RESTORATION HEALTH CLINIC

Dr Julie Durnan, ND | Dr Jennie Weisenburger, ND
Dr Ann Grimwood, ND | Dr Kathleen Mahannah, ND
Dr Tanner Alden | Dr Lyndsey Zigar, ND
Jen Cherewaty RAc, TCMP | Dr Carla Cupido, DC

NEW PATIENT INTAKE FORM – ADULT

Please print this form, complete as much as possible, and bring with you on the day of your first appointment to our clinic. We look forward to meeting you.

Name	Date of Birth	Age	Gender

Today's Date	Primary Phone (circle: home / cell / work)	Alternate Phone (circle: home / cell / work)

How would you prefer to receive appointment reminders? ○ Text ○ Voicemail ○ Email

Mailing Address

City Province Postal Code

Email	Skype name

Relationship status / Partner's name	Occupation (underline: part time / full time / other)

Emergency Contact Name / Relationship	Emergency Contact Phone

Are you currently receiving healthcare at another location/s? Please name other healthcare providers and their role in your medical care:

How did you hear about us?

1. Why did you choose to come to Restoration Health Clinic? What do you know about our approach?

2. What **three** expectations do you have for your first visit to our clinic?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0-10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. a) What behaviours or habits do you currently engage in regularly that you believe support your health?

b) What behaviours or lifestyle habits do you currently engage in regularly that you believe are damaging lifestyle habits?

5. What potential obstacles exist in your life that will prevent you from changing your lifestyle and adhering to suggestions we make for you?

6. What brings you joy?

Primary Concerns List in order of priority. Describe your concerns below if necessary.

Concern Example: Headaches	Onset Example: January 2013
1	
2	
3	
4	
5	

Medical History

Eyes Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Glasses or contacts	○	○	Recent change in vision	○	○	Eyes watery or dry
○	○	Colour blind	○	○	Blurred vision	○	○	Bloodshot eyes
○	○	Double vision	○	○	Eye pain/strain	○	○	Puffy eyes
○	○	Spots in eyes	○	○	Sensitivity to light			

Head Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Headaches	○	○	Jaw or TMJ problems	○	○	Head injury
○	○	Migraines						

Ear/Nose/Mouth/Throat/Neck Please check ✓all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Impaired hearing	○	○	Frequent colds or flus	○	○	Dental cavities or infections
○	○	Ringing in ears	○	○	Sleep Apnea	○	○	Jaw clicks
○	○	Sensitivity to noise	○	○	Teeth/gum problems	○	○	Cold sores
○	○	Earache	○	○	Mercury (silver) amalgam fillings	○	○	Root canals
○	○	Frequent ear infections	○	○	Copious saliva	○	○	Regular dental cleanings
○	○	Discharge from ears	○	○	Dry mouth	○	○	Lumps in neck
○	○	Nose bleeds	○	○	Mouth ulcers	○	○	Swollen nodes/glands
○	○	Sinus problems	○	○	Teeth grinding	○	○	Goiter
○	○	Stuffiness	○	○	Sore tongue or lips	○	○	Pain or stiffness in neck
○	○	Loss of smell	○	○	Hoarse voice	○	○	Other:
○	○	Hayfever	○	○	Loss of voice			
○	○	Frequent sore throat						

Respiratory Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Cough	○	○	Difficulty breathing	○	○	Asthma
○	○	Mucous/phlegm	○	○	Shortness of breath with light exercise	○	○	Bronchitis
○	○	Spitting up blood	○	○	Shortness of breath lying down	○	○	Pneumonia
○	○	Wheezing				○	○	Emphysema
○	○	Painful breathing				○	○	Other:

Cardiovascular + Blood Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Heart disease	○	○	Valve prolapse	○	○	Edema/swelling in ankles or feet
○	○	Elevated cholesterol	○	○	Blood clots	○	○	Deep leg pain
○	○	High blood pressure	○	○	Easy bleeding or bruising	○	○	Varicose veins
○	○	Low blood pressure	○	○	Chest pain	○	○	Cold hands/feet
○	○	Angina	○	○	Dizziness with standing or fainting	○	○	Anemia
○	○	Pacemaker	○	○	Murmurs	○	○	Other:
○	○	Rheumatic Fever	○	○	Palpitations or flutter			
○	○	Arrythmia						

Gastrointestinal Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Constipation	○	○	Flatulence	○	○	Gallbladder disease
○	○	Diarrhea	○	○	Nausea	○	○	Irritable Bowel Syndrome
○	○	Difficulty swallowing	○	○	Vomiting	○	○	Crohn's
○	○	Heartburn	○	○	Hemorrhoids	○	○	Ulcerative Colitis
○	○	Change in thirst	○	○	Black or dark tarry stools	○	○	Gastitis or Peptic Ulcer
○	○	Change in appetite	○	○	Blood or mucous in stool	○	○	GERD
○	○	Abdominal cramping or pain	○	○	Undigested food in stool	○	○	Celiac Disease
○	○	Burping	○	○	Jaundice (yellow skin)	○	○	Other:

Genital + Urinary Systems Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Increased frequency of urination	○	○	Difficulty starting to urinate	○	○	Kidney Stones
○	○	Frequency of urination at night (more than once)	○	○	Inability to hold urine	○	○	Urinary Tract Infections
○	○	Pain on urination	○	○	Blood in urine	○	○	Yeast Infections
						○	○	Other:

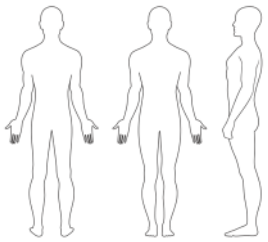
Inflammatory/Autoimmune Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Chronic Fatigue Syndrome	○	○	Poor Immune Function/ Frequent Infections	○	○	Multiple Chemical Sensitivities
○	○	Autoimmune Disease	○	○	Food Allergies	○	○	Latex Allergy
○	○	Rheumatoid Arthritis	○	○	Lupus SLE	○	○	Other
○	○	Immune Deficiency Disease	○	○	Environmental Allergies			
○	○	Severe Infectious Disease						

Metabolic/Endocrine Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Heat or cold intolerance	○	○	Frequent weight fluctuations	○	○	Hypoglycemia
○	○	Excessive thirst	○	○	Excessive sweating	○	○	Polycystic Ovarian Syndrome (PCOS)
○	○	Excessive fatigue	○	○	Night sweats	○	○	Bulimia
○	○	Excessive hair growth	○	○	Type 1 Diabetes	○	○	Anorexia
○	○	Thyroid – low or overactive	○	○	Type 2 Diabetes	○	○	Eating disorder
○	○	Weight gain	○	○	Metabolic Syndrome/Insulin Resistance	○	○	Other:
○	○	Weight loss						

Musculoskeletal Pain Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		
○	○	Joint pain or stiffness	○	○	Chronic Pain	Please mark areas of current pain:
○	○	Broken bones	○	○	Sprain	
○	○	Muscle weakness	○	○	Swelling	
○	○	Muscle cramping or spasms	○	○	Sciatica	
○	○	Arthritis	○	○	Motor vehicle accident	
○	○	Fibromyalgia	○	○	Other:	

Skin Diseases Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Rashes	○	○	Boils	○	○	Dry or scaling
○	○	Eczema	○	○	Colour change	○	○	Itching
○	○	Hives	○	○	Lumps	○	○	Hair loss
○	○	Psoriasis	○	○	New or changing mole	○	○	Other
○	○	Acne						

Mood + Emotional Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Depression	○	○	Tension	○	○	Considered suicide
○	○	Anxiety or nervousness	○	○	Easily stressed	○	○	Bipolar Disorder
○	○	Difficulty concentrating	○	○	Mood swings	○	○	Schizophrenia
○	○	Poor memory	○	○	Lack of pleasure or motivation			

Neurologic Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Vertigo	○	○	Autism	○	○	ALS
○	○	Loss of balance	○	○	Mild Cognitive Impairment	○	○	Seizures
○	○	ADD/ADHD	○	○	Multiple Sclerosis	○	○	Paralysis
○	○	Sensory Integrative Disorder				○	○	Other:

Cancer Please describe.

Male History Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Hernias	○	○	Venereal disease	○	○	Premature ejaculation
○	○	Prostate problems	○	○	Discharge or sores	○	○	Sexually transmitted infection
○	○	Testicular masses	○	○	Are you sexually active?	○	○	Type of birth control used (please list):
○	○	Testicular pain	○	○	Erectile dysfunction			
○	○	Do you do testicular self-exam?	○	○	Low libido			

Female History Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C	P		C	P		C	P	
○	○	Ireegular cycles	○	○	Are you sexually active	○	○	Difficulty conceiving
○	○	Bleeding between cycles	○	○	Low libido	○	○	Perimenopausal
○	○	Heavy or excessive flow	○	○	Pain with intercourse	○	○	Breast pain
○	○	Clotting	○	○	Vaginal dryness	○	○	Lumps in breast
○	○	Pain in abdomen/pelvis/back	○	○	Vaginal discharge	○	○	Do you do regular self breast exams?
○	○	PMS	○	○	History of sexually transmitted infection	○	○	Nipple discharge
○	○	Do you use contraception	○	○	History of sexual trauma			

Female History - Short Answer

Age at first period: Age at last period (if menopausal): Date of last menstrual period: Length of cycle (in days):	Duration of menses (in days): Number of pregnancies: Number of live births: Date of last pap:	Abnormal pap? When? Birth control type:

Family Medical History

List any diseases for each family member. Please include family member's age and cause of death if no longer alive.

Mother	Maternal Grandmother	Maternal Grandfather
Father	Paternal Grandmother	Paternal Grandfather
Siblings		

Surgeries & Hospitalizations Include injury, date, location.

Medical Testing Include xrays, CT scans, ultrasounds, MRI, ECG.

Medications & Supplements:

Medication (Over the counter / prescription)	Dosage & Frequency
Supplements (Including brand name)	Dosage & Frequency

Allergic reaction/intolerances to Medications Example: penicillin causes hives

Allergic reaction/intolerances (Foods, Environment) Example: cow's milk causes bloating

Diet & Lifestyle

1. What do you typically eat in a day?

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

2. What are the least healthful foods in your diet?

3. Do you drink: ○ Coffee ○ Black tea ○ Green tea ○ Juice ○ Pop _____
○ Milk (note if dairy alternative) _____
○ Alcohol _____ (Estimated drinks per week _____ Preferred drink _____)
○ Water _____

4. How often do you eat out?

5. Do you have any questions or concerns about your diet?

6. Do you exercise? ○ Yes ○ No Hours per week: _____ Type of exercise (describe):

7. Tobacco: ○ Yes ○ No

Yes: Cigarettes Age ____ to ____ / ____ packs per day ○ Yes: Cigars ○ Yes: Chewing tobacco

8. Prescription drugs used for recreational purposes: ○ Yes ○ No Type:

Other drugs: ○ Yes ○ No Type(s) and frequency:

9. How many hours sleep do you get?

10. What are your main interests and hobbies?

11. Do you have a religious or spiritual practice?

12. What are the major stressors in your life?

13. Who are the people in your life that are most supportive of you and any changes you make in your lifestyle?

14. Have you had any prior experiences with natural medicine? If so, please describe.

RESTORATION
HEALTH CLINIC

AUTHORIZATION AND CONSENT

Dear Patient,

Thank you for your interest in retaining Restoration Health Clinic Inc. ("Restoration") to provide you or your child with naturopathic care and guidance to support and improve your or your child's health and well being.

Prior to Restoration agreeing to accept you or your child as a patient and provide you or your child with its naturopathic services, Restoration requires that you review and agree to the terms and conditions contained in this letter agreement.

Throughout this letter agreement the terms "you", "I", "me" and "my" shall refer to you the undersigned individual or your child (as applicable), specified at the end of this letter agreement.

I wish to retain Restoration to provide me or my child with naturopathic care, treatment and guidance to support and improve my or my child's health and well being (the "Treatment"). I understand and agree that prior to Restoration providing me the Treatment, Restoration requires, and is relying on, my consent and the following representations, warranties and covenants:

1. I understand and acknowledge that Restoration employs naturopathic doctors ("ND") to provide the Treatment and does ***not*** employ traditional medical doctors to provide the Treatment. For the purposes of providing the Treatment, I consent to one or more of Restoration's NDs or staff to carry out the following tasks:

   (a) take a thorough case history and conduct a screening physical examination; which may include a breast exam, gynaecological, rectal, prostate, and blood and urine samples as required; and

   (b) recording your personal medical information and sharing your personal medical information with Restoration Staff and other medical professionals solely in connection with your Treatment and subject to strict confidentiality guidelines implemented by Restoration.

2. I understand and acknowledge that Restoration employs the use of Botanical Medicine, Traditional Chinese Medicine, Acupuncture, Bony manipulations, Massage, Hydrotherapy, Nutrition, Lifestyle Counseling, Psychological counseling, Homeopathy, Intramuscular injections, intravenous injections, Pharmaceutical prescriptions, or Vaccinations in providing the Treatment.

3. I represent and warrant that all medical information provided by me to Restoration during my initial health assessment is true and correct. I will advise Restoration as soon as possible of any errors in the medical information I provided to Restoration or any changes to my current health status including any disease or ailments that I may be suffering from, any medication or over the counter drugs that I am consuming and whether I am pregnant, suspect I may be pregnant or am breast-feeding.

4. I hereby acknowledge and agree that Restoration has not made any warranties or representations of any kind to me regarding results that may be achieved from the Treatment. I understand that any results or outcomes arising from the Treatment are individual and may vary from person to person. I understand that the results of the Treatment are not guaranteed and do not expect the ND's will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the Treatment provided to me by Restoration.

5. I hereby acknowledge and agree that the Treatment may lead to certain unforeseen complications, including but not limited to: aggravation of pre-existing symptoms; allergic reactions to pharmaceuticals, supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations. I also acknowledge that I have the right to accept or reject this medical care of my own free will and choice.

6. I recognize that specific foods, botanicals and medications may create allergic and possible serious reactions, in particular, products containing nuts. I further acknowledge that these allergies may cause me serious bodily harm. I represent and warrant that I have provided to Restoration during my initial health and assessment a list of all items which, to the best of my knowledge, I am allergic or sensitive to.

7. I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. 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 myself or unless law requires it. Notwithstanding, I understand that the Staff and ND's at Restoration are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats or harm to any individual and/or serious threat of suicide involved with my case. I understand that I may look at my medical records at anytime and can request a copy of it by paying the appropriate fees. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.

8. In consideration for Restoration agreeing to provide me with the Treatment, I hereby irrevocably and unconditionally release and forever discharge Restoration, its directors, officers, employees, agents and contractors and Restoration's successors, assigns, heirs and legal representatives (all such persons and entities being called the "Released Parties") of and from all manner of actions, causes of action, suits, demands, debts, accounts, covenants, contracts, damages and all other claims whatsoever, which the undersigned or its successors or assigns ever had, now has or may in the future have against any of the Released Parties for or by reason of any cause, matter or thing related to or arising from the Treatment provided to me including (but not limited to) any bodily harm or injury sustained by me or any other person. I further acknowledge and agree that the Released Parties will in no way be responsible for any bodily harm or injury suffered by me as a result of the Treatment.

9. I further agree and acknowledge that Restoration has the right to cease providing the Treatment to me at any time effective immediately, without any compensation to me whatsoever. This letter agreement will cover the entire course of my Treatment and I am free to withdraw my consent and to discontinue participation Treatment at any time.

10. Please note we require 48 hours notice for all cancelled appointments or the full visit fee will be charged.

We thank you for the opportunity of being able to work with you on improving your health, and wellbeing.

Yours truly,

RESTORATION HEALTH CLINIC INC.

I hereby certify that the representations and warranties contained in this letter agreement are true and correct and I hereby agree to the foregoing covenants and terms and conditions.

I hereby consent to _____ [enter name of ND] on behalf of Restoration and Restoration Health Clinic Inc. to provide me or my child with the Treatment described above.

Dated the _____ day of _____, 201___.

Print Name of Patient (if patient is a minor, print name guardian and relationship of guardian to patient):	
Signature of Patient (or signature of guardian if applicable):	
Address of Patient (and address of guardian if applicable):	
Telephone Number:	Email Address: