CONFIDENTIAL SENIOR INTAKE FORM (Please print clearly)

Name:_____ Date:_____

Date of Birth: YY/MM/DD_____ Age_____Sex: M F

Address:_____

Email Address:_____

☐ 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

Emergency Contact: Name:_____ Number:_____
Occupation:_____ Marital Status:_____
How did you hear about the Clinic? _____

Have you ever had previous Naturopathic Care? Y N

Please list your major health concerns in order of importance:

1.
2.
3.
4.

Please list all other Health Care Providers: (include name, title and phone number)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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

Name of medication	Dose	Frequency	Side effects?

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

Have you had all the standard vaccinations? Y N
How many times have you been treated with Antibiotics? _____

Please indicate if a close relative (parents, siblings, grandparents, aunts, uncles) has any of the following:

Asthma____ Eczema____ Cancer___ Anemia____ Glaucoma____ Seizures/Epilepsy___

Thyroid Problems____ Hypertension____ Heart Disease____ High Cholesterol____

Psychiatric Illness____ Diabetes____ Addiction/Alcoholism____ Arthritis____

Are you currently following any special diets? Y N _____

Have you ever smoked? Y N
Have you ever used recreational drugs? Y N

What is your current weight?_____ Maximum weight_____

Do you exercise regularly? Y N

What do you do for exercise, how much, how often?
_____
_____
_____
_____

Do you have a history of falls? Y N Please explain below:
_____
_____
_____

Have you had any memory impairment? Y N Please explain below:
_____
_____
_____

Have you noticed any recent weight loss? Y N Please explain below:
_____
_____
_____

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Do you require any walking or hearing aids? Y N Please explain below:

_____
_____
_____

Do you wear dentures? Y N
Do you live on your own? Y N
Do you suffer from depressed moods or depression? Y N

Do you have support from friends and family? Y N Please explain below:

_____
_____
_____
_____

Please list the two most stressful events in your life

1. _____

2. _____

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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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