

ADULT INTAKE FORM

PATIENT INFORMATION

Please note that all the information that you provide will be held absolutely confidential.
If you have any questions, feel free to ask. Thank you!

Today's Date: _____

Full Name: _____ Preferred Name: _____

Care Card Number (PHN): _____

Age: _____ Date of Birth (M/D/Y): _____ Gender: M ☐ F ☐

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone # (home): _____ (cell): _____ (work): _____

Email address: _____

Do you wish to receive Our seasonal health E-newsletter? Y ☐ N ☐

Can Dr. Lani contact you via email regarding your care? Y ☐ N ☐

Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership

Live with: ☐ Spouse ☐ Partner ☐ Parents ☐ Children (if yes, how many? _____) ☐ Friends ☐ Alone

Occupation: _____ Hours per week: _____

How did you hear about this clinic? _____

If you were referred, please indicate whom we may thank: _____

Emergency contact:

Name: _____ Relationship: _____ Phone: _____

Do you see a medical doctor? Y ☐ N ☐

Doctor's Name: _____ Telephone: _____ Fax: _____

Other types of health care: (ie. Chiropractor, massage therapy, physiotherapist) _____

Do you have extended coverage Y ☐ N ☐

Do you receive MSP premium assistance Y ☐ N ☐

What are your main health concerns? List as many as you can in order of importance.

1) _____

When did this start? _____

2) _____

When did this start? _____

3) _____

When did this start? _____

4) _____

When did this start? _____

CONTEXT OF CARE QUESTIONNAIRE

Why did you choose to come to this clinic?

What do you know about our approach?

*What expectations do you have for **this visit** to our clinic?*

*What **long-term** expectations do you have from working with our clinic?*

*What is **your present level of commitment** to address any underlying causes of your health concerns?*

0% 10 20 30 40 50 60 70 80 90 100%

*What potential **obstacles** do you foresee in adhering to the therapeutic protocols that I will be sharing with you?*

HEALTH HISTORY INFORMATION

FAMILY HISTORY

Do **you** or **anyone in your family** have a history of any of the following? (please check and say who)

- | | | | | |
|--|---------------------------------------|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Autoimmune | <input type="checkbox"/> Epilepsy/ seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies/ Hives | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Addiction | |

Any other relevant family history? _____

What is your family heritage? _____

PAST MEDICAL HISTORY

Please check if you had any of the following as a child:

- | | | | |
|--|-------------------------------------|--|---|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Chicken pox | Other: _____ |

VACCINATIONS

Have you received all scheduled vaccinations? Y ☐ N ☐

If no, please specify which you have had:

- | | | | |
|---------------------------------------|--|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Polio | <input type="checkbox"/> MMR (Measles/Mumps/Rubella) | <input type="checkbox"/> Pertussis | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Tetanus Shot | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | Other: _____ |

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, significant trauma, diagnostic testing (X-ray, CAT scan, MRI, EEG, EKG, etc...) have you had?

_____ year _____	_____ year _____
_____ year _____	_____ year _____
_____ year _____	_____ year _____

Major accidents/trauma (fall, motor vehicle accident, loss of loved one, etc.)

CURRENT MEDICAL INFORMATION

Do you have any known contagious diseases at this time? Y ☐ N ☐ If yes, what? _____

ALLERGIES/SENSITIVITIES

Any medication/drugs? _____

Any foods? _____

Any environmental, chemical or other? _____

CURRENT MEDICATION AND SUPPLEMENTS

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking, include dose and start date for each (Please bring all the medications and supplements you are taking to your first visit.)

- 1) _____ dose: _____ start date: _____
- 2) _____ dose: _____ start date: _____
- 3) _____ dose: _____ start date: _____
- 4) _____ dose: _____ start date: _____
- 5) _____ dose: _____ start date: _____
- 6) _____ dose: _____ start date: _____
- 7) _____ dose: _____ start date: _____
- 8) _____ dose: _____ start date: _____

GENERAL HEALTH HISTORY

Height: _____ Weight: _____ Weight 1 year ago: _____ Maximum Weight: _____ When: _____

When during the day is your energy the best? _____ Worst? _____

Level of stress: 1-10 _____ Main cause? _____

Main interests and hobbies: _____

Exercise: Y ☐ N ☐ If so, what kind and how often: _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Are you or have you ever been on a restricted diet? If so, what kind? _____

Alcohol consumption: ☐ None ☐ Once a month ☐ Once a week ☐ Every day ☐ Multiple times a day

What kind? _____

Caffeine consumption: ☐ None ☐ Once a month ☐ Once a week ☐ Every day ☐ Multiple times a day

What kind? _____ What do you add? _____

PLEASE CHECK IF THE FOLLOWING IS A CURRENT OR RECURRING SYMPTOM:

GENERAL

- | | | | |
|-------------------------------|---|-----------------------------------|---|
| Do you sleep well? | Y <input type="checkbox"/> N <input type="checkbox"/> | Treated for addiction/dependence? | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Hours of sleep? _____ | Awake rested? Y <input type="checkbox"/> N <input type="checkbox"/> | Use tobacco currently or in past? | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Have supportive relationship? | Y <input type="checkbox"/> N <input type="checkbox"/> | how many years? _____ | How many/day? _____ |
| Have a history of abuse? | Y <input type="checkbox"/> N <input type="checkbox"/> | Do you enjoy your work? | Y <input type="checkbox"/> N <input type="checkbox"/> |



Take vacations?	Y <input type="checkbox"/> N <input type="checkbox"/>	Do you eat refined sugar?	Y <input type="checkbox"/> N <input type="checkbox"/>
Spend time outside?	Y <input type="checkbox"/> N <input type="checkbox"/>	Do you add salt to your food?	Y <input type="checkbox"/> N <input type="checkbox"/>
Do you eat out often?	Y <input type="checkbox"/> N <input type="checkbox"/>	Toxic exposure (at home or work)?	Y <input type="checkbox"/> N <input type="checkbox"/>
Cravings?	Y <input type="checkbox"/> N <input type="checkbox"/>	Blood type: _____	

IMMUNE

<input type="checkbox"/> Reactions to immunizations	<input type="checkbox"/> Chronic fatigue syndrome	<input type="checkbox"/> Chills
<input type="checkbox"/> Chronically swollen glands	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Fever
<input type="checkbox"/> Slow wound healing	<input type="checkbox"/> Chronic infections	<input type="checkbox"/> Frequent cold/flu

SKIN/HAIR

<input type="checkbox"/> Rashes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Perpetual hair loss
<input type="checkbox"/> Acne/boils	<input type="checkbox"/> Hives	<input type="checkbox"/> Dandruff
<input type="checkbox"/> Change in skin color	<input type="checkbox"/> Itching	<input type="checkbox"/> change in hair or skin texture
<input type="checkbox"/> Lumps or bumps on skin	<input type="checkbox"/> Recent moles	<input type="checkbox"/> sweat easily

HEAD, EYES, EARS, NOSE, THROAT

<input type="checkbox"/> Impaired vision	<input type="checkbox"/> Earaches	<input type="checkbox"/> Pain or stiffness in neck
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Headaches	<input type="checkbox"/> Frequent sore throat
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Head injury	<input type="checkbox"/> Sores on tongue or lips
<input type="checkbox"/> Spots in vision	<input type="checkbox"/> Jaw or TMJ problems	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Color blindness	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Teeth grinding
<input type="checkbox"/> Night blindness	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Gum problems
<input type="checkbox"/> Tearing or dryness	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Dental cavities
<input type="checkbox"/> Eye pain or strain	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Facial pain
<input type="checkbox"/> Impaired hearing	<input type="checkbox"/> Lumps in neck	
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Difficulty swallowing	

RESPIRATORY

<input type="checkbox"/> Cough <input type="checkbox"/> Phlegm (Colour?)	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pain in breathing	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Tuberculosis

HEART AND CIRCULATION

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Thrombophlebitis
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Anemia	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Easy bleeding or bruising	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Swelling of extremities
<input type="checkbox"/> Fainting	<input type="checkbox"/> Deep leg pain	

ENDOCRINE

<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Heat or cold intolerance	<input type="checkbox"/> Difficulty exercising
<input type="checkbox"/> Excessive hunger or thirst	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Goiter

DIGESTION AND ELIMINATION

<input type="checkbox"/> Change in thirst	<input type="checkbox"/> Pancreatitis	Bowel movement frequency: _____
<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Heartburn	is this a change? Y <input type="checkbox"/> N <input type="checkbox"/>
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Abdominal pain or cramps	<input type="checkbox"/> Black stools
<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Belching or passing gas	<input type="checkbox"/> Blood in stools
<input type="checkbox"/> Ulcer	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Rectal pain
<input type="checkbox"/> Gall bladder or Liver disease	<input type="checkbox"/> Chronic laxative use	

GENITO-URINARY

- | | | |
|---|---|--|
| <input type="checkbox"/> Frequent or urgent urination | <input type="checkbox"/> Distinctive odor/colour to urine | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Inability to hold urine | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Pain in urination | <input type="checkbox"/> Frequent UTI's | <input type="checkbox"/> Genital warts |
| <input type="checkbox"/> Frequency at night | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Sores on genitals |

FEMALE REPRODUCTIVE

- | | | |
|--|--|---|
| Age of first menses: _____ | <input type="checkbox"/> Bleeding between cycles | <input type="checkbox"/> Difficulty conceiving |
| Length of cycle: _____ days | <input type="checkbox"/> Endometriosis | Number of pregnancies: _____ |
| Duration of menses: _____ days | <input type="checkbox"/> Ovarian cysts | Number of live births: _____ |
| Date of last menses: _____ | <input type="checkbox"/> Vaginal discharge/odor | Number of miscarriages: _____ |
| Are your cycles regular? <input type="checkbox"/> Y <input type="checkbox"/> N | Date of last pap smear: _____ | Number of abortions: _____ |
| <input type="checkbox"/> Painful menses | <input type="checkbox"/> Abnormal PAP | Do you perform monthly self-breast exams? <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Heavy or excessive flow | <input type="checkbox"/> Cervical dysplasia | <input type="checkbox"/> Breast pain/tenderness |
| <input type="checkbox"/> Clots | Are you sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> PMS | Birth control? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Nipple discharge |
| Symptoms: _____ | Type: _____ | <input type="checkbox"/> Menopausal symptoms? _____ |
| _____ | How long: _____ | _____ |
| _____ | <input type="checkbox"/> Pain during intercourse | _____ |

MALE REPRODUCTIVE

- | | | |
|--|--|--|
| Are you sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Hernias | <input type="checkbox"/> Prostate disease |
| Birth control? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Testicular masses | <input type="checkbox"/> Impotence |
| Type: _____ | <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Discharge or sores | | |

MENTAL/EMOTIONAL

- | | | |
|--|--|--|
| <input type="checkbox"/> Treated for emotional problem | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Attempted suicide |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Quick temper/irritable | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Do you have mood swings | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Considered suicide | <input type="checkbox"/> Seasonal depression |

NEUROLOGIC

- | | | |
|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Vertigo or dizziness | <input type="checkbox"/> Loss of balance/coordination |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Numbness or tingling | |

MUSCULOSKELETAL

- | | | |
|--|--|--|
| <input type="checkbox"/> Joint pain or stiffness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscle spasms or cramps |
| Indicate which areas: _____ | <input type="checkbox"/> Broken bones | Indicate which areas: _____ |
| _____ | <input type="checkbox"/> Bone pain | _____ |
| _____ | <input type="checkbox"/> Muscle weakness | _____ |

Thank you & Welcome! Looking forward to working with you on your path to better health!

INFORMED CONSENT AND REQUEST FOR NATUROPATHIC MEDICAL CARE & ACUPUNCTURE

I, _____, hereby request and consent to examination and treatment by Lani Nykilchuk, ND, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Nykilchuk, and/or with the allied health care provider, providing backup:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including pap smears, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including naturopathic/osseous manipulation of the spine and extremities)
- Dietary advice and therapeutic nutrition (including food, nutritional supplements, or intravenous injection of nutrients)
- Traditional Oriental medicine- including acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface), moxa and cupping.
- Botanical/ herbal medicines
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Lifestyle counseling (including but not limited to visualization for improved lifestyle strategies)
- Bowen therapy (gentle physical therapy)
- Prescribed medication (which are within the naturopathic scope of practice in BC)

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat, hydrotherapies; allergic reaction to prescribed herbs, supplements and medications; soft tissue or bony injury from physical manipulation; aggravation of pre-existing symptoms.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief or pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pace makers, and/or cancer: For your safety it is vital to alert your provider, Lani Nykilchuk, ND, of these conditions.

☐ I recognize that even the gentlest therapies may potentially have complications in certain conditions, in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy, and all medications, including over the counter drugs and supplements.

I do not expect Lani Nykilchuk, ND and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Nykilchuk explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Printed Name of Patient

Signature of Patient

Date

Confidential Information