



# Gaia Integrative Clinic

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## Adult-Patient Information and Consent Form

Please complete the following information in full:

Dr. Miss Mr. Mrs. Ms

First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

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

Suite/Apt./Unit No: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Gender: Male Female Date of Birth: \_\_\_\_\_  
Month / Day / Year

Work Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Other Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Preferred contact method: \_\_\_\_\_

May we leave a message? \_\_\_\_\_

Primary Practitioner: \_\_\_\_\_

### Family Doctor

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

### Emergency Contact

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

How did you hear about Gaia Integrative Clinic?

Referral Website Newspaper Yellow Pages  
Advertisement Friend/Family Other: \_\_\_\_\_



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I, the undersigned, voluntarily consent to the procedures and treatments provided to me at Gaia Integrative Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. With this knowledge, I understand and acknowledge that I may ask questions regarding my treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Gaia Integrative Clinic or any of its practitioners or personnel regarding cure or improvement of my condition.

I hereby consent to the collection, use and/or disclosure of my personal information for purposes related to the delivery of patient care and other related uses at Gaia Integrative Clinic. I understand that a record will be kept of the health services provided to me. I further understand that my personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Gaia Integrative Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 50% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a minimum of 24 hours advance notice.

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Patient's Name

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Patient's Signature

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Date



**Naturopathic Adult Intake**

**HEALTH INFORMATION**

What is your main health concern? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any other health concerns (physical, emotional, or mental) in order of importance.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How do you rate your overall health?      Poor    Fair    Good    Excellent  
 How do you rate your overall energy?    Poor    Fair    Good    Excellent

**MEDICATIONS**

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose/day	How long?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement	Dose/day	How long?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

How many courses of antibiotics have you had in the past 10 years? \_\_\_\_\_  
 Have you ever had a bad reaction to any medication? Y / N

**MEDICAL HISTORY**

Please indicate if you have had any of the following childhood illnesses (circle):

- |                                  |                         |                 |
|----------------------------------|-------------------------|-----------------|
| Asthma                           | Measles                 | Rheumatic fever |
| Chickenpox                       | Mumps                   | Scarlet fever   |
| Eczema                           | Polio                   | Whooping cough  |
| Frequent ear infections or colds | Rubella(German measles) | Other: _____    |

Please briefly describe your dental history (root canals, fillings, etc)

\_\_\_\_\_  
 \_\_\_\_\_



**Immunizations** (Check ✓)

- DPT                     Hemophilus influenza B     Hepatitis A                     Hepatitis B  
 Flu shot                 Tetanus Booster                 MMR                                 Polio  
 Smallpox                 Chicken Pox                     Other: \_\_\_\_\_

Any adverse reactions to vaccinations? Y / N. If yes, explain. \_\_\_\_\_

Please list (with approximate dates) any serious conditions, illnesses or injuries, and any hospitalizations.

**FAMILY HISTORY**

Please indicate whether any of your family members have, or have had the following:

	Relative		Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	

**LIFESTYLE FACTORS**

Please list any dietary restrictions (Vegan, vegetarian, lacto-ovo vegetarian, omnivore)

How much water do you drink a day? \_\_\_\_\_

How many and what type of alcoholic beverages do you have per week? \_\_\_\_\_

Do you smoke? Y / N

Are you frequently exposed to animals? Y / N

Are you regularly exposed to toxins or other hazards? Y / N. If yes, explain. \_\_\_\_\_

On average how many hours of sleep do you get a night? \_\_\_\_\_

Please list all allergies (food, environmental, or medications). \_\_\_\_\_

Do you exercise? Y / N

What type of exercise and how often? \_\_\_\_\_

What do you do for recreation and relaxation? \_\_\_\_\_

Occupation: \_\_\_\_\_ Do you work shift work? Y / N

Marital status: \_\_\_\_\_ Number of children: \_\_\_\_\_



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Describe the emotional climate of your home. \_\_\_\_\_

Rate your stress level (circle):            Low                    Average                    High                    Unbearable

Which factors most contribute to your stress? (circle)

Health                    Work                    Money                    Family                    Marriage                    Other: \_\_\_\_\_

### **WOMEN'S HEALTH**

Are you currently pregnant? Y / N

Do you get regular Pap smears? Y / N

Date of last Pap?(month/yr) \_\_\_\_ / \_\_\_\_\_

Have you ever had an abnormal Pap? Y / N

Age of first period? \_\_\_\_\_

Is your period regular? Y / N

Length of monthly cycle (days)? \_\_\_\_\_

Average length of period or flow (days)? \_\_\_\_\_

Do you experience PMS? Y / N

Are you menopausal? Y / N. If yes, age of last period \_\_\_\_

Are you currently sexually active? Y / N

Have you been sexually active in the past? Y / N

Current forms of contraception? \_\_\_\_\_

Have you ever had a sexually transmitted disease? Y / N

Number of pregnancies? \_\_\_\_            Births? \_\_\_\_            Miscarriages? \_\_\_\_            Abortions? \_\_\_\_

Have you had any of the following concerning your breasts?(circle)

Pain            Lumps            Infections            Cysts            Nipple discharge

Do you experience vaginal infections? Never            Rarely            Frequently

Do you experience bladder infections? Never            Rarely            Frequently

Do you have any sexual problems or concerns? Y / N. If yes, explain. \_\_\_\_\_

### **MEN'S HEALTH**

Do you get regular screening tests done (blood work, prostate examination)? Y / N

Date of last prostate examination?(month/yr) \_\_\_\_ / \_\_\_\_\_

Are you currently sexually active? Y / N

Have you been sexually active in the past? Y / N



Current forms of contraception? \_\_\_\_\_

Do you have difficulty urinating completely? Y / N

How many times do you get up from your sleep to go to the bathroom at night? \_\_\_\_\_

Have you had any of the following? (circle)

Testicular pain

Hernia

STDs

Discharge

Sores

Do you have any sexual problems or concerns? Y / N. If yes, explain. \_\_\_\_\_

**REVIEW OF SYSTEMS**

Please **circle** if you are currently experiencing any of the following or write a **P** if you experienced it in the past.

**General symptoms**

Headache  
Head injury  
Fever  
Chills  
Sweats  
Dizziness  
Fainting  
Loss of sleep  
Fatigue  
Nervousness  
Loss of weight  
Numbness or pain in arms/legs/hands  
Allergy  
Convulsions

**Skin**

Hives or allergy  
Acne or skin eruptions  
Itching  
Bruises easily  
Dryness  
Boils  
Varicose veins  
Sensitive skin  
Change in mole

**Kidneys & Reproduction**

Inability to control urine  
Frequent urination  
Painful urination  
Blood in urine  
Pus in urine

**Eyes, Ears, Nose, Throat**

Dental decay  
Gum trouble  
Frequent colds  
Enlarged thyroid  
Tonsillitis  
Sore throat  
Hoarseness  
Enlarged glands  
Glaucoma  
Failing vision  
Cataracts  
Eye pain  
Ear discharge  
Deafness  
Ear ache  
Nasal drainage  
Nose bleeds  
Nasal obstruction  
Sinus infection  
Hay fever  
Mercury tooth fillings

**Muscle & Joint**

Stiff neck  
Back pain  
Muscle weakness  
Swollen joints  
Painful tailbone  
Foot trouble  
Pain in shoulders  
Hernia

**Cardiovascular**

Low blood pressure  
High blood pressure  
Previous heart stroke  
Hardening of the arteries  
Swelling of the ankles  
Poor circulation  
Paralytic stroke  
Irregular heart beat  
Shortness of breath  
Chest pain

**Gastrointestinal**

Excessive thirst  
Excessive hunger  
Belching  
Gas (flatulence)  
Nausea  
Vomiting  
Vomiting of blood  
Abdominal cramps  
Constipation  
Diarrhea  
Colon trouble  
Hemorrhoids (piles)  
Intestinal worms  
Liver problems  
Gallbladder problems  
Jaundice  
Colitis

**Respiratory**

Asthma



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Kidney infection  
Kidney stones  
Prostate trouble  
Sores on genitals

Spinal curvature  
Faulty posture  
Arthritis  
Fracture/dislocation

Chronic cough  
Spitting up phlegm  
Spitting up blood  
Difficult breathing

Current Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_ Maximum weight and when: \_\_\_\_\_ Height: \_\_\_\_\_

What are your treatment goals and expectations?

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Is there anything else that you feel has not been covered?

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*Thank you very much for taking the time to complete this form. It will greatly assist in the formulation of a treatment protocol specific to your healthcare needs.*