Adult Intake Questionnaire - 2020

Smart Form submission for
Adult Intake Questionnaire

1. General Overview

Please complete the following general information:

Status:	◯ Single ◯ Married ◯ Divorced ◯ Living with partner ◯ Widowed ◯ Other
Emergency Contact:	First Name: First Name Last Name: Last Name Relationship: Relationship Mobile Phone: Mobile Phone Home Phone: Home Phone Work Phone: Work Phone
Where did you hear about us?	◯ Newspaper ◯ Internet search ◯ Walk by ◯ Referral by another healthcare practitioner ◯ Referral by another patient ◯ Other
Do you have a family doctor?	◯ Yes ◯ No
When was your last physical exam? Add the date if you know it.	

YYYY-MM-DD

Did you have bloodwork or other tests done at that time? ◯ Yes ◯ No

Who are your other health care providers?

Name:

Name

Phone:

Phone

Fax:

Fax

Specialty / Focus?

Specialty / Focus

Are you currently under this practitioner's care?

Do we have your permission to discuss your case with this practitioner?

When was the last time you had an appointment with this practitioner?

+ Add Provider

Please list your health concerns, chronic health conditions, or diagnoses in order of importance to you. Indicate any treatment or testing you have had or are currently receiving for any of these concerns.

Concern:

Concern

Since When?

Since When?

Date?

YYYY-MM-DD

Any treatment / testing received? If so, please indicate how satisfied you are with the treatment on a scale of 1 to 10, 10 being entirely satisfied.

Treatment

Any other details about this concern that you would like to mention?

Treatment

+ Add Concern

Has anything recently changed, or become worse?

Additional general comments:

2. General Health History

Please complete the following general health history:

Current Height:	cm	ft	in

Current Weight:	kg lbs
Maximum Weight	kg lbs When?
Minimum Weight	kg lbs When?
What do you feel is the most comfortable weight for you?	kg lbs
When is the last time you were at this weight?	
Do you have any chronic health condition which you did not list under the Health Concerns section?	
How would you rate your energy on a scale of 1 – 10, with 10 being the most energy?	0 1 2 3 4 5 6 7 8 9 10
Is there a time of day when your energy is better?	Worse?
Do you have trouble concentrating or thinking clearly?	◯ Yes ◯ No
How is your sleep?	
How many hours of sleep do you get per night on average?	hours
What time do you typically go to bed?	
What time do you typically wake up?	
Do you have trouble getting to sleep?	◯ Yes ◯ No ◯ Sometimes
Do you wake up during the night?	◯ Yes ◯ No ◯ Sometimes
Are you able to get back to sleep right away?	◯ Yes ◯ No ◯ Sometimes

Do you feel rested on waking?	◯ Yes ◯ No ◯ Sometimes
Do you snore?	◯ Yes ◯ No ◯ Sometimes
Do you have sleep apnea?	◯ Yes ◯ No
Do you need coffee or other stimulants to get going in the morning?	◯ Yes ◯ No ◯ Sometimes
Do you take naps?	◯ Yes ◯ No ◯ Sometimes
How do you rate your sleep?	◯ Excellent ◯ Good ◯ Poor ◯ Getting Better ◯ Getting Worse

Additional comments regarding your general health:

3. Personal Medical History

Please check the conditions you have had or currently have. Please list any additional conditions not found in this table in the comments box at the end of this section. (P = Past Condition, C = Current Condition)

P ☐ **C** ☐ Acne	**P** ☐ **C** ☐ Alcoholism	**P** ☐ **C** ☐ Allergies	**P** ☐ **C** ☐ Anemia
P ☐ **C** ☐ Angina / Heart Attack	**P** ☐ **C** ☐ Anxiety, Nervousness, Tension	**P** ☐ **C** ☐ Appendicitis	**P** ☐ **C** ☐ Arthritis
P ☐ **C** ☐ Asthma	**P** ☐ **C** ☐ Autoimmune	**P** ☐ **C** ☐ Cancer	**P** ☐ **C** ☐ Candida
P ☐ **C** ☐ Celiac Disease	**P** ☐ **C** ☐ Cervical Dysplasia	**P** ☐ **C** ☐ Chicken Pox	**P** ☐ **C** ☐ Chronic Bronchitis
P ☐ **C** ☐ Chronic Fatigue	**P** ☐ **C** ☐ Colitis / Crohn’s	**P** ☐ **C** ☐ Depression	**P** ☐ **C** ☐ Diabetes

P ☐ C ☐ Digestive Issues	P ☐ C ☐ Diphtheria	P ☐ C ☐ Drug Abuse	P ☐ C ☐ Easy Bleeding / Bruising
P ☐ C ☐ Ectopic Pregnancy	P ☐ C ☐ Eczema	P ☐ C ☐ Emphysema/COPD	P ☐ C ☐ Endometriosis
P ☐ C ☐ Enlarged Prostate	P ☐ C ☐ Epilepsy	P ☐ C ☐ Fibromyalgia	P ☐ C ☐ Food Sensitivities
P ☐ C ☐ Gallstones	P ☐ C ☐ German Measles	P ☐ C ☐ Gonorrhea	P ☐ C ☐ Gout
P ☐ C ☐ Head Injury	P ☐ C ☐ Headaches / Migraine	P ☐ C ☐ Heart Disease	P ☐ C ☐ Heart Murmur
P ☐ C ☐ Hemorrhoids	P ☐ C ☐ Hepatitis	P ☐ C ☐ High Blood Pressure	P ☐ C ☐ High Cholesterol
P ☐ C ☐ HIV	P ☐ C ☐ Hives	P ☐ C ☐ HPV	P ☐ C ☐ Hyperthyroid
P ☐ C ☐ Hypothyroid	P ☐ C ☐ Intestinal Polyps	P ☐ C ☐ Irregular Menses	P ☐ C ☐ Kidney Disease
P ☐ C ☐ Kidney Stones	P ☐ C ☐ Liver Disease / Jaundice	P ☐ C ☐ Low Blood Pressure	P ☐ C ☐ Lupus
P ☐ C ☐ Lyme Disease	P ☐ C ☐ Measles	P ☐ C ☐ Memory Loss	P ☐ C ☐ Meningitis
P ☐ C ☐ Mental Illness	P ☐ C ☐ Miscarriage	P ☐ C ☐ Mononucleosis	P ☐ C ☐ Multiple Sclerosis
P ☐ C ☐ Mumps	P ☐ C ☐ Nasal Polyps	P ☐ C ☐ Nerve Damage	P ☐ C ☐ Osteoporosis
P ☐ C ☐ Overweight	P ☐ C ☐ Parasites	P ☐ C ☐ Pelvic Inflammatory Disease	P ☐ C ☐ Peritonitis
P ☐ C ☐ Pleurisy	P ☐ C ☐ Pneumonia	P ☐ C ☐ Polio	P ☐ C ☐ Polycystic Ovaries
P ☐ C ☐ Psoriasis	P ☐ C ☐ Rheumatic Fever	P ☐ C ☐ Rheumatism	P ☐ C ☐ Roseola
P ☐ C ☐ Rubella	P ☐ C ☐ Scarlet Fever	P ☐ C ☐ Seizures / Convulsions	P ☐ C ☐ Sickle Cell Anemia

P ☐ **C** ☐ Strep Throat	**P** ☐ **C** ☐ Stroke	**P** ☐ **C** ☐ Syphilis	**P** ☐ **C** ☐ Thyroid
P ☐ **C** ☐ Tuberculosis	**P** ☐ **C** ☐ Ulcers	**P** ☐ **C** ☐ Varicose Veins	**P** ☐ **C** ☐ Whooping Cough

Please provide details on above conditions, or describe any other conditions you may have that are not included in the table above:

Please list any major trauma, stresses, injury, or accident you have experienced in your life.

Date	**Trauma, Stress, Injury, or Accident**	**Long Term Effects**
YYYY-MM-DD	Details	Effects

+ Add Row

Please list any surgical procedures you have undergone.

Date	**Procedure**	**Results / Complications**
YYYY-MM-DD	Details	Effects

+ Add Row

Additional comments regarding your medical history:

4. Medications and Supplements

Please list any prescription medications, over-the-counter medications, vitamins or other supplements you are taking. Please include dosages. Remember to include: appetite suppressants, antacids, laxatives, pain relievers, cortisone/prednisone, nasal decongestants tranquilizers, anti-depressants, sleeping pills, hormones, birth control pills, drugs, herbs, minerals, homeopathics, bach flower remedies, Chinese herbal remedies, and anything else you take regularly or are on currently.

Please bring all medications and supplements to your first appointment

Name:

Name

Recommended by:

Recommended By

Started:

YYYY-MM-DD

Stopped:

YYYY-MM-DD

Dosage:

Dosage

Reason For Use:

Reason For Use

+ Add Medication / Supplement

Please complete the following general information:

Have you ever taken antibiotics? ◯ Yes ◯ No

Additional Comments regarding any medications and supplements you are / were using:

5. Family Medical History

Please indicate any health conditions for the following family members. Please list any additional conditions not found in this table in the comments box at the end of this section.

Condition	Mother	Father	Sister	Brother	Maternal Grandparents	Paternal Grandparents	Other blood relatives
Age (if Living)							
Overall Health							
Age at death							
Cause of death							
Cancer	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Hay Fever / Hives	☐	☐	☐	☐	☐	☐	☐
Food sensitivities	☐	☐	☐	☐	☐	☐	☐
Digestive issues	☐	☐	☐	☐	☐	☐	☐

Celiac disease	☐	☐	☐	☐	☐	☐	☐
Crohn's / colitis	☐	☐	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐	☐	☐
Autoimmune	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐
Depression / anxiety	☐	☐	☐	☐	☐	☐	☐
Neurological Disease	☐	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Seizures/Epilepsy	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Please provide additional details on above conditions:

Please describe any other family health conditions that you feel are relevant:

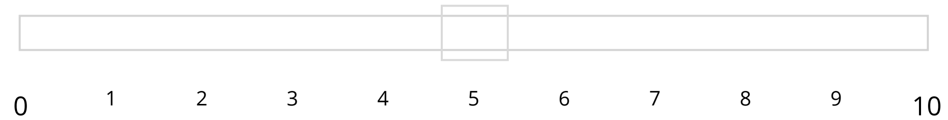
6. Work And Lifestyle

Please complete the following general information about your work and lifestyle:

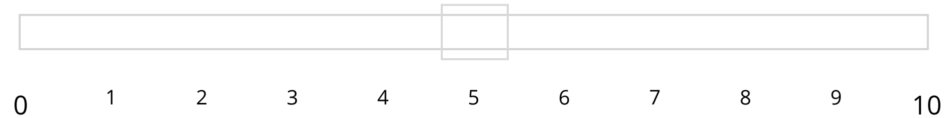
Have you ever been a smoker?	◯ Yes ◯ No
Are you exposed to second hand smoke?	◯ Yes ◯ No
Do you use any recreational drugs currently, or in the past?	◯ Past ◯ Currently ◯ No
Do you consume alcohol?	◯ Yes ◯ No
Do you enjoy your work (or retirement)?	◯ Yes ◯ No
How many hours per week do you work?	____ hours
Have you ever had a job that you felt exposed you to dangerous or toxic compounds?	◯ Yes ◯ No
Has there been any recent remodeling, construction, new carpets, or new paint?	◯ Yes ◯ No
How would you describe the emotional climate of your home?	
Do you exercise regularly?	◯ Yes ◯ No
Do you take vacations?	◯ Yes ◯ No
What do you do in your spare time?	
What are your interests and hobbies?	

What do you do for yourself?

What level of personal stress are you experiencing at the present moment? (1=low, 10=high)



How would you rate your average stress level over the last 3 months on a scale of 1 – 10? (1=low, 10=high)



What are your top three stressors in your life?

How well do you handle these stresses?

Has there been an event in your life that you have never recovered from?

◯ Yes ◯ No

Additional comments regarding work and lifestyle:

7. Allergies, Sensitivities, and Environmental Toxins

Please list any allergies, sensitivities and/or intolerances of which you are aware:

Medications*	**Food***	**Environmental / Chemical***

*Separate each item with a comma.

Please provide any additional details on above sensitivities:

Additional comments regarding allergies and sensitivities:

8. Food And Digestion

Please complete the following general information about Food And Digestion:

How many cups do you have of the following, on average, each day?

Water:
cups

Coffee:
cups

Tea:
cups

Pop / Soft Drinks:
cups

Juice:
cups

How many servings of fruits and vegetables do you eat on an average day?	
How many times per week do you eat out?	
How often do you have a bowel movement?	
Do you have any issues with digestion (i.e. heartburn, gas, bloating, indigestion)?	◯ Yes ◯ No
List the primary foods included in your diet for:	Breakfast: Lunch: Dinner: Snacks: Drinks:
Are there any foods you exclude from your diet, or do you restrict your diet in any way?	◯ Yes ◯ No
Are there any foods that you crave specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy)	◯ Yes ◯ No

Do you have, or have you ever had an eating disorder? ◯ Yes ◯ No

Additional comments regarding food and digestion:

9. Female Reproductive System

Please complete the following general information:

Age of first menses?	
Average number of days period lasts for:	
Average number of days of cycle?	
Date of last period?	YYYY-MM-DD
Number of pregnancies?	
Number of live births?	
Number of miscarriages?	
Number of terminated pregnancies?	
Have you had any difficulty conceiving?	◯ Yes ◯ No ◯ N/A
Do you perform regular breast self-exams?	◯ Yes ◯ No

Do you have menopausal symptoms? ◯ Yes ◯ No

Additional Comments regarding the female reproductive system:

10. Sexuality

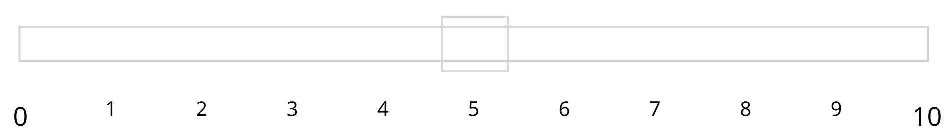
Please complete the following general information:

Are you currently sexually active?	◯ Yes ◯ No
What type of birth control and/or sexual protection do you use?	
What is your sexual preference?	◯ Heterosexual ◯ Homosexual ◯ Bisexual ◯ Asexual ◯ Non-heterosexual ◯ Pansexual ◯ Polysexual ◯ Queer

Additional Comments regarding sexuality:

11. Context Of Care

Please complete the following section regarding your expectations and health goals:

Why did you choose to come to our clinic?	
What do you know about our approach to health care?	
If 100% is perfect health, how would you rate your overall, current state of health?	%
What is your present level of commitment toward addressing the underlying causes of your signs and symptoms that may be related to lifestyle? Rate from zero to 100% commitment:	 0 1 2 3 4 5 6 7 8 9 10
What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health?	
What behaviours or lifestyle habits do you currently engage in regularly that you believe are harming your health?	
What potential problems or obstacles may you have in making changes to your current behaviours or lifestyle habits or in sticking to your treatment plan?	
What type of care are you looking for?	☐ Relief care (symptomatic relief of a condition) ☐ Corrective Care (having the cause of the symptoms corrected and relieved) ☐ Wellness Care (no symptoms or complaints, but wish to maintain optimal function and overall wellness)
Indicate what you see as your long term health goals:	Energy / Vitality: ☐ Increase Energy ☐ Eliminate dependence on over-the-counter medications

- [ ] Reduce fatigue
- [ ] Sleep more soundly
- [ ] Increase endurance
- [ ] Improve sex drive
- [ ] Eliminate allergies
- [ ] Be free of pain

Body Composition:

- [ ] Lose weight
- [ ] Gain weight
- [ ] Maintain my current weight
- [ ] Increase flexibility
- [ ] Increase muscle strength
- [ ] Increase muscle tone

Mental / Emotional:

- [ ] Learn to reduce stress
- [ ] Increase mental focus
- [ ] Improve memory
- [ ] Reduce depression
- [ ] Stabilize moods
- [ ] Be more decisive
- [ ] Be more motivated

Life Enrichment:

- [ ] Shift from treating illness to creating and optimizing wellness
- [ ] Slow down aging
- [ ] Reduce risk of chronic disease
- [ ] Maintain healthy life longer

Other:

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

What do you love to do?

Is there anything else that you feel I need to know?

12. Wheel Of Balance

Please answer the following questions.

Wellness is a balance of many factors. Using the sliders below, indicate your level of satisfaction in each area as it relates to you. For example, if you are extremely happy in your career, slide the Career Slider below all the way to the right. Do the same for each area. The Wheel Of Balance chart will update as you make your selections.

Career

Money

Health

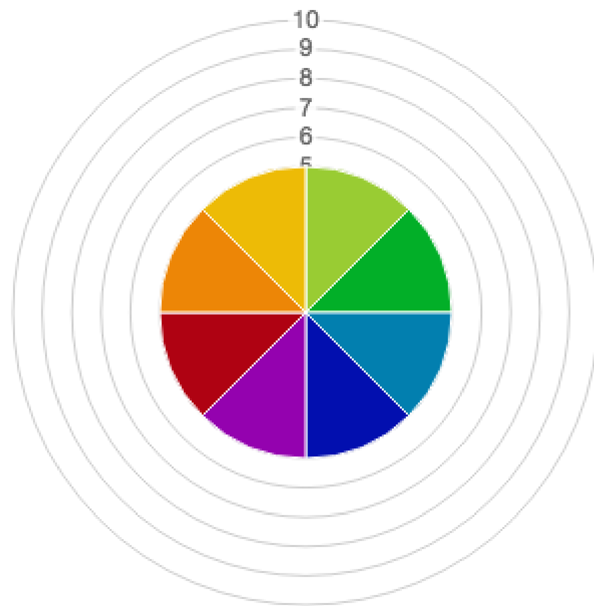
Significant Other / Romance

Fun & Recreation

Personal Growth

Family & Friends

Physical Environment



Do you have anything to add about your overall satisfaction with your health and lifestyle?

13. COVID-19 Screening

These screening questions are based on the latest COVID-19 case definitions and the Coronavirus disease (COVID-2019) situation reports published by the World Health Organization. All questions are required.

Did you have close contact with ◯ Yes ◯ No

anyone with acute respiratory Illness or have you traveled outside of the province/state or the country **that our clinic is located in** within the past 14 days?

Do you have a confirmed case of COVID-19 or have you had close contact with a confirmed case of COVID-19?	◯ Yes ◯ No
Have you been named as a possible contact and currently under self-isolation?	◯ Yes ◯ No
Do you have any household members who are currently under self-isolation?	◯ Yes ◯ No
Do you have any of the following symptoms? (Please check all that apply)	☐ Fever ☐ New onset of cough ☐ Worsening chronic cough ☐ Shortness of breath ☐ Difficulty breathing ☐ Sore throat ☐ Difficulty swallowing ☐ Decrease or loss of sense of taste or smell ☐ Chills ☐ Headaches ☐ Unexplained fatigue/malaise/muscle aches (myalgias) ☐ Nausea/vomiting, diarrhea, abdominal pain ☐ Pink eye (conjunctivitis) ☐ Runny nose/nasal congestion without other known cause
If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?	◯ Yes ◯ No

14. Cancellation Policy

Please be advised of my cancellation policy: In the event of a missed appointment with less than 24 hours notice,

100% of the visit fee will apply.

I acknowledge that I have been informed of, and fully understand the above:

◯ Yes ◯ No

15. Consent To Email Communications

I hereby acknowledge that I have requested the opportunity to communicate by email. I understand that in communicating in this manner that I am exposing myself to certain risks. These risks include:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and retain emails that pass through their systems.
- It is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- If the patient’s email requires or invites a response from the Naturopathic Doctor and the patient has not received a response within a reasonable time period it is the patient’s responsibility to follow up to determine

whether the intended recipient, Dr. Antonia Tsallas, ND received the email and when the recipient will respond.

- The patient is responsible for informing the Naturopathic Doctor of any types of information the patient does not want sent by email.

I acknowledge that I have been informed of, and fully understand the above:	◯ Yes ◯ No
Date:	
Patient Name:	
Patient Email Address:	

16. Declaration And Consent for Collection use and Disclosure of Personal Information

Patient Consent for Collection Use and Disclosure of Personal Information

Protecting your personal information is of the utmost importance. While providing naturopathic care, I require the collection, use and disclosure of your personal information. Your personal information will be handled with care, honesty and transparency. All information will be kept confidential.

To ensure your privacy is protected my privacy policy outlines how I can ensure that:

Please see below.

· only necessary information is collected about you;

· I only share your information with your consent;

· storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;

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

I will collect, use and disclose your personal information for the sole purposes outlined below:

· to assess your health concerns
· to provide health care
· 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 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 process credit card payments
· to collect unpaid accounts
· to assist the Clinic in complying with all regulatory requirements
· to comply generally with the law

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

I have reviewed the above information that explains how my Naturopathic Doctor will use my personal information, and the steps she is taking to protect my information. I agree that Dr. Antonia Tsallas, ND can collect, use and disclose personal information as set out above.

I acknowledge that I have been informed of, and fully understand the above:	◯ Yes ◯ No
Date:	
Patient Name:	

17. Declaration And Consent To Treatment

Informed Consent to Naturopathic Diagnostic and Treatment Procedures

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your naturopathic doctor will take a thorough case history, perform a physical examination, including when necessary, a breast exam, gynecological, rectal, prostate or genital exam. If your case requires, the Naturopathic Doctor may take blood and urine samples.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. The Naturopathic Doctor is trained to handle emergencies should the need arise.

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

• Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.

• Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.

• Pain, bruising or injury from venipuncture or acupuncture or parental therapy.

• Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa.

• Muscle strains and sprains or disc injuries from spinal manipulation.

• There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened by the intern prior to manipulating the neck.

I hereby request and consent to the act of naturopathic treatment.

- I understand that in the practice of Naturopathic Medicine, a number of different modalities may be suggested through out the course of treatment, including, but not limited to, Botanical Medicine, Hydrotherapy, Traditional Chinese Medicine and Acupuncture, Homeopathy, Physical Medicine, Nutrition and Lifestyle Counseling. As such, the Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.

- I understand that Dr. Antonia Tsallas is a licensed Naturopathic Doctor. As such, I hereby acknowledge that she has explained to me the nature of the naturopathic treatment I am to receive including the benefits of the treatment, any risks associated with the treatment and any medical alternatives.
- I understand that I may seek and/or continue to seek medical care from another health care provider qualified to practice in Ontario.
- I understand that the Naturopathic Doctor reserves the right to determine which cases fall outside their scope of practice, and will recommend an appropriate referral to an alternative health care provider.

- 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 unless so directed by the law.

- I understand that I may look at my medical record at anytime and can request a copy by paying the appropriate fee ($15).

- I am aware that I may withdraw my consent to treatment at anytime.

- I understand that the services offered are not OHIP covered, and that fees are payable at the end of each appointment; including fees for services, prescriptions, and laboratory tests.

- I understand that 24 hours notice is required for appointment cancellation and/or reschedule, otherwise I will be responsible for paying 100% of the scheduled office visit fee paid prior to the next visit.
- I understand that any therapies recommended will be explained to me in full by the Naturopathic Doctor, and that I will give consent to treatment based on informed consent. I understand that results are not guaranteed.

I acknowledge that I have been informed of, and fully understand the above:	◯ Yes ◯ No
Date:	
Patient Name:	
Patient Email Address:	

Clear

sign above

Thank You For Completing The Questionnaire!

Thank you for taking the time to complete this questionnaire. Click the "submit" button to submit this form to your practitioner .