

New Patient Information

Welcome to the Armstrong Clinic for Naturopathic Medicine!

We kindly ask that you complete the following intake form before the appointment time to maximize your visit time used in gathering medical information and completing your health assessment.

We also ask that you bring in the following:

- All prescription and non-prescription medications (name, dose, frequency)
- All natural health product or supplement information (name, dose, frequency)
- Recent (within 3 months) lab test and diagnostic imaging results if applicable.
- A 7-day dietary record including meals, snacks beverages, daily amount of sleep and exercise.

Thank you in advance for this preparation for your first visit to The Armstrong Clinic.

For your driving reference, The Armstrong Clinic locations are as follows:

Simcoe: 55 Kent Street South 519.426.4275

Tillsonburg: 518 Broadway 519.409.0808

Confidential Intake Form

Today's Date _____

Name: _____ Age: ____ Birth Date: _____ Sex: F M

How would you prefer to be addressed in our office? _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____

Profession: _____ Employed Full or Part-time: _____

Employer: _____

Check one: Married Single Widowed Divorced Separated Common law Same sex

Number of Children: _____ Referral source? _____

Person to notify in case of emergency: _____

Phone Number: _____ Relationship: _____ Address: _____

E-mail Address: _____

OHIP Number: _____

Current Health

What health concerns/problems brought you into this office today?

1. _____ 2. _____

3. _____ 4. _____

Has anything recently changed or become worse? _____

What effect has this had on your life? _____

Religious affiliations and beliefs relevant to health care and treatment:

Is a medical physician treating you now? Y N Name/Phone #: _____

Current Medications

Please list all medications, non-prescription medication , vitamins, minerals, herbs, etc. If possible, also list dosage information. If needed, please attach a separate sheet.

Type of birth control method used: _____ Dosage and Duration: _____

Have you ever taken antibiotics? yes no When/Dosage/Duration: _____

For what condition? _____

Known Allergies: such as medications, pollens, foods:

Hospitalizations, Surgeries, Serious Injuries: Date and reason for hospitalization:

Health History:

Childhood Illnesses:

Measles Mumps Rubella Whooping cough Chicken pox
Rheumatic fever Scarlet fever Polio Tuberculosis

Adult Illnesses:

Diabetes Hypertension Hepatitis Asthma HIV

Current Health Status:

Height: _____ Weight: _____ Weight 1 year ago: _____ Max weight: _____ Date: _____

Have you gained or lost any weight lately? IF so, please state how much: _____

Smoker: Y N Smoked _____ Years, Amount/Day _____ Year Stopped: _____

Diet: Food Groups Avoided: _____ Why: _____

Diet: Food Cravings: _____

Diet: Do you consume dairy products? Y N

Do you choose organic food? _____ What types? _____

Do you consume freshwater fish? _____ What types? _____

Circle if you use the following:

Alcohol Candy Carbonated Beverages Tobacco Coffee Tea Laxative
Sweets Eat Fast Foods Often Fried Foods Antacids Margarine Salt
Distilled water Luncheon Meats: _____ Nonsugar Sweetener: _____

Please list your dietary intake over the last 24 hours:

How much time do you spend outdoors on a daily basis? _____

Regular exercise: Y N Type: _____ Duration: _____ Frequency: _____

On a scale of 1 to 10 with 10 being the highest, please rate your stress _____ and energy levels _____

How many hours of sleep you get per night? _____. Do you wake up feeling rested? yes no sometimes

If female, are you currently pregnant? yes no not sure Age of first menses: _____ Menopause _____

Number of pregnancies _____ Number of live births _____

Vaccination/Immunization History: please fill in the appropriate boxes

Vaccine	Age at each	Date(s) of each immunization:	Noted reactions/side effects:
Hep B			
HiB			
Polio			
MMR			
Varicella			

Informed Consent to Treatment

This consent form applies to patients of the Naturopathic Doctors (ND) at the Armstrong Clinic for Naturopathic Medicine. By consenting to treatment you are authorizing your ND to have access to your file, personal information, and authorizing payment of services and tests rendered. Please ask to review the privacy policy if you have questions about the use of your personal information by the Armstrong Clinic.

Even the gentlest therapies have their complication in certain physiological conditions such as pregnancy, lactation, in patients who are very young/very old, or in people who take multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, lung, heart, liver, or kidney disease. It is very important that you are completely forthright in informing your ND of any disease process currently going on in your body, if you are on any prescription medication or OTC drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding please inform your ND immediately.

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing conditions and symptoms
- Allergic reactions to supplement or botanical prescriptions
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting, organ puncture with acupuncture needles, accidental burning of the skin from the use of moxa.
- Muscle strains, sprains and disc injuries from spinal manipulation
- The potential for stroke or emboli is a concern in cervical spinal manipulation and proper pre-requisite tests will be done before such manipulations are performed to prevent such an outcome.

I understand that my ND keeps a record of services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that I must pay for all tests, in-office prescriptions and services when rendered, without refund after 14 days from purchase date. I understand that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect my ND to be able to anticipate and explain all risks and complications. I will rely on my ND to exercise the best judgement in my best interests, based on the facts and findings then known. With this knowledge, I voluntarily consent to a physical exam, diagnostic and therapeutic procedures, except for: (please list exceptions)_____.

I intend this consent form to cover the entire course of treatment presented for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time in written or verbal format.

Patient Sign: _____ Date: _____

Parent Signature if under 18 _____ Date: _____

Primary Naturopathic Doctor: _____ Date: _____

