DR. ANDREA GRI
naturopathic doctor | family medicine

ADULT INTAKE - CONTACT INFORMATION

Name: _____
(Last) (First) (Preferred Name)

Address: _____ City: _____

Postal Code: _____ Email: _____

Home/Cell phone number: _____ Work: _____

Preferred form of contact for reminder/follow up calls:

□ Home number □ Cell phone □ Email□ Other – Please specify: _____

Age: _____ Date of Birth: _____ Sex: □ M □ F Ethnicity: _____

Occupation: _____

Name of Family Physician: _____

Phone Number of MD: _____ Fax: _____

Health Card #: _____

Emergency Contact Name: _____ Phone Number: _____

Relation: _____

How did you hear about Dr. Gri?

□ Brochure/newsletter at the clinic

□ Another health care provider: _____

□ Google search on the internet

□ Sign outside the clinic

□ Health talk given by Dr. Gri

□ Health food store

□ Friend/Relative/Co-worker

□ Other (please specify): _____

Would you like to be added to the patient email newsletter list to receive healthy living tips and recipes (one email per month)? □ Yes □ No Signature: _____

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ADULT INTAKE FORM

Name: _____
(Last) (First) (Preferred Name)

Please list your health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list all medications (prescription, over-the-counter) and natural products (vitamins, herbs) you are currently taking.

Medication/Natural Product	Dose/quantity per day	Why are you taking this product?

Please list any allergies or sensitivities to medications, food, and the environment.

_____

_____

Family Health History

	Age (or age at death)	Health Concerns
Mother		
Father		
Sister(s)		
Brother(s)		
Grandparents		

Please list all hospitalizations, surgeries and/or major injuries you have experienced.

Description	Year	Outcome/complications?

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Please check off any condition(s) you currently or previously have had:

- ☐ Acne
- ☐ Alcohol abuse
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Cervical dysplasia
- ☐ Chicken pox
- ☐ Chronic bronchitis
- ☐ Crohn's
- ☐ Diabetes
- ☐ Depression
- ☐ Eczema
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Head injury
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Hives
- ☐ HPV
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Lupus
- ☐ Measles
- ☐ Memory loss
- ☐ Meningitis
- ☐ Mental illness
- ☐ Miscarriage
- ☐Mononucleosis
- ☐ Nasal polyps
- ☐ Osteoporosis
- ☐ Parasites
- ☐ Pelvic inflammatory disease
- ☐ Pneumonia
- ☐ Polycystic ovaries
- ☐ Psoriasis
- ☐ Rheumatic fever
- ☐ Rubella
- ☐ Scarlet fever
- ☐ Sexually transmitted infection
- ☐ Strep throat
- ☐ Suicide
- ☐ Thalassemia
- ☐ Ulcerative colitis
- ☐ Urinary tract infections
- ☐ Whooping cough
- ☐ Other: _____

Personal Health Habits:

Height: _____ Weight: _____ Max Weight: _____ When? _____

Smoker? ☐ Yes ☐ No Amount/day: _____ Years smoked: _____ Year stopped: _____

Do you do recreational drugs? ☐ Yes ☐ No Type: _____

Alcohol use? ☐ Yes ☐ No Type: _____ Frequency: _____

Caffeine use? ☐ Yes ☐ No Type: _____ Frequency: _____

Please list any dietary restrictions: _____

Do you exercise? ☐ Yes ☐ No Type: _____ Frequency: _____

How many hours do you sleep per night? _____ Do you wake rested? ☐ Yes ☐ No

Rate your energy level (1 = low, 10 = high): 1 2 3 4 5 6 7 8 9 10

Rate your stress level (1 = low, 10 = high): 1 2 3 4 5 6 7 8 9 10

What are the three major contributors to stress in your life?

1. _____

2. _____

3. _____

What do you do to relax? _____

Describe your support network: _____

Describe your living situation: _____

Review of Systems:

Endocrine

- ☐ 20lbs change in weight
- ☐ generally feel cold
- ☐ excessive sweating
- ☐ poor concentration
- ☐ low blood sugar
- ☐ excessive hunger
- ☐ generally feel hot
- ☐ sluggish after eating
- ☐ excessive thirst

Immune

- ☐ chronic infections
- ☐ frequent antibiotics
- ☐ swollen glands or lymph nodes
- ☐ poor childhood health/sick often
- ☐ cold sores
- ☐ frequent sore throats

Neurological/Musculoskeletal

- ☐ numbness
- ☐ joint pain
- ☐ muscle cramps or spasms
- ☐ tingling
- ☐ loss of balance
- ☐ loss of memory
- ☐ paralysis
- ☐ vertigo or dizziness

Skin, Hair & Nails

- ☐ rashes
- ☐ night sweats
- ☐ dry skin
- ☐ itching
- ☐ brittle nails
- ☐ warts
- ☐ lumps or abscesses
- ☐ hair loss
- ☐ change in size, shape or colour of a mole or freckle

Head, Ears, Eyes, Nose, Throat

- ☐ headache/migraines
- ☐ itchy ear canal
- ☐ cataracts
- ☐ post nasal drip
- ☐ sore throat
- ☐ ringing in the ears
- ☐ earaches
- ☐ visual disturbances
- ☐ runny nose
- ☐ jaw pain and clicking
- ☐ impaired hearing
- ☐ dry eyes
- ☐ nose bleeds
- ☐ hoarseness
- ☐ teeth grinding

Respiratory System

- ☐ chronic cough
- ☐ wheezing
- ☐ cough up blood
- ☐ pain while breathing
- ☐ chronic phlegm
- ☐ shortness of breath

Cardiovascular System

- ☐ chest pain
- ☐ varicose veins
- ☐ cold hands and feet
- ☐ fainting
- ☐ easy bleeding or bruising
- ☐ feel dizzy when stand up quickly
- ☐ heart palpitations
- ☐ heart murmurs
- ☐ pain or heaviness in legs

Gastrointestinal System

- ☐ trouble swallowing
- ☐ burping
- ☐ diarrhea or loose stools
- ☐ constipation
- ☐ undigested food in stools
- ☐ change in appetite
- ☐ blood in stools or on tissue
- ☐ mucous in stools
- ☐ hard stool
- ☐ heart burn
- ☐ nausea
- ☐ stomach cramps or pain
- ☐ gas and/or bloating
- ☐ black stools

How often do you have a bowel movement? _____

Have you ever travelled to a developing country? ☐ Yes ☐ No

If so, please specify where and for how long? _____

Urinary System

□ pain on urination
□ frequent bladder infections
□ inability to hold urine
□ must strain to urinate
□ wake up to urinate
□ increased frequency

Mental/Emotional

□ abuse
□ irritability
□ phobias
□ anxiety or nervousness
□ panic attacks
□ mental illness
□ mood swings
□ depression
□ prolonged sadness or grief

Men's Health (if applicable)

□ hernia
□ discharge or sores
□ testicular mass
□ sexual difficulties
□ testicular pain
□ impotence
□ low sex drive
□ prostate condition

Are you sexually active? □ Yes □ No When was your last prostate exam? _____

Women's Health (if applicable)

□ fibrocystic breasts
□ puckering of skin around nipple
□ sexual difficulties
□ odour
□ pain during intercourse
abnormal pap test
□ breast tenderness
□ nipple discharge
□ abortions
□ miscarriages
□ low sex drive
Date of last pap: _____
□ breast lumps or cysts
□ vaginal discharge
□ vaginal itching
□ vaginal dryness
□ menopausal symptoms□

Do you perform monthly self breast examinations? □ Yes □ No

When was your last mammogram? _____

Are you sexually active? □ Yes □ No Type of birth control (if any): _____

Age of first menses _____ Number of pregnancies: _____

Date of last menstrual cycle _____ Are you currently pregnant? □ Yes □ No

Length of cycle (days) _____ Are you trying to conceive? □ Yes □ No

□ menstrual pain or cramping
□ bloating
□ light flow
□ water retention
□ bleeding after intercourse
□ missed periods
□ breast tenderness
□ heavy flow
□ irregular cycles
□ low back pain
□ clotting
□ loose stools
□ mood swings
□ bleeding between periods
□ headaches

Environmental Exposures:

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations), at work or while traveling? □ Yes □ No

Have you ever experienced health problems after putting down new carpeting, painting renovations or having your lawn sprayed with herbicide? □ Yes □ No

Are you particularly sensitive to perfume, gasoline or other vapor? □ Yes □ No

Have you ever lived near a refinery or a polluted area? ☐ Yes ☐ No

Have you ever lived in a home built in or prior to the 1970's? ☐ Yes ☐ No

Do you have mercury dental fillings? ☐ Yes ☐ No

What behaviours or lifestyle habits do you currently engage in that you believe support your health?

Has there been an illness or event in your life that you feel you have never fully recovered from? If so, please specify.

Is there anything else I should know about your health?

Thank you for taking the time to complete this form. I look forward to meeting you and working with you towards achieving your health goals.

Best in Health,
Dr. Andrea Gri, B.Kin, ND

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INFORMED CONSENT & PRIVACY POLICY

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional, and genetic aspects of the individual. Treatment modalities may include diet, lifestyle counseling, clinical nutrition (primarily via supplementation), botanical medicine, homeopathy, and Asian medical theory and acupuncture.

During your initial visits your Naturopathic Doctor will take a thorough case history, perform a basic/complaint-oriented physical examination, and when indicated order laboratory testing. Even the gentlest of therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness.

Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease, in young children, those taking multiple medication, or pregnancy/lactation. It is very important, therefore, that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, please advise your Naturopathic Doctor immediately.

Health risks associated with Naturopathic Medicine include, but are not limited to:

- Aggravation of pre-existing symptoms during the healing process
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles

I understand that the Naturopathic Doctor will answer my questions that I have to the best of her ability. I understand that results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all the risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):_____

_____

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. 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 fees and supplements are to be paid for in full at the time of the consultation. I also understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours notice.

I have read and understand 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:_____ Signature: _____ Date: _____

Naturopathic Doctor: _____ ND Signature: _____

Collection, Use and Disclosure of Personal Information.

Privacy of your personal information is an important part of our Clinic, and protecting your personal information is something we take very seriously. We are committed to collecting, using and disclosing your personal information responsibly.

In this Clinic, Dr. Andrea Gri, Naturopathic Doctor acts as the Information Officer for naturopathic patient files. All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed and they have been trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislature, and privacy protection protocols;
- To advise you of treatment options;
- To establish and maintain contact with you;
- To send you newsletters and other information mailings;
- To remind you of upcoming appointments;
- To provide health care

Our privacy policy protocols comply with privacy legislation and standards of our regulatory body, the College of Naturopaths of Ontario.

The Clinic will collect, use and disclose information about you for the following purposes:

- To communicate with other treating health care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body, the College of Naturopaths of Ontario
- To invoice for goods and services
- To collect unpaid accounts
- To assist this Clinic to comply with all regulatory requirements
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this form, you agree that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient name:_____ Signature: _____ Date: _____

Witness Signature: _____ Date: _____