



Dr. Han Ping Helen Cen, ND 201, 8135 102 St. Edmonton, AB, T6E 4A4  
www.drcennd.ca 780-414-1466

## Adult Intake Form

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

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Current weight: \_\_\_\_\_ Height: \_\_\_\_\_

Who is filling out this form if not self? (Name and relationship) \_\_\_\_\_

Address: \_\_\_\_\_

Phone (Primary): \_\_\_\_\_ (Other): \_\_\_\_\_

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital status: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Pregnant? Y/ N If Y, how many weeks: \_\_\_\_\_ Breastfeeding: \_\_\_\_\_

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

Name of Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you received *naturopathic* care previously? \_\_\_\_\_

If so, when? \_\_\_\_\_ Name of Practitioner: \_\_\_\_\_

For what reason? \_\_\_\_\_

How did you hear of us/who were you referred by: \_\_\_\_\_

*This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless authorized by you.*

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees, missed appointment fees as well as other applicable fees. A receipt will be provided for your private insurance coverage and/or income tax purposes.

Patient's Full Name: \_\_\_\_\_ Date of Consent: \_\_\_\_\_

Signature of Patient or Lawful Representative: \_\_\_\_\_

### Health Concerns

What are your main health concerns in order of importance to you?

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## Vitamins and Supplements

Please list all vitamin/mineral/herbal supplements you are currently taking:

**\*\*Please bring in all supplements info (or photo) to initial visit\*\***

Supplement (including brand)	Dosage	When did you begin this supplement?

## Medication

Please list all prescription and non-prescription medications you are currently taking:

**\*\* Please bring in all medications to initial visit\*\***

Medication	Dosage	When did you begin this medication?

Please list all prescription medications you have taken in the past for longer than six months.  
Indicate how long you took each medication.

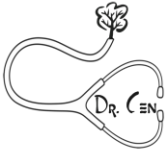
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## Family History

Is there a history of any of the following in your family? Please check and then list relationship of family member beside the condition.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Depression          | <input type="checkbox"/> Celiac           |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Colitis          |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Schizophrenia    |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Hyperactivity       | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Bed Wetting      | <input type="checkbox"/> Kidney Disease      |   |
| <input type="checkbox"/> Candida Albicans | <input type="checkbox"/> Learning Disability |   |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Mental Disease      |   |
| <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Multiple Sclerosis  |   |



**Medical History**

*Please list any injuries and/or major surgery you have had and when they occurred.*

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*Please list any major illnesses or diseases that you have or have had.*

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**Vaccinations (please check)**

- DPT (Diphtheria, Pertussis, Tetanus)
- MMR (Measles, Mumps, Rubella)
- Chicken Pox
- Polio
- Flu Shot
- Hepatitis A
- Hepatitis B
- Other

*Did you experience any symptoms from them? If yes, please explain.*

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**Diet**

- Non Vegetarian
  - Vegetarian
  - Vegan
- For how long?

How many cups/bottles/glasses do you drink, on average, per day?

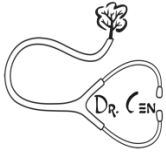
- |            |           |                       |
|------------|-----------|-----------------------|
| Coffee     | Milk 2%   | Fruit juice           |
| Tea        | Skim milk | Soft drinks (diet)    |
| Water      | Beer      | Soft drinks (regular) |
| Herbal tea | Wine      | Vegetable juice       |
| Milk 1%    | Liquor    | Other                 |

All allergies/intolerances/sensitivities:

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## Review of Symptoms

Please check  any of the following that apply to you or write "P" beside the box if you have experienced any in the past.

### General

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Allergies                | <input type="checkbox"/> Sleep problems, hours per night ____ |
| <input type="checkbox"/> Change in appetite     | <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> Sudden drop in energy (time?)        |
| <input type="checkbox"/> Change in thirst       | <input type="checkbox"/> Cancer                   |   |
| <input type="checkbox"/> Bleed or bruise easily |   |   |
| <input type="checkbox"/> Night sweats           |   |   |

### Skin

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Rashes/hives/itching          | <input type="checkbox"/> Hair changes (colour/quantity) | <input type="checkbox"/> Skin ulcers/skin cancer |
| <input type="checkbox"/> Eczema/psoriasis              | <input type="checkbox"/> Changes in skin color          | <input type="checkbox"/> Warts                   |
| <input type="checkbox"/> Nail changes (strength/shape) | <input type="checkbox"/> Excess dryness/moistness       | <input type="checkbox"/> Recent moles            |
| <input type="checkbox"/> Acne/boils                    |   |  |

### Head, eyes, ears, nose, and throat

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headache                    | <input type="checkbox"/> Blurred/double vision                      | <input type="checkbox"/> Ringing in the ears     |
| <input type="checkbox"/> Problems with jaw joint/TMJ | <input type="checkbox"/> Use of glasses _____ Date of last eye exam | <input type="checkbox"/> Poor hearing            |
| <input type="checkbox"/> Head injury                 | <input type="checkbox"/> Cataract                                   | <input type="checkbox"/> Sinus issues            |
| <input type="checkbox"/> Migraines                   | <input type="checkbox"/> Floaters/blind spot                        | <input type="checkbox"/> Frequent colds          |
| <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Earache/infection                          | <input type="checkbox"/> Mercury dental fillings |
| <input type="checkbox"/> Light-headedness            | <input type="checkbox"/> Excess ear wax                             | <input type="checkbox"/> Cold sore/ canker sore  |
| <input type="checkbox"/> Eye pain                    |   | <input type="checkbox"/> Swollen glands          |

### Heart and circulation

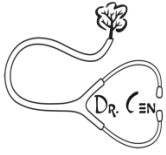
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Irregular heartbeat    | <input type="checkbox"/> Varicose veins      |
| <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Palpitation/fluttering | <input type="checkbox"/> Blood clots         |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Cold hands and feet |

### Lungs and breathing

- |  |                                     |                                 |
|--|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Chronic cough       | <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Other  |

### Gastrointestinal

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heartburn/acid reflux | <input type="checkbox"/> Gall bladder stones/removal | <input type="checkbox"/> Diarrhea             |
| <input type="checkbox"/> Trouble swallowing    | <input type="checkbox"/> Ulcers                      | <input type="checkbox"/> Constipation         |
| <input type="checkbox"/> Nausea/vomiting       | <input type="checkbox"/> Belching/burping/gas        | <input type="checkbox"/> Black tarry stool    |
| <input type="checkbox"/> Indigestion           | <input type="checkbox"/> Hernia                      | <input type="checkbox"/> Chronic laxative use |
| <input type="checkbox"/> Blood in stool        |  |   |



Neurological

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Fainting/loss of consciousness | <input type="checkbox"/> Speech problems/slurring | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Seizures                       | <input type="checkbox"/> History of concussion    | <input type="checkbox"/> Twitching         |
|   | <input type="checkbox"/> Loss of sensation        | <input type="checkbox"/> Tremors           |
|   |   | <input type="checkbox"/> Memory problems   |

Endocrine

- |   |                                      |  |
|---|--------------------------------------|--|
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Hormone replacement therapy |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Weight Loss |  |

Musculoskeletal

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Muscle weakness    | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Sciatica             | <input type="checkbox"/> Muscle spasm/cramp |                                       |

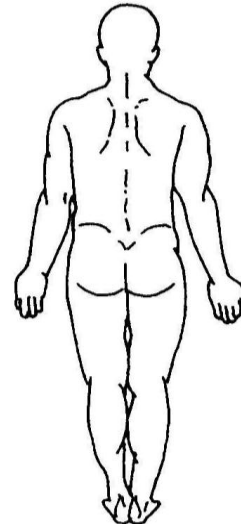
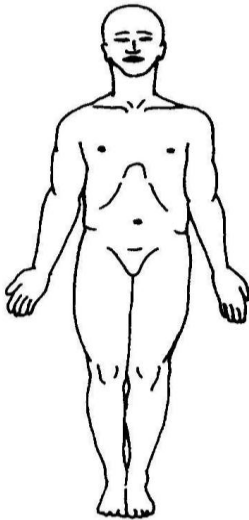
Urinary

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pain/burning while urinating | <input type="checkbox"/> Urinary tract infections | <input type="checkbox"/> Kidney problems         |
| <input type="checkbox"/> Inability to hold urine      | <input type="checkbox"/> Blood in urine           | <input type="checkbox"/> Kidney stones/infection |
|   | <input type="checkbox"/> Urgency/hesitancy        |  |

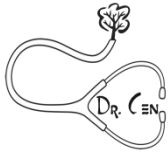
Sexual health

- |  |  |
|--|--|
| <input type="checkbox"/> Sexually active   | <input type="checkbox"/> Sexually transmitted infections |
| <input type="checkbox"/> Contraception use |  |

*Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed in color or texture (e.g. moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.*



**Thank you for taking the time to complete this form to your best knowledge.**



## Informed Consent

**Please note that this form must be signed prior to your first appointment.**

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. Your clinician, Han Ping Helen Cen ND, will take a thorough case history, perform a physical examination, which can include a breast exam, and take blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

There are some slight potential risks associated with treatment by naturopathic medicine. These include but are not limited to:

- ♦ Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- ♦ Some patients experience allergic reactions to certain supplements and herbs. Please advise your clinician of any allergies you may have.
- ♦ Pain, bruising or injury from venipuncture or acupuncture or parental therapy.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient, you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

The Naturopathic Doctor is trained to handle emergencies should the need arise.

### **I understand:**

- That naturopathic treatments and conventional treatments are not mutually exclusive and therefore I am free to seek or continue medical care from a qualified physician.
- The clinic does not guarantee treatment results.
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- I am free to withdraw my consent and to discontinue treatment at any time.

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Patient or Lawful Representative Signature

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Date signed

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Full Name Printed