

# Naturopathic Intake Form

## Dr. Ruchira Shetty, B.Sc., N.D.

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First Name: \_\_\_\_\_ Last name: \_\_\_\_\_ Gender: M / F

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Please list only the numbers at which you would like to be contacted.

Phone (home): \_\_\_\_\_ Phone (work): \_\_\_\_\_

Email: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to you? \_\_\_\_\_

Other health care providers:

Name: _____	Name: _____	Name: _____
Type: _____	Type: _____	Type: _____
For: _____	For: _____	For: _____
(____) _____	(____) _____	(____) _____

How were you referred? : \_\_\_\_\_

**This is a confidential record of your medical history. Information contained here will not be released to anyone without your authorization. Please complete this questionnaire as thoroughly as possible.**

What are your health concerns, in order of importance to you:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

If you are female are you currently pregnant? Yes No

Medical history

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, injuries, or hospitalization.

Condition	Date

Do you have any allergies (medicines, environmental, etc.)?


Please list all current **prescription** medications:


Please list past prescription medications.


Please list all over-the-counter medications, vitamins, herbs and homeopathics:


How many times have you been treated with antibiotics? \_\_\_\_\_

Do you use any of the following?

	form, amount, how often		form, amount, how often
<input type="checkbox"/> Aspirin		<input type="checkbox"/> Caffeine	
<input type="checkbox"/> Laxatives		<input type="checkbox"/> Alcohol	
<input type="checkbox"/> Diet Pills		<input type="checkbox"/> Pop	
<input type="checkbox"/> Antacids		<input type="checkbox"/> Tobacco	
<input type="checkbox"/> Birth Control		<input type="checkbox"/> Recreational Drugs	

Please indicate the immunizations you have had:

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Tetanus booster; when? _____         | <input type="checkbox"/> "Flu"                   | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> MMR (measles, mumps, rubella)        | <input type="checkbox"/> Polio                   | <input type="checkbox"/> Smallpox    |
- Other \_\_\_\_\_

Please indicate if any caused adverse reactions: \_\_\_\_\_

Do you get regular screening tests done by another doctor (blood tests, pap test, etc.)? Yes No

Diet

Do you have any food allergies or intolerances?

Please list:


Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? \_\_\_\_\_

Describe a typical day's diet:

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages (quantity)	

Family history

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other: _____	
Diabetes		Other: _____	

I don't know my family medical history

Environment

Do you exercise regularly?      Yes    No

What do you do for exercise	how much	how often

Are you exposed to significant tobacco smoke (work, home, etc.)?      Yes    No

Are you frequently exposed to animals (work, pets, etc.)?      Yes    No

How is your home heated? \_\_\_\_\_

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How would you describe the emotional climate of your home?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How stressful is your work, or other aspects of your life? How do you handle these stresses?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything that you feel is important that has not been covered?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SYSTEMS REVIEW

Below is a list of symptoms which may or may not seem relevant to your current health concerns. Please answer completely as a detailed health history is necessary to develop a personalized health plan. The relevant issues brought up by this questionnaire will be discussed during your appointment.

Please check (√) "C" if you currently have the symptom or "P" if you have had it in the past.

Skin	C	P
Rashes		
Hives		
Acne		
Boils		
Eczema		
Psoriasis		
Dry skin		
Itching		
Lumps		
Night sweats		
Other		

Head	C	P
Tension headaches		
Migraine headaches		
Head Injury		
Dizziness		
Other		

Eye	C	P
Impaired vision		
Use of contact lenses/ glasses		
Eye pain		
Tearing		
Dryness		
Double vision		
Glaucoma		
Cataracts		
Blurring		
Light Sensitivity		
Itching		
Redness		
Discharge		
Blind spot		
Other		

Ears	C	P
Impaired hearing		
Earache		
Dizziness		
Discharge		
Infections		
Excessive wax		
Other		

Nose & Sinuses	C	P
Frequent colds		
Nose bleeds		
Stuffiness		
Hay fever		
Infections		
Other		

Mouth & Throat	C	P
Hoarseness		
Gum problems		
Difficulty swallowing		
Dental problems		
Sores		
Dryness		
Sore throat		
Loss of taste		
Other		

Neck	C	P
Lumps		
Swollen glands		
Goiter		
Pain or stiffness		
Other		

Respiratory	C	P
Cough		
Sputum		
Spitting up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Pain on breathing		
Shortness of breath		
Positive tuberculin test		
Last TB test:		
Last chest x-ray:		
Other		

Cardiovascular	C	P
Angina		
Murmurs		
Chest pain		
Swelling in ankles		
Palpitations, fluttering		
Last ECG:		
Other		

Breasts	C	P
Do you perform self-breast exams?		
Lumps		
Pain (or tenderness)		
Nipple discharge		
Last mammogram		
Other		

Gastrointestinal	C	P
Vomiting		
Heartburn		
Change in appetite		
Nausea		
Frequency of Bowel Movements		
Vomiting blood		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		
Constipation		
Blood in stools		
Hemorrhoids		
Black, tarry stool		
Jaundice		
Liver disease		
Gallbladder disease		
Food allergy		
Hiatus hernia		
Other		

Blood/Lymphatic	C	P
Anemia		
Easy bleeding/ bruising		
Past transfusions		
Lymph node swelling		
Other		

Please check (√) "C" if you currently have the symptom or "P" if you have had it in the past.

Urinary	C	P
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced urine flow		

Musculoskeletal	C	P
Broken bones		
Muscle spasms/ cramps		
Weakness		
Joint swelling		
Backache		
Other		

Peripheral vascular	C	P
Deep leg pain		
Cold hands/ feet		
Varicose veins		
Leg cramps		
Extremity numbness		
Extremity swelling		
Extremity ulcers		
Other		

Neurologic	C	P
Fainting		
Seizure/ Convulsions		
Paralysis		
Muscle weakness		
Numbness or tingling		
Loss of memory		
Involuntary movements		
Speech problems		
Other		

Endocrine	C	P
Heat/ cold intolerance		
Thyroid trouble		
Excessive thirst		
Excessive hunger		
Excessive sweating		
Diabetes		
Low blood sugar		

Emotional	C	P
Depression		
Extreme anger		
Mood swings		
Anxiety		
Nervousness		
Tension		
Phobias		
Insomnia		
Sexual difficulties		
Drug abuse		
Psychiatric care		
Psychological counseling		
Other		

Male Reproductive	C	P
Hernia		
Testicular mass		
Testicular pain		
Impotence		
Premature ejaculation		
Venereal disease		
Discharge of sores		
Sexually active		
Last prostate exam:		
Last PSA level:		
Other		

Female Reproductive	C	P
Age of first menses:		
Last menstrual period:		
Number of days of menses:		
Length of cycle:		
Bleeding btwn periods		
Irregular cycles		
PMS		
Heavy flow		
Menopause		
Age of onset:		
Hormone therapy		
Last gynecological exam:		
Number of pregnancies:		
Number of live births:		
Number of miscarriages:		
Number of abortions:		
Difficulty conceiving		
Vaginal discharge		
Vaginal itching		
Sexually active		
Pain during intercourse		
Other		

## **Consent to Treatment with Naturopathic Doctor, Ruchira Shetty**

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. A number of different approaches are used including diet and nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, and lifestyle counseling.

Even the gentlest therapies can sometimes cause complications. Some therapies must be used with caution in conditions such as diabetes, heart, liver, or kidney disease, during pregnancy, while breastfeeding, and while taking other medications. It is very important therefore that you inform the Naturopath of any health conditions you have, any changes in your health status, as well as any prescribed or over the counter medications or supplements you are taking. If you are pregnant or suspect you are pregnant or are breastfeeding please advise the Naturopath immediately.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to: aggravation of pre-existing condition, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from acupuncture.

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 required by law. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that I am at liberty to seek or continue medical care from a medical doctor or other health care providers. No one under the direction of Ruchira Shetty has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

I understand that the results are not guaranteed. I do not expect the Naturopath to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: \_\_\_\_\_.  
I intend this consent form to cover the entire course of treatment for my present condition. I understand that I must inform the ND of any positive or negative changes in my health status before each successive treatment and I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient's printed name: \_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Naturopathic Doctor: \_\_\_\_\_