Suzanne Ho-Miecznikowski, B.Sc., N.D
NATUROPATHIC DOCTOR

ADULT INTAKE FORM

Welcome to Naturopathic Medicine at the Village Healing Centre. To better understand how I can help you, please fill out this form to the best of your ability. This is a confidential record of your medical history and information will not be released to any person without your authorization.

Name:___________________________________ Date of birth: __________________

Address: ____
Street City Province Postal code

Home phone: ________________________ Work phone: ________________________

Mobile phone: _____________________________Email: ______________________________

Occupation: ___________________ Place of work: __________________________________

Marital status: _____________________________ Number of children: _____________

Emergency contact name: _______________________________Relationship: ____________
Home phone: ____________ Work phone: ____________Mobile:__________________

Please indicate how you found out about my practice: Google Yelp Bing Yahoo Friend referred Family referred Health food store OAND Other: ___________

Would you like to receive my quarterly information-packed e-newsletter? Yes No

HEALTHCARE PROVIDERS

Primary Healthcare Physician: ____
When was your last check-up? ____
Are you currently under the care of a specialist?
Name: ____________________________________Specialty: ______________________

Are you currently under the care of other healthcare providers?
Name: ____________________________________Specialty: ______________________

CURRENT HEALTH ISSUES

What is your **main** reason for coming in today? When did this issue become a concern?
____

List in order of importance any **other** health problems that are troubling you.
1. ____
2. ____
3. ____

CURRENT HEALTH INFORMATION

Height: _______________ Current weight: ______________________ One year ago: ________________

Are you currently using any non-prescription drugs, vitamins, herbs, homeopathic remedies? Yes / No

Are you currently using any prescription or over-the-counter medication? Yes / No

Supplement/medication (incl brand)	Total per day	Reason for taking supplement/med

Do you have allergies (food, chemical, environmental)?

FAMILY MEDICAL HISTORY

Please circle any of the following that blood relatives have had (not including yourself):

Alcoholism *Allergies* *Asthma* *Arthritis* *Bleeding conditions* *Cancer* *Diabetes*

Depression *Epilepsy* *Heart conditions* *Heart attack* *High blood pressure* *High cholesterol* *Kidney conditions*

Mental health issues *Obesity* *Stroke* *Substance abuse* *Tuberculosis* *Thyroid conditions* *Osteoporosis*

PAST MEDICAL HISTORY

Vaccinations (please circle)

Childhood - DPTP and MMR *Chickenpox* *Hepatitis A* *Other*

Tetanus *Flu shot* *Hepatitis B*

Past injuries/accidents/surgeries (please include date and description):

Please describe any adverse reactions you have had to prescription drugs, over-the-counter drugs or recreational drugs, vaccinations (childhood, travel, flu, hepatitis), or natural medicines (herbs, vitamins, minerals, homeopathics):

Name of drug, vaccine or natural remedy	Describe the reaction

Please circle all major illnesses you have experienced:

Measles *Mumps* *Chicken pox*

Diphtheria *Rheumatic fever* *Whooping cough*

Alcoholism *Anemia* *Addiction*

Diabetes *Jaundice* *High blood pressure*

Chronic infections *Rubella* *Gout*

Hepatitis *Weight problems* *Leukemia*

Malaria	*Worms/parasites*	*Polio*
Typhoid fever	*Acne*	*Boils/Abscess*
German measles	*Eating disorder*	*Mononucleosis*
Cancer	*Substance abuse*	*Chronic fatigue syndrome*

MENTAL/EMOTIONAL

Abuse	*Irritability*	*Bipolar disorder*	*Panic attacks*
Anxiety	*Depression*	*Phobia*	*Memory problems*

Please list the three most significant, stressful events in your life, from the most recent to distant.
1. ______________________________ Date: ______________
2. ______________________________ Date: ______________
3. ______________________________ Date: ______________

Has there been an event or illness that you have never fully recovered from? ______________________________

What do you enjoy most in your life? ______________________________

What do you worry about the most? ______________________________

ENDOCRINE

20 lbs change in weight in the last year	*Low energy after meals*	*Hypoglycemia (low blood sugar)*	*Generally feel hot*
Mental dullness	*Thyroid condition*	*Poor concentration*	*Generally feel cold*

How is your energy level on a scale of 1 to 10 (1= low energy and 10=high energy):

When you get up in the morning	1	2	3	4	5	6	7	8	9	10
Afternoon	1	2	3	4	5	6	7	8	9	10
Evening	1	2	3	4	5	6	7	8	9	10
Night	1	2	3	4	5	6	7	8	9	10

How would you rate your quality of sleep on a scale of 1 to 10 (10=excellent) 1 2 3 4 5 6 7 8 9 10

How many of hours of sleep do you get each night? ______________

Do you have trouble falling asleep or staying asleep? *Yes / No*

Do you need a nap during the day? *Yes / No*

IMMUNE

Chronic infections	*Frequent antibiotics*	*Frequent colds/flu*	*Swollen glands/nodes*
Frequent sore throats	*Slow wound healing*	*Cold sores*	*Shingles*

How often do you get colds, flu, or sore throats in a year? ______________________

HEAD

Headaches/migraine	*Stroke*	*Fainting*	*Cataracts*	*Glaucoma*	*Hearing loss*
Ringing in ears	*Ear infections*	*Loss of taste*	*Seizure/epilepsy*	*Cold sores*	*Canker sores*
Allergies	*Hayfever*	*Influenza*	*Sinusitis*	*Strep throat*	*Vision changes*
Vertigo	*Concussion*	*Loss of balance*			

CHEST

Heart conditions	*Chest pain/angina*	*Palpitations/murmurs*	*Asthma*	*Pneumonia*
Tuberculosis	*Bronchitis*	*Emphysema*	*Heart attack*	*Pacemaker*
Difficulty breathing	*Chronic cough*	*Shortness of breath*	*Wheezing*	

EXTREMITIES

Cold hands/feet	*Numbness/tingling*	*Warts*	*Varicose veins*	*Arthritis*
Gout	*Swelling of limbs*	*Raynaud's Disease*	*Eczema/psoriasis*	*Bleeding conditions*

DIGESTIVE

Heartburn	*Nausea/vomiting*	*Diarrhea*
Constipation	*Excessive gas*	*Bloating*
Blood in stools	*Mucous in stools*	*Undigested food in stools*
Black stools	*Light-coloured stools*	*Floating stools*
Hemorrhoids	*Parasites*	*Irritable bowel*
Candida (yeast)	*Appendicitis*	*Bad breath*
Change in appetite	*Change in thirst*	*Chronic laxative use*
Gastric or duodenal ulcers	*Gallstones*	

KIDNEYS AND BLADDER

Inability to urinate	*Frequent urination*	*Blood in urine*	*Cloudy urine*
Bladder infections	*Burning during urination*	*Incontinence*	*Kidney stones*

REPRODUCTIVE

Are you sexually active? *Yes / No*
Do you use birth control? *Yes / No* If yes, what type? ______________________________
Please circle if you have had:

HIV	*Syphilis*	*Gonorrhea*	*Genital herpes*	*Chlamydia*
Human Papilloma virus (HPV)	*Low sex drive*	*Other STD*		

FEMALE

Abnormal vaginal discharge	*Irregular periods*	*Mood swings*	*Vaginal dryness*
Vaginal itching	*Sores/growths/lumps*	*Heavy periods*	*Spotting between periods*
Fibrocystic breasts	*Nipple discharge*	*Cramps*	*Pain with intercourse*
Fibroids	*Ovarian cysts*	*Endometriosus*	

Age of first menstrual period? ___________________________ Have your periods ever stopped? *Yes / No*

Do you have a regular cycle? *Yes / No* Length of cycle: ____________How long are your periods? ______

Do you use tampons or pads? ___________________________

Menopause? *Yes / No* Age: _______________

Date of last PAP smear?________________________ Any abnormal PAP smears? *Yes / No*

Do you perform breast self-examinations? *Yes / No* Have you noticed any breast lumps? *Yes / No*
Date of last breast exam/mammogram: ___________________________________

Are you pregnant? *Yes / No* Are you trying to conceive? *Yes / No*

Number of: Pregnancies: _________Live births: _____________ Miscarriages: __________ Abortions: ______

MALE

Abnormal discharge *BPH* *Trouble getting/maintaining an erection*

Have you had your prostate examined? *Yes / No* When? _______________________

HOUSEHOLD/OCCUPATIONAL

Please circle if any of the following apply to your home: *Damp or mouldy* *Live in city* *Air filtration*

Please circle if any of the following apply to your workplace:

Office building *Air filtration* *Work in presence of fumes or chemicals*

Are you currently exposed to second-hand smoke? *Yes / No*

What type of water do you drink? *Tap* *Bottled* *Filtered* *Reverse osmosis* *Distilled*

Have you ever been exposed to mould, solvents, lead paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations), at work, or while travelling?	Y	N
Have you ever experienced health problems after putting in new carpeting, painting your home, doing renovations, or having your lawn sprayed with herbicide?	Y	N
Are you particularly sensitive to perfume, gasoline or other vapours?	Y	N
Have you ever lived near a refinery or a polluted area?	Y	N
Have you ever lived in a home more than 50 years old?	Y	N
Do you have mercury dental fillings?	Y	N
Have you had any dental root canal procedures?	Y	N
Do you have any surgical implants (cosmetic/medical)?	Y	N
Do you live near large power lines?	Y	N

PERSONAL HABITS

With whom do you currently live?

Spouse *Partner* *Parents* *Friends* *Children* *Alone*

What are your hobbies and interests? ____________________

How often do you have leisure time? *Once/day* *Every other day* *Once/week* *Other*

Do you find your work fulfilling? *Yes / No* Do you take vacations? *Yes / No*

Do you exercise regularly? *Yes / No* If yes, how often? ____________________
What forms of exercise do you do: ____________________ Duration: __________

Circle any that you are currently using:

Alcohol *Antacids* *Coffee* *Laxatives* *Sedatives* *Tobacco* *Recreational drugs*

How often and how much? ____________________

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

Y N 1. Has your doctor ever said you have heart trouble and that you should only do physical activity recommended by a doctor?
Y N 2. Do you feel pain in your chest when you do physical exercise?
Y N 3. In the past month, have you had chest pain when you were not doing physical activity?
Y N 4. Do you lose your balance because of dizziness or do you ever lose consciousness?
Y N 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
Y N 6. Is your doctor currently prescribing drugs (e.g. water pills) for your blood pressure or heart condition?
Y N 7. Do you know of any other reason why you should not do physical activity?

Is there anything else that you feel I should know about you? ____________________
____
____
____

Thank you for taking the time to complete this questionnaire. This information is important for your overall assessment and will be kept in strict confidence.

VISIT FEES

Office visits:

Initial consultation (90 minutes) *Consultation, complaint-based physical exam, urine test*	$180
Second visit (60 minutes) *Screening physical exam, laboratory tests, initiation of treatment plan*	$120
Follow-up visits (30-45 minutes) *Consultation and monitoring of treatment plan*	$100

* Special rates available for children (12 years and under) and seniors (65 years and over).

Telephone, Skype and email consultations:

Please note: these are generally intended for follow-up consultations and clarification of treatment protocols.

Remote consultations are offered only after an initial visit has been conducted and a treatment plan has been initiated.

First 5 minutes	No charge
20 minute consults	$45
30 minutes or longer	Follow-up visit fees apply

Diagnostic services and naturopathic supplements

Suzanne has functional laboratory services provided by LifeLabs and In-Common Laboratories. This enables her to perform comprehensive blood work, urine and stool testing, as well as special tests using saliva and hair. OHIP does not cover laboratory services requested by naturopathic doctors, therefore, patients are required to pay for these services.

Suzanne also carries a limited selection of professional quality products that are not available through health food stores. Patients are required to pay for products that they choose to purchase from Suzanne.

Booking appointments

Please schedule your appointments and plan to arrive for appointments on time. I try my best to be punctual for appointments.

Cancelled and missed appointments

Please ensure to give at least one business day cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled ON THE SAME DAY or missed appointments, the FULL COST of the appointment will be charged. Consideration will be given to unforeseeable circumstances.

Payment for consultation fees

Payment for services is due at the end of each visit and a receipt will be given when payment is received. Please retain your receipt for claiming your insurance, if applicable. **Fees may be paid by cash, cheque, credit card or e-transfer.** Any prescribed botanicals, supplements, or homeopathics are not included in the above consultation fees.

Confidentiality

Everything that you communicate, directly or indirectly, to Suzanne is confidential unless you give written permission to disclose information to a third party.

It is important to note that there are exceptions to confidentiality that include the legal and/or ethical obligations to:

1. report incidents of child abuse (physical, sexual or emotional) and neglect;
2. comply with court-ordered subpoena;
3. prevent harm to yourself or another person should such plans be disclosed;
4. report a health professional who has sexually abused a patient.

Privacy consent

Privacy of your personal information is an important part of providing you with quality naturopathic care. I understand the importance of protecting your personal information. I am committed to collecting, using, and disclosing your personal information responsibly. I will take steps to protect your personal health information from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal.

With regard to uses and disclosures of personal health information, it will be used to:
- treat and care for you,
- get payment for your treatment and care (from WSIB, your private insurer or others),
- plan, administer and manage my internal operations,
- conduct risk management and quality improvement activities,
- compile statistics,
- comply with legal and regulatory requirements, and
- fulfill other purposes permitted or required by law.

I understand that **Suzanne Ho-Miecznikowski, B.Sc., N.D.** will only collect, use and disclose my personal health information with my consent unless a particular collection, use or disclosure is permitted or required by law without my consent.

I also understand that I can refuse to sign this consent form. I can also withdraw my consent any time by writing to Suzanne Ho-Miecznikowski.

I hereby authorize Suzanne Ho-Miecznikowski to collect, use and disclose my personal health information for the purposes that have been indicated above.

Statement of Acknowledgement

I, ______________________ have read, understood, and agree to the contents herein. I also attest that the information
Print name

provided about me is true and accurate to the best of my knowledge.

Patient signature: ____

Date: ____