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Naturopathic Doctor

General Patient Information and Consent Form

Name: _____ Date: _____
DOB: _____ Age: _____ Gender: M F
(mm/dd/yyyy) Phone: (W) _____
Address: _____ (C) _____
City: _____ (H) _____
Postal Code: _____
Birthplace: _____ Email: _____
Occupation: _____ Marital Status: _____
Length of Empl.: _____

Emergency Contact: _____
Emergency Contact #: _____

Please describe your primary reasons for seeking healthcare. If this involves a specific condition, please list when you first noticed symptoms or when an initial diagnosis was made.

1 _____ Since: _____
2 _____ Since: _____
3 _____ Since: _____

Check the conditions that you are currently experiencing, or have experienced often in the past. If more space is required please use the reverse side of this sheet.

	Current	Previous
General		
Fatigue	❒	❒
Fever	❒	❒
Sweats	❒	❒
Fainting	❒	❒
Dizziness	❒	❒
Insomnia	❒	❒
Loss of consciousness	❒	❒
Poor memory	❒	❒
Frequent colds	❒	❒
Weight gain	❒	❒
Weight loss	❒	❒
	❒	❒
Psychological	❒	❒
Alcoholism	❒	❒
Depression	❒	❒
Anxiety	❒	❒
Mania	❒	❒
Panic Attacks	❒	❒
Schizophrenia	❒	❒
Substance Abuse	❒	❒

	Current	Previous
Head/Neck		
Headaches	❒	❒
Type: _____	❒	❒
Frequency: _____	❒	❒
Vision Problems	❒	❒
TMJ Concerns	❒	❒
Decreased hearing	❒	❒
Ringing in the ears	❒	❒
Difficulty swallowing	❒	❒
Hair loss	❒	❒
Hypothyroid	❒	❒
Hyperthyroid	❒	❒
Tonsillitis	❒	❒
Whooping Cough	❒	❒
Skin		
Rashes/Eczema	❒	❒
Itching	❒	❒
Bruise Easily	❒	❒
Dryness	❒	❒
Boils/Hives	❒	❒
Contagious Skin Disease	❒	❒

	Current	Previous
Cardiovascular		
High blood pressure	❒	❒
low blood pressure	❒	❒
Chest pain/tightness	❒	❒
palpitations	❒	❒
Heart Disease	❒	❒
Angina	❒	❒
Artery Hardening	❒	❒
Varicose veins	❒	❒
Swelling of the ankles	❒	❒
Poor circulation	❒	❒
Numbness/tingling	❒	❒
Stroke	❒	❒
Elevated cholesterol	❒	❒
Bleeding disorder	❒	❒
Anemia	❒	❒
Leukemia	❒	❒
Rheumatic Fever	❒	❒

	Current	Previous
Genitorurinary		
Difficulty Urinating	❒	❒
Painful urination	❒	❒
Frequent Urination	❒	❒
Blood in Urine	❒	❒
Kidney Infections	❒	❒
Bed Wetting	❒	❒
Leakage	❒	❒
Prostate trouble	❒	❒
Difficulty with sex	❒	❒
Difficulty with arousal	❒	❒
Pain with intercourse	❒	❒
Abnormal discharge	❒	❒
Plantar warts	❒	❒
Venereal Warts (HPV)	❒	❒
Tubercolosis	❒	❒
HIV/AIDS	❒	❒
Cancer	❒	❒
Chickenpox	❒	❒
Lyme Disease	❒	❒
Malaria	❒	❒
Measles	❒	❒
Mumps	❒	❒
Rubella	❒	❒
Scarlet Fever	❒	❒
Monoucleosis	❒	❒
Typhoid Fever	❒	❒
Yellow Fever	❒	❒
Parasites/worms	❒	❒

	Current	Previous
Gastrointestional		
Poor digestion	❒	❒
Heartburn	❒	❒
Excessive hunger	❒	❒
Excessive thirst	❒	❒
Belching or gas	❒	❒
Nausea/Vomitting	❒	❒

	Current	Previous
Women's Health		
Painful Menstruation	❒	❒
Excessive flow	❒	❒
Irregular Cycle	❒	❒
Hot flushes	❒	❒
PMS	❒	❒
Muscles and Joints		
Stiff neck	❒	❒
Backache, stiff back	❒	❒
Swollen joints	❒	❒
Weakness	❒	❒
Loss of Strength	❒	❒
Foot Trouble L/R	❒	❒
Shoulder pain L/R	❒	❒
Elbow pain L/R	❒	❒
Wrist pain L/R	❒	❒
Hip pain L/R	❒	❒
Knee pain L/R	❒	❒
Arthritis	❒	❒
Scoliosis	❒	❒
Gout	❒	❒
Multiple Sclerosis	❒	❒
Chronic Fatigue	❒	❒
Syndrome	❒	❒
Fibromyalgia	❒	❒
Parkinsons Disease	❒	❒

MMR (measeles/mumps/rubella)		
"Flu" Shot		
Polio		
Hepatitis A		
Hepatitis B		
Smallpox		
Other		

List any medications or supplements you are taking

1	Reason:		Dosage:		Since:	
2	Reason:		Dosage:		Since:	
3	Reason:		Dosage:		Since:	
4	Reason:		Dosage:		Since:	

Are you under the regular care of any other healthcare practitioners? YES/NO ❒ ❒

(MD, chiropractor, RMT, homeopath)?

Practitioner		Reason:		Since:	
Practitioner		Reason:		Since:	
Practitioner		Reason:		Since:	

Do you have any allergies, sensitivities, or intolerances to the following?

Substance	YES/NO		Please explain
Medications or Drugs	❒	❒	
Cats, dogs, or other animals	❒	❒	
Feathers	❒	❒	
Molds	❒	❒	
Dust	❒	❒	
Smoke	❒	❒	
Exhaust	❒	❒	
Perfumes, soaps or detergents	❒	❒	
Latex	❒	❒	
Synthetic chemicals	❒	❒	
Nuts	❒	❒	
Milk products	❒	❒	
Other	❒	❒	

Do you use any of the following? If so, please indicate amount and duration of use.

	Amount	Since		Amount	Since
Alcohol			Fried Food		
Tea			Fast Food		
Coffee			Distilled Water		
Carbonated Beverages			Tobacco		
Non-sugar sweetner			Recreational Drugs		
Candy			Antacids		
Chocolate			Pain Relief medications		
Sweets			OTC medication		
Salt			Laxatives		
Margarine			Sleeping Pills		
Luncheon meats			Hormone Therapy		

Do you do any of the following? If yes, please explain.

	YES/NO		Explain
Diet Often	❒	❒	
Exercise	❒	❒	
Enjoy your work	❒	❒	
Experience exposure to chemicals *(work, home, hobbies, pesticides, etc.)*	❒	❒	
Experience Exposure to tobacco smoke	❒	❒	
Sleep near electrical appliances	❒	❒	
Volunteer, partake in hobbies or leisure activities that you enjoy	❒	❒	
Have a mind-body practice *(yoga, tai-chi, meditation, visualization)*	❒	❒	
Watch television *(hours per day)*	❒	❒	
Use a computer *(hours per day)*	❒	❒	

HEALTH PARAMETERS

Please describe your energy: _____ Recent Changes? _____

Please describe your mood: _____ Recent Changes? _____

Please describe your appetite: _____ Recent Changes? _____

Do you eat 3 meals daily? Yes ❒ NO ❒ Sometimes ❒

Do you have any specific dietary restrictions? Yes ❒ NO ❒

If yes, please describe: _____

How much water do you drink daily? _____ glasses/day

Please describe your sleep? _____ Recent Changes? _____

How many hours do you sleep each night? _____ hours/night

Do you have difficulty falling asleep? Yes ❒ NO ❒ Sometimes ❒

If yes, do you use anything to help you asleep? _____

Do you awaken refreshed? Yes ❒ NO ❒ Sometimes ❒

Do you nap during the day? Yes ❒ NO ❒ Sometimes ❒

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Consent re: Personal Information and Treatment

We value the trust you have placed in us and are taking all appropriate measures to safeguard your personal information and confidence. We have established a privacy policy to ensure that your personal information and personal health information is protected. Our privacy policy is available at our reception and at *www.satoriwellness.com.* In accordance with our privacy policy, we request that you provide your consent as set out below.

I agree that Satori Urban Wellness can collect, use and disclose my personal information and personal health information provided by me in this client health inquiry history form to provide me with the services I request and for the other limited purposes set out in Satori Urban Wellness' privacy policy.

I hereby give my consent for treatment. I am also aware that Satori Urban Wellness will bear no responsibility in the event of any injury or harm that may occur as a result of treatment reasonably and professionally administered. I acknowledge that Satori Urban Wellness will not be responsible for any lost or stolen personal belongings.

I declare I will inform Satori Urban Wellness if there are any changes in my health history, upon my next visit.

I have been advised Satori Urban Wellness' 24hr cancellation policy, and I authorize a full service charge should this be enforced.

(Signature of Patient) (Date)