Gaia Integrative Clinic
blending science and nature

Adult-Patient Information and Consent Form

Please complete the following information in full:
Dr. Miss Mr. Mrs. Ms

First Name: _____

Middle Initial: _____

Last Name: _____

Address: _____
Suite/Apt./Unit No: _____
City: _____ Province: _____
Postal Code: _____

Gender: Male Female Date of Birth: _____
Month / Day / Year

Work Phone:_____ Extension: _____
Home Phone: _____ Mobile Phone: _____
Fax Number:_____ Other Phone: _____
E-mail: _____
Preferred contact method: _____
May we leave a message? _____

Primary Practitioner: _____
Family Doctor
Name: _____ Phone Number: _____
Address: _____

Emergency Contact
Name: _____ Phone Number: _____
Relationship: _____

How did you hear about Gaia Integrative Clinic?
Referral Website Newspaper Yellow Pages
Advertisement Friend/Family Other:_____

P.O. Box 1401, 4907-47th Street, Yellowknife, NT, X1A 2P1•Phone: 867-873-3669• Fax: 867-873-5642
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I, the undersigned, voluntarily consent to the procedures and treatments provided to me at Gaia Integrative Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. With this knowledge, I understand and acknowledge that I may ask questions regarding my treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Gaia Integrative Clinic or any of its practitioners or personnel regarding cure or improvement of my condition.

I hereby consent to the collection, use and/or disclosure of my personal information for purposes related to the delivery of patient care and other related uses at Gaia Integrative Clinic. I understand that a record will be kept of the health services provided to me. I further understand that my personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Gaia Integrative Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 50% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a minimum of 24 hours advance notice.

_____
Patient's Name

_____ _____
Patient's Signature Date

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Naturopathic Adult Intake

HEALTH INFORMATION

What is your main health concern? _____
_____
_____

Please list any other health concerns (physical, emotional, or mental) in order of importance.
1. _____
2. _____
3. _____

How do you rate your overall health? Poor Fair Good Excellent
How do you rate your overall energy? Poor Fair Good Excellent

MEDICATIONS

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose/day	How long?
1.		
2.		
3.		
4.		

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement	Dose/day	How long?
1.		
2.		
3.		
4.		

How many courses of antibiotics have you had in the past 10 years? _____
Have you ever had a bad reaction to any medication? Y / N

MEDICAL HISTORY

Please indicate if you have had any of the following childhood illnesses (circle):

Asthma	Measles	Rheumatic fever
Chickenpox	Mumps	Scarlet fever
Eczema	Polio	Whooping cough
Frequent ear infections or colds	Rubella(German measles)	Other: _____

Please briefly describe your dental history (root canals, fillings, etc)
_____
_____

Immunizations (Check ✓)

€DPT	€Hemophilus influenza B	€Hepatitis A	€Hepatitis B
€Flu shot	€Tetanus Booster	€MMR	€Polio
€Smallpox	€Chicken Pox	€Other: _____	

Any adverse reactions to vaccinations? Y / N. If yes, explain. _____
_____

Please list (with approximate dates) any serious conditions, illnesses or injuries, and any hospitalizations.
_____
_____
_____

FAMILY HISTORY

Please indicate whether any of your family members have, or have had the following:

	Relative		Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	

LIFESTYLE FACTORS

Please list any dietary restrictions (Vegan, vegetarian, lacto-ovo vegetarian, omnivore)
_____
How much water do you drink a day?_____
How many and what type of alcoholic beverages do you have per week?_____
Do you smoke? Y / N
Are you frequently exposed to animals? Y / N
Are you regularly exposed to toxins or other hazards? Y / N. If yes, explain. _____
_____
_____
On average how many hours of sleep do you get a night?_____
Please list all allergies (food, environmental, or medications). _____
_____
_____
_____

Do you exercise? Y / N
What type of exercise and how often? _____

What do you do for recreation and relaxation? _____
_____

Occupation: _____ Do you work shift work? Y / N

Marital status: _____ Number of children: _____

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Describe the emotional climate of your home. _____
_____

Rate your stress level (circle): Low Average High Unbearable

Which factors most contribute to your stress? (circle)

Health Work Money Family Marriage Other: _____

WOMEN'S HEALTH

Are you currently pregnant? Y / N

Do you get regular Pap smears? Y / N

Date of last Pap?(month/yr) _____/_____ Have you ever had an abnormal Pap? Y / N

Age of first period? _____ Is your period regular? Y / N

Length of monthly cycle (days)? _____ Average length of period or flow (days)? _____

Do you experience PMS? Y / N Are you menopausal? Y / N. If yes, age of last period____

Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N

Current forms of contraception? _____

Have you ever had a sexually transmitted disease? Y / N

Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____

Have you had any of the following concerning your breasts?(circle)

Pain Lumps Infections Cysts Nipple discharge

Do you experience vaginal infections? Never Rarely Frequently

Do you experience bladder infections? Never Rarely Frequently

Do you have any sexual problems or concerns? Y / N. If yes, explain. _____
_____
_____

MEN'S HEALTH

Do you get regular screening tests done (blood work, prostate examination)? Y / N

Date of last prostate examination?(month/yr) _____/_____

Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N

Current forms of contraception? _____

Do you have difficulty urinating completely? Y / N

How many times do you get up from your sleep to go to the bathroom at night? _____
Have you had any of the following? (circle)

Testicular pain Hernia STDs Discharge Sores

Do you have any sexual problems or concerns? Y / N. If yes, explain. _____

REVIEW OF SYSTEMS

Please **circle** if you are currently experiencing any of the following or write a **P** if you experienced it in the past.

General symptoms
Headache
Head injury
Fever
Chills
Sweats
Dizziness
Fainting
Loss of sleep
Fatigue
Nervousness
Loss of weight
Numbness or pain in arms/legs/hands
Allergy
Convulsions

Skin
Hives or allergy
Acne or skin eruptions
Itching
Bruises easily
Dryness
Boils
Varicose veins
Sensitive skin
Change in mole

Kidneys & Reproduction
Inability to control urine
Frequent urination
Painful urination
Blood in urine
Pus in urine

Eyes,Ears,Nose,Throat
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sore throat
Hoarseness
Enlarged glands
Glaucoma
Failing vision
Cataracts
Eye pain
Ear discharge
Deafness
Ear ache
Nasal drainage
Nose bleeds
Nasal obstruction
Sinus infection
Hay fever
Mercury tooth fillings

Muscle & Joint
Stiff neck
Back pain
Muscle weakness
Swollen joints
Painful tailbone
Foot trouble
Pain in shoulders
Hernia

Cardiovascular
Low blood pressure
High blood pressure
Previous heart stroke
Hardening of the arteries
Swelling of the ankles
Poor circulation
Paralytic stroke
Irregular heart beat
Shortness of breath
Chest pain

Gastrointestinal
Excessive thirst
Excessive hunger
Belching
Gas (flatulence)
Nausea
Vomiting
Vomiting of blood
Abdominal cramps
Constipation
Diarrhea
Colon trouble
Hemorrhoids (piles)
Intestinal worms
Liver problems
Gallbladder problems
Jaundice
Colitis

Respiratory
Asthma

Kidney infection	Spinal curvature	Chronic cough
Kidney stones	Faulty posture	Spitting up phlegm
Prostate trouble	Arthritis	Spitting up blood
Sores on genitals	Fracture/dislocation	Difficult breathing

Current Weight:_____ Weight one year ago:_____ Maximum weight and when:_____ Height:_____

What are your treatment goals and expectations?

_____
_____
_____

Is there anything else that you feel has not been covered?

_____
_____
_____

Thank you very much for taking the time to complete this form. It will greatly assist in the formulation of a treatment protocol specific to your healthcare needs.

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