**CONFIDENTIAL ADULT INTAKE FORM**

**PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION** (Please print clearly)

Name:_____Date:_____ Date of Birth: DD/MM/YY_____ Age: _____ Sex: M F
Address:_____
_____
_____

Email Address:_____(optional)

☐ I would like to be put on clinic email list to receive newsletters and clinic updates.

Telephone number: Home:_____ Work:_____

May we leave a message at these numbers? Y N Occupation:_____
Marital status:_____ Emergency contact: Name_____
Phone number_____

How did you hear about us?_____

Have you ever had previous naturopathic care? Y N If you are female, are you currently pregnant? Y N

Please list your major health concerns in order of importance:

| |
|---|
| 1. |
| 2. |
| 3. |
| 4. |



Wortley Village
Priority Massage & Health
172 Wortley Rd, London, ON
N6C3P7 tel:519-642-7469

Dorchester Village
Dorchester Chiropractic &Wellness
3944 Hamilton Rd, Dorchester ON
NOL 1G2 tel: 519-268-6000

Blenheim Village
McLauchlin Wellness Clinic
110 talbot St. W. Blenheim, ON
NOP 1A0 tel: 519-676-3311

**Medical History**

Please list all other health care providers: (include name, title and phone number)

1. _____
   _____
2. _____
   _____
3. _____
   _____

Do you have any ALLERGIES? (include medicines, environmental, foods etc)

_____
_____
_____

List all past hospitalizations, surgeries, accidents and major illnesses: (include dates)

_____
_____
_____
_____

Please list all PRESCRIPTION medications: (including birth control pills)

| Name of medication | Dose | Frequency | Date Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |



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Please list all NON PRESCRIPTION medications that you take on a regular basis: (including vitamins, minerals, herbs, homeopathics, over-the-counter etc.)

| Name of Supplement | Dose | Frequency | Date Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

How many times have you been treated with Antibiotics? _____

When was your last physical exam? _____
Do you have any other screening tests done regularly? (ex. PAP, prostate exam, breast exam, mammogram, blood work, etc. )

_____
_____
_____

**Family History**

Include history of heart disease, autoimmune disease, cancer, mental illness, addiction, skin conditions, allergies, anemia, bowel disease, arthritis, asthma and any other known health condition.

| Relation | Age | Condition | Cause, if deceased |
|---|---|---|---|
| Grandparents | | | |
| | | | |
| Mother | | | |
| | | | |
| Father | | | |
| | | | |
| Siblings | | | |
| | | | |
| Children | | | |
| | | | |



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**Diet and Lifestyle**

Are you currently following any special diets? Y N _____ Have you ever smoked? Y N
Amount/day?_____ # Years smoked?_____ Year stopped? _____

Alcohol Use? Y N Type: _____ Frequency: _____
Recreational drug use? Y N Type: _____Frequency:_____ Caffeine use (coffee, tea, pop)? Y N
Type: _____ Frequency: _____

How many servings of fruits and vegetables do you eat per day? _____

How much water do you drink per day? _____ L or _____ cups

What foods do you crave? _____

Do you sleep well? Y N Do you wake rested? Y N

What is your energy level? (please rate out of 10 with 10 being highest) _____

What is your current weight?_____ Maximum weight_____ Ideal weight_____

How often do you exercise per week? _____ For how long? _____

What do you do like to do for activity?
_____

What is your stress level? (please rate out of 10 with 10 being highest) _____

How do you deal with stress? _____

Please list the two most stressful events in your life:
1. _____ 2._____



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Please rate your level of satisfaction with each of the following areas in your life:

( 1 = Not satisfied, 4 = highly satisfied)

| | | | | |
|---|---|---|---|---|
| HEALTH | 1 | 2 | 3 | 4 |
| DIET | 1 | 2 | 3 | 4 |
| LIFESTYLE | 1 | 2 | 3 | 4 |
| WORK | 1 | 2 | 3 | 4 |
| FAMILY LIFE | 1 | 2 | 3 | 4 |
| RELATIONSHIPS | 1 | 2 | 3 | 4 |

What are your health goals?

_____

What are your goals in life?

_____

Is there anything you feel important to disclose that has not been asked?

_____



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# INFORMED CONSENT TO TREATMENT

**General Information**

This form applies to patients of Richard Vuksinic, ND and/or Kristina Kastelanac, ND – Naturopathic Medicine. By consenting to treatment, your naturopathic doctor will have access to your file and personal information.

Though gentle, naturopathic therapies have complications associated with certain conditions. It is **essential** to be complete in informing your doctor of your current state of physical and mental health, if you are on prescription, over-the-counter or recreational drugs, or if you suspect you are pregnant or are currently breastfeeding.

There are some minor risks associated with naturopathic therapies which include but are not limited to: bruising, pain or injury from acupuncture, fainting, organ puncture from acupuncture, aggravation of pre-existing symptoms and conditions, allergic reactions to botanicals or supplements, muscle sprains, strains or disc injury from spinal manipulation. The utmost care will be taken to prevent such outcomes.

**Patient Consent to Treatment**

1. This is to acknowledge that I have been informed and understand that any advice or treatment that I receive as a patient at this clinic is not mutually exclusive from any other treatment I am currently receiving or may in the future receive from another licensed health care provider.
2. I understand that I may seek and/or continue to receive medical care from another healthcare provider qualified to practice in Ontario.
3. I understand that no one at this clinic is suggesting I refrain from seeking advice from another qualified health care provider.
4. I understand that my Naturopathic Doctor (ND) keeps a record of services provided to me, and this record is kept confidential, only to be released to others if directed by myself or if required by law. I may request to see this record at any time and have a copy of this record by paying a fee.
5. I understand that my ND reserves the right to determine if my health concerns fall out of the scope of her practice, in which case an appropriate referral may be recommended.
6. I understand that services at this clinic are not covered by OHIP, and I will be paying for fees at the time of the appointment; including fees for the visits, prescriptions, services and tests.
7. I understand that of my own free will, I would accept or reject the treatment protocol recommended by this clinic.
8. I understand that therapies recommended to me will be explained in full by my doctor, and that my questions will be answered as best as possible, in a manner which I can comprehend.
9. I understand that the results are not guaranteed. I do not expect my ND to anticipate all risks and complications, but rely on her to utilize appropriate judgment in my best interests, based on the facts and findings then known.
10. I understand that 24hrs notice is required for visit cancellation or change of appointment, or I will be charged the full cost of a visit.

11. I understand that my naturopathic doctor may prescribe to me medicines or devices ,and that I may purchase them from my naturopathic doctor, a pharmacy, a health food store, or a medical supply company of my choice.



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I voluntarily consent to treatment at: (please circle one)

a) Priority Massage and Health with KRISTINA KASTELANAC, ND or RICHARD VUKSINIC, ND

b) McLauchlin Wellness Clinic with RICHARD VUKSINIC, ND

c) Dorchester Chiropractic KRISTINA KASTELANAC, ND

using the diagnostic and therapeutic procedures mentioned above, except for (please list treatments you do NOT want to receive below):

**I have read, understand and agree to the above statements.**
**I understand I am free to withdraw my consent to discontinue treatment at any time, informing the clinic in a written or verbal format.**

**Patient Name: _____ Parent/Guardian Signature**

**if under 18:_____**

**Patient Signature: _____**



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