Nardella
Creating Healthier Lives

Oncological Naturopathic Intake Form

Personal Information

Date: _____

Name: _____ Age: _____

Birth Date: ____dd/mm/yyyy_____ Sex: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Telephone: (Home) _____ (Cell) _____

Email: _____

Occupation: _____ Are you currently working? Yes No

Marital Status: _____ Number of Children: _____

Family Physician: _____

Phone Number: _____ Fax Number: _____

Oncologist: _____

Phone Number: _____ Fax Number: _____

In Case of emergency contact: _____

Address: _____ Phone Number: _____

Relationship: _____

Do you have extended health insurance? __ Yes __ No

If yes, please list provider: _____

Please list all known allergies (medications, food, pollen, etc.):

_____

_____

_____

How did you hear about our clinic? _____

Have you seen a Naturopathic Doctor before? □Yes □No

If yes, for what reason(s)? _____

I would like to be on the clinic's general mailing list to receive clinic information, such as subscriber specials and the clinic newsletter. Please circle YES/NO.

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Current Health History

Height: _____ Weight: _____ Weight one year ago: _____

Cancer Diagnosis

Current Cancer Diagnosis: _____
Stage: _____ Grade: _____
Other pathology information (margins/lymph nodes): _____
When were you diagnosed? _____
What stage were you at the time of diagnosis? _____
Is this initial diagnosis or recurrence? _____
Are there sights of metastasis? _____ If so, where? _____

Hospital Information

What hospital are you receiving treatment from? _____
Who is on your oncology team?
_____
_____

What type of treatment are you receiving and what is the schedule?
_____
_____
_____
_____

Have you received surgery? Yes No Type of Surgery: _____
Date of Surgery: _____

What was the final outcome of the surgery (boarders removed, lymph nodes, etc.)
_____
_____

How did you recover from surgery (including side effects)?
_____
_____

Do you have any remaining side effects of the surgery?
_____
_____

Chemotherapy

Have you received chemotherapy? Yes No

If yes, which chemotherapeutic agents are currently being used and what dates were they started?
_____
_____

Which chemotherapeutics have been used in the past? When were they started and when were they discontinued?
_____
_____
_____

Why were chemotherapeutics discontinued in the past?
_____
_____

What is your current chemotherapeutic schedule (include amount of cycles)?
_____
_____
_____

How well did you tolerate chemotherapy and what side effects did you experience?
_____
_____
_____

Radiation

Are you currently receiving radiation? Yes No Where? _____

When did you start radiation? _____

How often did you receive it? _____

What type of radiation do you receive? _____

How well is/was the radiation tolerated?_____

What was the result of treatment? _____

Any unresolved symptoms? _____

Other Oncology Treatments

Are you receiving hormone therapy? Yes No
If yes, what type? _____

Are you receiving targeted therapy? Yes No

If yes, what type? _____

Are you receiving other cancer treatments? If so, what type?
_____
_____
_____

Are you seeing or have you seen other alternative health care providers for your cancer treatment? Yes No
If yes, who and what treatments? Were they effective?
_____
_____
_____

Other Health Concerns

Please list any additional current diagnoses you have been given (if any) and when:
_____
_____

Do your health concerns interfere with any of the following?
___Work ___Sleep ___Daily Routine ___Other

Have you ever had any mental or emotional disorders? _____
If yes, please list: _____
If yes, when? _____

Are you currently seeing anyone for psychological support? _____

When was your last physical exam? _____

When did you last have blood work done? _____

Please indicate how often you go for dental visits:
___ Every 6 Months ___ Yearly ___ Toothache or Emergency ___Wear Dentures

What other therapies are you currently using? (Chiropractic, Physiotherapy, Acupuncture, etc.)
_____
_____

What other treatments have you tried in the past for these concerns?

_____

_____

Are you currently under the care of any other physicians or practitioners? Yes No
If yes, please give names and contact info:

_____

_____

Medication and Supplement History
Please list all supplements, herbs, and medications you are currently taking:

Medication (Please list all of your prescription and non-prescription medication, including birth control, aspirin, and over the counter medications)

Medication	Dosage	Since	Reason

Are you currently experiencing any side effects from your medication? Yes No

Supplements (Please list any vitamin, mineral, or natural supplements you are taking with doses and brands)

Supplements	Dosage	Since	Reason

History of antibiotic use: (last two years)
When: _____
How long: _____
For what condition(s):
_____
_____

Did you experience any side effects? Yes No

Health History

Please indicate which of the following conditions you have had:

Abscesses
Alcoholism/Substance abuse
Allergies/Hay fever
Amnesia
Anemia
Anxiety/Depression
Asthma
Autoimmune disease
Bells' Palsy
Cancer
Chicken Pox
Cold Sores
Concussion
Diabetes
Eating Disorder
Emphysema
Epilepsy
Eye disease
Gall Stones
Goiter
Gout
Heart Disease
Hepatitis
High Blood Pressure
Influenza
Kidney Disease
Leukemia
Lyme disease
Malaria
Measles
Miscarriage
Mononucleosis
Mumps
Neurological disease
Obesity
Osteoporosis
Parasites
Peritonitis
Pneumonia
Prostatitis
Rheum. Fever
Rubella
Scarlet Fever
Sexually Transmitted Infection (STI)
Sinusitis
Skin Disease
Sleep apnea
Strep Throat
Stroke
Thyroid disease
Tonsillitis
Tuberculosis
Typhoid
Warts
Yellow Fever

Please indicate if you have or have had any of the following symptoms (C for currently experiencing and P for experienced in the past):

GENERAL
__ Allergies
__ Chills
__ Convulsions
__ Dizziness
__ Fainting
__ Fatigue
__ Headache
__ Migraines
__ Loss of sleep
__ Weight loss
__ Weight gain
__ Nervousness
__ Depression
__ Neuralgia
__ Sweats
__ Tremors
__ Weakness

GASTROINTESTINAL
__ Abdominal pain
__ Acid reflux
__ Belching
__ Bloating
__ Blood in mucous or stool
__ Change in taste or thirst
__ Colitis/IBD
__ Constipation
__ Diarrhea/loose stools
__ Difficult digestion
__ Excessive hunger
__ Gallbladder trouble
__ Heartburn
__ Hemorrhoids
__ Jaundice

__ Liver trouble
__ Nausea
__ Poor appetite
__ Rectal itching
__ Trouble swallowing
__ Ulcers
__ Vomiting
__ Vomiting of blood

How often do you have a bowel movement?
_____
Have you had a colonoscopy? Yes/No
If yes, when? _____

CARDIOVASCULAR
__ Arteriosclerosis or Atherosclerosis
__ Chest pain
__ Clots
__ Deep leg pain
__ High blood pressure
__ High cholesterol
__ Low blood pressure
__ Murmur
__ Pitting edema
__ Poor circulation
__ Rapid heart beat/palpitations
__ Swelling of ankles
__ Varicose veins

RESPIRATORY
__ Chronic cough
__ Difficult breathing
__ Pain with breathing
__ Shortness of breath while laying down
__ Shortness of breath with activity
__ Slow breathing
__ Spitting up blood
__ Spitting up phlegm
__ Wheezing

MUSCOSKELETAL
__ Bursitis
__ Difficulty chewing/jaw clicking
__ Hernia
__ Joint pain
__ Joint stiffness
__ Joint swelling/redness
__ Low back pain
__ Muscle spasms/cramps
__ Neck pain/stiffness
__ Numbness/tingling
__ Osteoarthritis
__ Rheumatoid arthritis
__ Shoulder pain
__ Tendonitis

NEUROLOGICAL
__ Bells' palsy
__ Carpal tunnel syndrome
__ Paralysis
__ Peripheral neuropathy
__ Sciatica
__ Tremors

EYES, EARS, NOSE, THROAT
__ Bad breath
__ Blurry vision
__ Deafness
__ Dental decay
__ Detached retina
__ Double vision
__ Ear discharge
__ Earache
__ Enlarged glands/Swollen lymph
__ Enlarged thyroid
__ Eye pain
__ Eye strain
__ Far-sightedness
__ Floaters
__ Gingivitis
__ Glaucoma
__ Gum trouble
__ Hay fever
__ Hoarseness
__ Increased ocular pressure
__ Loss of central vision
__ Loss of peripheral vision
__ Loss of taste or smell
__ Macular edema
__ Mercury fillings
__ Mouth sores
__ Nasal obstruction
__ Near-sightedness
__ Nosebleeds
__ Root canals
__ Sensitivity to light
__ Sensitivity to noise
__ Sinus infection
__ Sore throat
__ Tearing or dryness
__ Tinnitus
__ Tonsillitis
__ Tooth pain

SKIN
__ Acne
__ Bruise easily
__ Cellulite
__ Dryness/Eczema
__ Hair loss
__ Hives/Allergies
__ Itching
__ Moles removed
__ Psoriasis
__ Rash
__ Rosacea
__ Vitiligo

GENITO-URINARY
__ Bed-wetting
__ Blood in urine
__ Frequent urination
__ Painful urination

MEN
__ Erectile dysfunction
__ Low libido
__ Penile discharge
__ Prostatitis

Have you had a rectal exam? Yes/No
If yes, when? _____

WOMEN
__ Excessive menstrual flow
__ Fertility issues
__ Low libido
__ Lumps in breast
__ Menopausal symptoms
__ Painful menstruation
__ Tender/swollen breasts
__ Vaginal discharge

Are you pregnant? ___
Number of pregnancies: ___
Have you had a recent pap? ___
Have you had a recent mammogram? ___

Please indicate if you've had any hospitalizations, surgeries, or serious injuries:

Hospitalizations/Surgeries:

Operation	When	Complications?

Injuries:

Injury	When	Long-Term Effects?

Diet and Lifestyle

How much of the following substances do you use on a daily basis? (Heavy, moderate light, or none)
Alcohol: _____ Caffeine: _____
Recreational Drugs: _____ Laxatives: _____ Carbonated beverages: _____

Are you seeking guidance in nutrition and daily lifestyle? □ Yes □ No

Do you use any tobacco products? _____ Type and quantity per day: _____

Have you had a recent chest x-ray? _____ If yes, when? _____

Have you had any exposure to toxic chemicals? _____ If yes, which ones:
_____

Are there any foods or food groups that you avoid? Yes No
If yes, which ones and why?
_____
_____
_____

How often do you engage in physical activity?
Daily ___ 2-3 times/week ___ Once/week ___ Less than once/week ___
What type of activities? _____

On average, how many hours of sleep do you get per night? _____

How many glasses of water do you drink per day? _____

Have you traveled to a foreign country in the last five years? Yes No
If yes, where? _____

Please list any illnesses you had while abroad: _____

Have you had any recent vaccinations? Yes No
If yes, which ones: _____

Family Health History

Please indicate any relevant health conditions of your blood relatives only.

Relation	Past and Present Health Problems	Age at time of death (if applicable)

INFORMED CONSENT

I would like to take this opportunity to welcome you to the clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and supplemental therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history, which may include a physical exam and specific laboratory testing as part of the treatment. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

I, (printed name) _____ as a patient of this clinic, have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As the clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest of therapies potentially have their complications in certain physiological conditions, in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture; and muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so declaring.

I understand that, as a patient, I am responsible for all costs incurred as a result of the decision including, but not limited to; the cost of all procedures involved in the treatment plan, the care provider's time, supplements, supplies and appointments missed or cancelled without sufficient notice (48 hours). I am aware that all telemedicine appointments will be charged to the credit card on file seven (7) days in advance of the appointment. I am aware that treatments are not covered through Alberta Health Care and may not be covered under private health insurance.

_____ _____

SIGNATURE **DATE**