel movement every day	No			Yes
Coated tongue	0	1	2	3	Stools have corners, or edges are flat and/or ribbon shaped	0	1	2	3
Feel worse in moldy or musty places	0	1	2	3	Stools are not well formed (loose)	0	1	2	3
Taken an antibiotic for a length of time of 1 = < 1 mo, 2 = < 3 mos., 3 = > 3 mos.	0	1	2	3	Irritable bowel syndrome	0	1	2	3
Fungus or yeast infections	0	1	2	3	Blood in stool	0	1	2	3
Ring worm, "jock itch", athlete's foot, or nail fungus	0	1	2	3	Mucus in stool	0	1	2	3
Eating sugar, starch or drinking alcohol increases yeast symptoms	0	1	2	3	Excessive foul smelling gas	0	1	2	3
Stools hard or difficult to pass	0	1	2	3	Bad breath or strong body odor	0	1	2	3
History of parasites	No			Yes	Painful to press outer sides of thighs	0	1	2	3
					Cramping in lower abdomen	0	1	2	3

MINERAL NEEDS

History of carpal tunnel syndrome	No			Yes	Morning stiffness	0	1	2	3
History of lower right abdominal pain	No			Yes	Vomiting or nausea	0	1	2	3
History of stress fractures	No			Yes	Crave chocolate	0	1	2	3
Bone loss (reduced density on bone scan)	0	1	2	3	Feet have a strong odor	0	1	2	3
Are you shorter than you used to be?	No			Yes	Tendency to anemia (low red blood cells)	0	1	2	3
Calf, foot or toe cramps at rest	0	1	2	3	Whites of eyes (sclera) are tinted blue	0	1	2	3
Cold sores, blisters or herpes lesions	0	1	2	3	Hoarseness of voice	0	1	2	3
Frequent fevers	0	1	2	3	Difficulty swallowing	0	1	2	3
Frequent skin rashes and/or hives	0	1	2	3	Lump in throat	0	1	2	3
Have you ever had a herniated disc?	No			Yes	Dry mouth, eyes and/or nose	0	1	2	3
Excessively flexible joints/double jointed	0	1	2	3	Gag easily	0	1	2	3
Joints pop or click	0	1	2	3	White spots on fingernails	0	1	2	3
Pain or swelling in joints	0	1	2	3	Cuts heal slowly and/or scar easily	0	1	2	3
Bursitis or tendonitis	0	1	2	3	Decreased sense of taste or smell	0	1	2	3
History of bone spurs	No			Yes					

ESSENTIAL FATTY ACIDS

Aspirin is an effective pain reliever	No			Yes	Headaches when out in the hot sun	0	1	2	3
Crave fatty or greasy foods	0	1	2	3	Sunburn easily or suffer sun stroke	0	1	2	3
Low or reduced-fat diet (past or present)	0	1	2	3	Muscles become easily fatigued	0	1	2	3
Tension headaches at base of skull	0	1	2	3	Dry, flaky skin and/or dandruff	0	1	2	3

SUGAR HANDLING

Awaken a few hours after falling asleep, and difficulty getting back to sleep	0	1	2	3	Fatigue that is relieved by eating	0	1	2	3
Crave sweets	0	1	2	3	Headache if meals are skipped or delayed	0	1	2	3
Eat desserts or sugary snacks	0	1	2	3	Irritable when skipping meals	0	1	2	3
Binge or uncontrolled eating	0	1	2	3	Shaky if meals are delayed	0	1	2	3
Excessive appetite	0	1	2	3	Family members with diabetes 0 = 0 1 = 2 or less, 2 = 2 – 4, 3 = More than 4	0	1	2	3
Crave coffee or sugar in the afternoon	0	1	2	3	Frequent thirst	0	1	2	3
Sleepy in afternoon	0	1	2	3	Frequent urination	0	1	2	3

VITAMIN NEEDS

Muscles become easily fatigued	0	1	2	3	Vulnerable to insect bites	0	1	2	3
Feel worse or sore after exercise	0	1	2	3	Heaviness in arms/legs	0	1	2	3

Enlarged heart, or heart failure	0	1	2	3	Night sweats	0	1	2	3
Pulse slow (< 65 beats per minute)	No			Yes	Restless leg syndrome	0	1	2	3
Ringing in ears	0	1	2	3	Cracks or cuts at corner of mouth	0	1	2	3
Numbness, tingling or itching					Fragile skin, easily chaffed (ie. shaving)	0	1	2	3
in extremities	0	1	2	3	Polyps or warts	0	1	2	3
Depressed	0	1	2	3	MSG sensitivity	0	1	2	3
Fear of impending doom	0	1	2	3	Can't remember dreams on waking	0	1	2	3
Worrier, apprehensive, anxious	0	1	2	3	Taking the birth control pill	0	1	2	3
Nervous or agitated	0	1	2	3	Small bumps on back of upper arms	0	1	2	3
Feelings of insecurity	0	1	2	3	Strong light at night irritates eyes	0	1	2	3
Heart races	0	1	2	3	Nose bleeds and/or easy bruising	0	1	2	3
Can hear heart beat on pillow at night	0	1	2	3	Bleeding gums (ie. when brushing teeth)	0	1	2	3
Body or limb jerks when falling asleep	0	1	2	3					

ADRENAL GLAND

Tend to be a "night person"	0	1	2	3	Crave salty foods	0	1	2	3
Difficulty falling asleep	0	1	2	3	Salt foods before tasting	0	1	2	3
Slow starter in the morning	0	1	2	3	Perspire easily	0	1	2	3
Keyed up, trouble calming down	0	1	2	3	Chronic fatigue, or get drowsy often	0	1	2	3
High blood pressure (normal = 110/70)	0	1	2	3	Afternoon yawning	0	1	2	3
Headache after exercising	0	1	2	3	Afternoon headache	0	1	2	3
Feeling wired or jittery with coffee	0	1	2	3	Asthma, wheezing or difficulty				
Clench or grind teeth	0	1	2	3	breathing	0	1	2	3
Calm on the outside, troubled inside	0	1	2	3	Pain on the inner side of the knee	0	1	2	3
Chronic low back pain, worse tired	0	1	2	3	Tendency to sprain ankles or develop				
Become dizzy/faint upon standing	0	1	2	3	"shin splints"	0	1	2	3
Difficult maintaining a chiropractic					Tendency to require sunglasses	0	1	2	3
adjustment	0	1	2	3	Allergies and/or hives	0	1	2	3
Pain after manipulative correction	0	1	2	3	Weakness, dizziness	0	1	2	3
Arthritic tendencies	0	1	2	3	Easily stressed out	0	1	2	3

PITUITARY GLAND

Over 6'6" tall	0	1	2	3	Decreased libido	0	1	2	3
Early sexual development (< age 10)	No			Yes	Abnormal thirst	0	1	2	3
Increased libido	0	1	2	3	Weight gain around hips or waist	0	1	2	3
Splitting type headache	0	1	2	3	Menstrual disorders	0	1	2	3
Memory failing	0	1	2	3	Delayed sexual development (> age 13)	No			Yes
Ability to tolerate sugar; fine with eating	0	1	2	3	Tendency to have ulcers or colitis	0	1	2	3
Under 4'10" (mature height)	0	1	2	3					

THYROID

Allergic to iodine	0	1	2	3	Mentally sluggish, lacking motivation	0	1	2	3
Difficulty gaining weight	0	1	2	3	Easily fatigued, sleepy during the day	0	1	2	3
Nervous, emotional, or can't work					Cold hands and feet, poor circulation	0	1	2	3
under pressure	0	1	2	3	Chronic constipation or sluggish digestion	0	1	2	3
Inward trembling	0	1	2	3	Excessive hair loss and/or coarse hair	0	1	2	3
Flush easily	0	1	2	3	Morning headaches, fade with time	0	1	2	3
Fast pulse at rest	0	1	2	3	Loss of outside 1/3 of eyebrow	0	1	2	3
Intolerance to high temperatures	0	1	2	3	Seasonal sadness	0	1	2	3
Difficulty losing weight	0	1	2	3					

Initial Intake Form

MEN ONLY

Prostate problems	0	1	2	3	Interruption of stream during urination	0	1	2	3
Urination difficult or dribbling	0	1	2	3	Pain on inside of legs or heels	0	1	2	3
Difficult to start and stop urine stream	0	1	2	3	Feeling of incomplete bowel evacuation	0	1	2	3
Pain or burning with urination	0	1	2	3	Decreased sexual function	0	1	2	3
Waking to urinate at night	0	1	2	3	History of sexually transmitted infections	No		Yes	

WOMEN ONLY

Depression during periods	0	1	2	3	Vaginal discharge	0	1	2	3
Premenstrual syndrome (PMS)	0	1	2	3	Vaginal dryness	0	1	2	3
Crave chocolate around periods	0	1	2	3	Vaginal itchiness	0	1	2	3
Breast tenderness associated with cycle	0	1	2	3	Weight gain around hips, thighs				
Excessive menstrual flow	0	1	2	3	and buttocks	0	1	2	3
Scanty blood flow during periods	0	1	2	3	Excess facial or body hair	0	1	2	3
Occasional skipped periods	0	1	2	3	Thinning skin	0	1	2	3
Variations in menstrual cycles	0	1	2	3	Hot flashes	0	1	2	3
Endometriosis	0	1	2	3	Night sweats (in menopausal females)	0	1	2	3
Uterine fibroids	0	1	2	3	Pregnant	No		Yes	
Breast fibroids, benign masses	0	1	2	3	History of sexually transmitted infections	No		Yes	
Painful intercourse (dyspareunia)	0	1	2	3	Difficulty conceiving/infertility	No		Yes	

CARDIOVASCULAR

Aware of heavy and/or irregular					Ankles swell, especially at end of day	0	1	2	3
breathing	0	1	2	3	Cough at night	0	1	2	3
Discomfort at high altitudes	0	1	2	3	Blush or face turns red for no reason	0	1	2	3
"Air hunger" and/or yawn frequently	0	1	2	3	Dull pain or tightness in chest, possibly				
Compelled to open windows in a					radiates into arm, worse w/exertion	0	1	2	3
closed room	0	1	2	3	Muscle cramps with exertion	0	1	2	3
Shortness of breath with exertion	0	1	2	3					

KIDNEY & BLADDER

Pain in mid back region	0	1	2	3	Cloudy, bloody or darkened urine	0	1	2	3
Dark circles under eyes and/or puffy eyes	0	1	2	3	Urine has a strong odor	0	1	2	3
History of kidney stones	No		Yes						

IMMUNE SYSTEM

Runny or drippy nose	0	1	2	3	Never get sick	0	1	2	3
Catch colds at the beginning of winter	0	1	2	3	Acne (adult)	0	1	2	3
Mucus-producing cough	0	1	2	3	Itchy skin/dermatitis	0	1	2	3
Frequent infections (ear, sinus, lung,					Cysts, boils, rashes	0	1	2	3
skin, bladder, kidney, etc.)	0	1	2	3	History of viruses: Epstein Bar/mono,				
Frequent colds or flu	0	1	2	3	herpes, shingles, hepatitis	0	1	2	3

PSYCHOLOGICAL

Treated for emotional issues	0	1	2	3	Mood swings	0	1	2	3
Depression	0	1	2	3	Ever considered suicide	0	1	2	3
Anxiety/nervousness	0	1	2	3	Ever attempted suicide	0	1	2	3
Poor concentration	0	1	2	3					