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ADULT INTAKE FORM

Name:
D.O.B

List your primary health concerns

1. _____ 2. _____
 3. _____ 4. _____

List any treatments/lifestyle changes that you have undertaken for these health concerns: _____

List any obstacles to achieving your health goals: _____

Have you had any serious illnesses, injuries or hospitalizations (include date):

Do you have any allergies (medication, environmental, food, pet): _____

If you are female, are you currently pregnant? Y/N Or trying to conceive? Y/N

Please list any current medications or supplements:

Name	Dose	Taken since	Improvement?

How would you describe yourself? _____

What do you love to do? _____

List the 3 most significant events in your life _____

Who do you live with? _____

What is the atmosphere of your home? _____

How old is your home? _____ Have you recently renovated? _____

Do you have any pets? _____ Are you sensitive to fragrance/scents? _____

Which toxins or chemicals are you regularly exposed to? _____

Any recent vaccinations? _____

How often do you exercise? _____ days/week Type of exercise: _____

Current height? _____ Weight? _____ Is this a change for you? _____

What is your current energy level? /10 (10 = most energy)

What is your current stress level? /10 (10 = most stress)

What is/are your major source(s) of stress (circle all that apply):

work financial family partner relationships personal health spiritual other

Are you sexually active? (circle) Yes No Past

Method of contraception (condoms, birth control pill, IUD) _____

Sleep

What time do you go to bed? _____ Wake up in the morning? _____

Do you wake feeling refreshed? Y / N Do you have difficulty falling asleep? Y / N

Do you wake during the night? Y / N What wakes you? _____

Diet

Do you have any dietary restrictions? _____

Please outline your diet during a typical day:

B: _____

L: _____

D: _____

Snacks: _____

How often do you consume the following: (indicate /day, /week or /month)

Water_____ Pop_____ Milk_____ Juice_____

Fresh vegetables/fruits_____ Cold-water fish_____ Tuna_____

Red meat_____ Chocolate_____ Processed food_____

Fast food_____ Canned goods_____ Microwavable meals_____

Do you use/have any of the following? Check off all that apply and indicate the frequency of use:

- | | |
|---|--|
| <input type="checkbox"/> Coffee _____ | <input type="checkbox"/> Allergy meds _____ |
| <input type="checkbox"/> Tea _____ | <input type="checkbox"/> Anti-acids_____ |
| <input type="checkbox"/> Alcohol _____ | <input type="checkbox"/> Birth control pills |
| <input type="checkbox"/> Tobacco _____ | <input type="checkbox"/> Birth control implants (IUD) |
| <input type="checkbox"/> Recreational drugs _____ | <input type="checkbox"/> Birth control injections or patch |
| <input type="checkbox"/> Aspirin _____ | <input type="checkbox"/> Hormone replacement therapy |
| <input type="checkbox"/> Tylenol _____ | <input type="checkbox"/> Metal implants _____ |
| <input type="checkbox"/> Other pain meds _____ | <input type="checkbox"/> Mercury filings _____ |
| <input type="checkbox"/> Laxatives _____ | <input type="checkbox"/> Resin filings _____ |
| <input type="checkbox"/> Diet pills _____ | <input type="checkbox"/> Second hand smoke_____ |

Health Screening

Please check off which of the following tests you have had in the past 5 years, and indicate any significant results:

- CBC _____
- Cholesterol _____
- Blood sugar _____
- Thyroid _____
- Iron _____
- B12 _____
- Blood pressure _____
- Bone Density _____
- Colonoscopy _____
- STI testing _____

Women only:

- PAP smear _____
- Breast exam _____
- Mammogram _____

Men only:

- Digital rectal exam _____
- PSA _____

Family Health History

Family Member	Health Concerns	Family Member	Health Concerns
Mother		Father	
Maternal grandmother		Paternal grandmother	
Maternal grandfather		Paternal grandfather	
Siblings		Children	

Review of Systems

Check the appropriate box: C for current conditions, P for Past conditions

General symptoms		Cardiovascular		Skin	
Dizziness	C <input type="checkbox"/> P <input type="checkbox"/>	High blood pressure	C <input type="checkbox"/> P <input type="checkbox"/>	Itching	C <input type="checkbox"/> P <input type="checkbox"/>
Fainting	C <input type="checkbox"/> P <input type="checkbox"/>	Low blood pressure	C <input type="checkbox"/> P <input type="checkbox"/>	Rashes, Eczema	C <input type="checkbox"/> P <input type="checkbox"/>
Sweats	C <input type="checkbox"/> P <input type="checkbox"/>	Bleeding disorders	C <input type="checkbox"/> P <input type="checkbox"/>	Psoriasis	C <input type="checkbox"/> P <input type="checkbox"/>
Cold hands / feet	C <input type="checkbox"/> P <input type="checkbox"/>	Anemia	C <input type="checkbox"/> P <input type="checkbox"/>	Acne	C <input type="checkbox"/> P <input type="checkbox"/>
Insomnia	C <input type="checkbox"/> P <input type="checkbox"/>	Chest pain	C <input type="checkbox"/> P <input type="checkbox"/>	Dry skin	C <input type="checkbox"/> P <input type="checkbox"/>
Weight loss	C <input type="checkbox"/> P <input type="checkbox"/>	Angina	C <input type="checkbox"/> P <input type="checkbox"/>	Changes in mole	C <input type="checkbox"/> P <input type="checkbox"/>
Weight gain	C <input type="checkbox"/> P <input type="checkbox"/>	Murmurs	C <input type="checkbox"/> P <input type="checkbox"/>	Easy bruising	C <input type="checkbox"/> P <input type="checkbox"/>
Fatigue	C <input type="checkbox"/> P <input type="checkbox"/>	Palpitations	C <input type="checkbox"/> P <input type="checkbox"/>	Hives	C <input type="checkbox"/> P <input type="checkbox"/>
Alcoholism	C <input type="checkbox"/> P <input type="checkbox"/>	Heart disease	C <input type="checkbox"/> P <input type="checkbox"/>	Warts	C <input type="checkbox"/> P <input type="checkbox"/>
Anemia	C <input type="checkbox"/> P <input type="checkbox"/>	Stroke	C <input type="checkbox"/> P <input type="checkbox"/>		
Nutrient deficiency	C <input type="checkbox"/> P <input type="checkbox"/>	Artery hardening	C <input type="checkbox"/> P <input type="checkbox"/>	Muscles and Joints	
Weak/brittle nails	C <input type="checkbox"/> P <input type="checkbox"/>	Varicose veins	C <input type="checkbox"/> P <input type="checkbox"/>	Stiff neck	C <input type="checkbox"/> P <input type="checkbox"/>
		Ankle swelling	C <input type="checkbox"/> P <input type="checkbox"/>	Backache/tension	C <input type="checkbox"/> P <input type="checkbox"/>
Head & Neck		Poor circulation	C <input type="checkbox"/> P <input type="checkbox"/>	Swollen joints	C <input type="checkbox"/> P <input type="checkbox"/>
Headaches	C <input type="checkbox"/> P <input type="checkbox"/>			Joint pain	C <input type="checkbox"/> P <input type="checkbox"/>
Head injury	C <input type="checkbox"/> P <input type="checkbox"/>	Gastrointestinal		Arthritis	C <input type="checkbox"/> P <input type="checkbox"/>
TMJ pain	C <input type="checkbox"/> P <input type="checkbox"/>	Trouble swallowing	C <input type="checkbox"/> P <input type="checkbox"/>	Weakness	C <input type="checkbox"/> P <input type="checkbox"/>
Poor vision	C <input type="checkbox"/> P <input type="checkbox"/>	Poor digestion	C <input type="checkbox"/> P <input type="checkbox"/>	Muscle spasms	C <input type="checkbox"/> P <input type="checkbox"/>
Itchy/red eyes	C <input type="checkbox"/> P <input type="checkbox"/>	Heartburn	C <input type="checkbox"/> P <input type="checkbox"/>	Broken bones	C <input type="checkbox"/> P <input type="checkbox"/>
Circles under eyes	C <input type="checkbox"/> P <input type="checkbox"/>	Change in thirst	C <input type="checkbox"/> P <input type="checkbox"/>	Gout	C <input type="checkbox"/> P <input type="checkbox"/>
Earaches/ infection	C <input type="checkbox"/> P <input type="checkbox"/>	Change in appetite	C <input type="checkbox"/> P <input type="checkbox"/>		
Hearing loss	C <input type="checkbox"/> P <input type="checkbox"/>	Change in weight	C <input type="checkbox"/> P <input type="checkbox"/>	Neurological	
Ringling in ears	C <input type="checkbox"/> P <input type="checkbox"/>	Belching or gas	C <input type="checkbox"/> P <input type="checkbox"/>	Numbness, tingling	C <input type="checkbox"/> P <input type="checkbox"/>
Sinus problems	C <input type="checkbox"/> P <input type="checkbox"/>	Nausea / Vomiting	C <input type="checkbox"/> P <input type="checkbox"/>	Changes in sensation	C <input type="checkbox"/> P <input type="checkbox"/>
Loss of smell	C <input type="checkbox"/> P <input type="checkbox"/>	Abdominal pain	C <input type="checkbox"/> P <input type="checkbox"/>	Poor memory	C <input type="checkbox"/> P <input type="checkbox"/>

Change in taste	C <input type="checkbox"/> P <input type="checkbox"/>	Constipation	C <input type="checkbox"/> P <input type="checkbox"/>	Seizures	C <input type="checkbox"/> P <input type="checkbox"/>
Gum disease	C <input type="checkbox"/> P <input type="checkbox"/>	Diarrhea	C <input type="checkbox"/> P <input type="checkbox"/>	Paralysis	C <input type="checkbox"/> P <input type="checkbox"/>
Cavities	C <input type="checkbox"/> P <input type="checkbox"/>	Blood in stool	C <input type="checkbox"/> P <input type="checkbox"/>	Loss of balance	C <input type="checkbox"/> P <input type="checkbox"/>
Hoarseness	C <input type="checkbox"/> P <input type="checkbox"/>	Black, tarry stool	C <input type="checkbox"/> P <input type="checkbox"/>	Speech problems	C <input type="checkbox"/> P <input type="checkbox"/>
Difficulty swallowing	C <input type="checkbox"/> P <input type="checkbox"/>	Hemorrhoids	C <input type="checkbox"/> P <input type="checkbox"/>	Men's Health	
Sore throat	C <input type="checkbox"/> P <input type="checkbox"/>	Parasites / yeast	C <input type="checkbox"/> P <input type="checkbox"/>	Testicular masses	C <input type="checkbox"/> P <input type="checkbox"/>
Strep throat	C <input type="checkbox"/> P <input type="checkbox"/>	Liver concerns	C <input type="checkbox"/> P <input type="checkbox"/>	Testicular pain	C <input type="checkbox"/> P <input type="checkbox"/>
Swollen glands	C <input type="checkbox"/> P <input type="checkbox"/>	Jaundice	C <input type="checkbox"/> P <input type="checkbox"/>	Prostate trouble	C <input type="checkbox"/> P <input type="checkbox"/>
Thyroid imbalance	C <input type="checkbox"/> P <input type="checkbox"/>	Gall bladder trouble	C <input type="checkbox"/> P <input type="checkbox"/>	Discharge or sores	C <input type="checkbox"/> P <input type="checkbox"/>
Loss of hair	C <input type="checkbox"/> P <input type="checkbox"/>	Ulcer	C <input type="checkbox"/> P <input type="checkbox"/>	Sexual difficulties	C <input type="checkbox"/> P <input type="checkbox"/>
Dry/oily hair	C <input type="checkbox"/> P <input type="checkbox"/>	Hernias	C <input type="checkbox"/> P <input type="checkbox"/>	Women's Health	
Premature grey hair	C <input type="checkbox"/> P <input type="checkbox"/>	Diabetes	C <input type="checkbox"/> P <input type="checkbox"/>	Painful menses	C <input type="checkbox"/> P <input type="checkbox"/>
Thinning eyebrows	C <input type="checkbox"/> P <input type="checkbox"/>	Food sensitivities	C <input type="checkbox"/> P <input type="checkbox"/>	Painful intercourse	C <input type="checkbox"/> P <input type="checkbox"/>
Excess hair growth	C <input type="checkbox"/> P <input type="checkbox"/>	Food cravings	C <input type="checkbox"/> P <input type="checkbox"/>	Heavy menses	C <input type="checkbox"/> P <input type="checkbox"/>
Respiratory		Genitorurinary		Irregular cycle	C <input type="checkbox"/> P <input type="checkbox"/>
Cough	C <input type="checkbox"/> P <input type="checkbox"/>	Pain on urination	C <input type="checkbox"/> P <input type="checkbox"/>	Hot flashes	C <input type="checkbox"/> P <input type="checkbox"/>
Shortness of breath	C <input type="checkbox"/> P <input type="checkbox"/>	Blood in the urine	C <input type="checkbox"/> P <input type="checkbox"/>	Cramps or backache	C <input type="checkbox"/> P <input type="checkbox"/>
Wheezing	C <input type="checkbox"/> P <input type="checkbox"/>	Kidney stones	C <input type="checkbox"/> P <input type="checkbox"/>	Vaginal discharge	C <input type="checkbox"/> P <input type="checkbox"/>
Asthma	C <input type="checkbox"/> P <input type="checkbox"/>	Urgency	C <input type="checkbox"/> P <input type="checkbox"/>	Vaginal itch	C <input type="checkbox"/> P <input type="checkbox"/>
Difficulty breathing	C <input type="checkbox"/> P <input type="checkbox"/>	Increased frequency	C <input type="checkbox"/> P <input type="checkbox"/>	Ovary/ uterine pain	C <input type="checkbox"/> P <input type="checkbox"/>
Sputum	C <input type="checkbox"/> P <input type="checkbox"/>	Hesitancy	C <input type="checkbox"/> P <input type="checkbox"/>	Endometriosis	C <input type="checkbox"/> P <input type="checkbox"/>
Allergies	C <input type="checkbox"/> P <input type="checkbox"/>	Bladder infections	C <input type="checkbox"/> P <input type="checkbox"/>	Fibroids	C <input type="checkbox"/> P <input type="checkbox"/>
Pneumonia	C <input type="checkbox"/> P <input type="checkbox"/>	Mental/emotional		Breast tenderness	C <input type="checkbox"/> P <input type="checkbox"/>
Infections / Illnesses		Severe stress	C <input type="checkbox"/> P <input type="checkbox"/>	Lumps in the breast	C <input type="checkbox"/> P <input type="checkbox"/>
Frequent colds, flus	C <input type="checkbox"/> P <input type="checkbox"/>	Anxiety	C <input type="checkbox"/> P <input type="checkbox"/>	Nipple discharge	C <input type="checkbox"/> P <input type="checkbox"/>
Cold sores	C <input type="checkbox"/> P <input type="checkbox"/>	Depression	C <input type="checkbox"/> P <input type="checkbox"/>	Post-partum depression	C <input type="checkbox"/> P <input type="checkbox"/>
Mono	C <input type="checkbox"/> P <input type="checkbox"/>	Mood changes	C <input type="checkbox"/> P <input type="checkbox"/>	Do you do self breast exams?	
Genital herpes	C <input type="checkbox"/> P <input type="checkbox"/>	Mental illness	C <input type="checkbox"/> P <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis	C <input type="checkbox"/> P <input type="checkbox"/>	Child abuse	C <input type="checkbox"/> P <input type="checkbox"/>	Age of menarche _____	
Shingles	C <input type="checkbox"/> P <input type="checkbox"/>	Physical abuse	C <input type="checkbox"/> P <input type="checkbox"/>	Age at menopause _____	
Tuberculosis	C <input type="checkbox"/> P <input type="checkbox"/>	Emotional abuse	C <input type="checkbox"/> P <input type="checkbox"/>	# of pregnancies _____	
STI	C <input type="checkbox"/> P <input type="checkbox"/>	Sexual abuse	C <input type="checkbox"/> P <input type="checkbox"/>	# of live births _____	
HIV / AIDS	C <input type="checkbox"/> P <input type="checkbox"/>			# of miscarriages _____	
Cancer	C <input type="checkbox"/> P <input type="checkbox"/>			# of abortions _____	
				# of vaginal births _____	
				# of C-sections _____	

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CONSENT TO NATUROPATHIC CARE

Naturopathic Medicine is the treatment and prevention of disease using natural therapies including lifestyle counseling, clinical nutrition, botanical medicine, homeopathy, Traditional Chinese Medicine and acupuncture, physical medicine and hydrotherapy. Naturopathic Medicine respects the body's natural ability to heal and provides an individualized and holistic approach to health care.

Naturopathic Doctors (NDs) in Ontario are licensed primary health care providers. As such, your visits with Dr. Erica Nikiforuk, ND may involve any or all of the following: a detailed health history, physical exam, relevant laboratory assessment and individualized treatment plan. NDs assess the whole person, and realize that health is achieved and maintained by addressing physical, mental, emotional and spiritual well-being.

By signing below I agree to the following:

Health services

I realize that Naturopathic Medicine is not an isolated system and that I am free to seek or continue treatment from any other health care professional of my choice. I understand that any treatment or advice provided to me is not being provided in place of, or in exclusion of, any treatment or advice that I may now be receiving or may in future receive by another licensed health care provider. I will advise Dr. Nikiforuk of any change in my condition or medications, new symptoms or medical results.

I understand that, as in all health care, there are some risks to treatment, including, but are not limited to, aggravation of pre-existing symptoms, allergic reactions, and pain or bruising from acupuncture. I do not expect Dr. Nikiforuk to be able to anticipate or explain all risks or possible complications; however I rely on her to exercise her best judgment during the course of my treatment, and to provide care that is in my best interest, given the facts known at the time. I further understand that results cannot be guaranteed.

Privacy policy

I understand that my record of health services will be kept confidential and will not be released to others without my direct consent, unless required by law. I may review my medical records at any time and may request a copy by paying an administrative fee.

Fees

Initial Naturopathic consultation	\$150
Follow-up consultation	\$70
Acupuncture treatment (Initial consultation required)	\$55
Telephone consultation (billed based on time)	\$25+
Missed appointment fee (without 24 hours notice)	\$50

The prices listed above include HST. Payment is due at the end of each visit. Any supplements or laboratory tests that may be recommended are at an additional cost. I understand that I am free to purchase these items from Dr. Erica Nikiforuk or elsewhere.

I, _____ (Print Name), acknowledge that I am aware and agree to the above. I intend this consent to cover the entire course of my treatment. I am free to withdraw my consent and may discontinue my treatment at any time.

Signature: _____ Date: _____