Imagine Healing

Intake Form

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Blenheim 7201
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www.imaginehealing.co.nz

Name: _____ Date: _____

Address:_____

City: _____ Postal Code: _____

Home:_____ Mobile:_____

Email:_____

Would you like to receive info by email? Yes ☐

Gender: _____ Age:_____ Date of Birth: _____

Marital Status:_____Number of Children:_____

Occupation:_____Employed by: _____

Emergency Contact:_____Phone:_____Relation:_____

How did you hear about our practice?_____

HEALTH CONCERNS

Please, list your health concerns in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Vitamins and Supplements

List all vitamins/minerals/herbal supplements you are currently taking:

_____

_____

_____

Medications

List all prescription and non-prescription medications you are currently taking:

_____

Medical History

List any major illness, injuries and/or surgeries that you have had and when:

_____

_____

_____

Allergies

Do you have any hypersensitivity or allergy to any drugs?_____

Do you have any food intolerances or allergies?_____

Do you have any environmental sensitivity? _____

General

Height: _____ Weight:_____ Weight 1 year ago:_____

Family History

Please put an "L" for living and "D" for deceased and present age or age at time of death. Indicate if the family member suffered from any disease or conditions such as cancer, high blood pressure, heart attack, stroke or diabetes.

Relationship	L/D	Age	Health Conditions/Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sister (s)			
Brother (s)			

Dental

Do you have any root canals? Yes ☐ No ☐ If yes, how many? _____

Do you have any amalgam fillings? Yes ☐ No ☐ If yes, how many? _____

Typical Food Intake

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
To Drink: _____

Habits:

Activities and hobbies: _____
Do you exercise? No☐ Yes☐ If yes, how often? _____
Do you smoke? No☐ Yes☐ How long? _____ How many per day?_____
Do you use recreational drugs? Yes☐ No☐ If yes, which ones? _____
Rate your Energy: (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Rate your Stress: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Sleep

How many hours of sleep do you get on average? _____
Do you have difficulty falling asleep? Yes No ☐
Do you wake up during the night? Yes No ☐ If yes, how often?_____
Do you feel refreshed in the morning? Yes No ☐

Digestive Health

How frequently do you move your bowels? _____
Do you experience any of the following?

Loose Stools?	Yes	No ☐	Mucous in stools?	Yes	No ☐
Diarrhea?	Yes	No ☐	Gas?	Yes	No ☐
Hard Stools?	Yes	No ☐	Bloating?	Yes	No ☐
Difficulty Passing?	Yes	No ☐	Heartburn/Reflux?	Yes	No ☐
Blood in Stools?	Yes	No ☐	Abdominal Pain?	Yes	No ☐
Undigested Foods in Stools?	Yes	No ☐			

Do you have your gallbladder? Yes☐ No☐ Do you have your appendix? Yes☐ No☐

Female Reproductive

Age of your first menses?_____ How many days of menses? _____

How long is your cycle?_____ When was your last pap test? _____

Do you get yeast infections? Yes ☐ No ☐

History of abnormal pap? Yes ☐ No ☐

Are you menopausal? Yes ☐ No ☐ If yes, age of last menses _____

Have you had a hysterectomy? Yes ☐ No ☐

Do you experience any of the following?

Heavy flow Yes No ☐

Light flow Yes No ☐

Clotting Yes No ☐

Bleeding between periods Yes ☐ No ☐

If you experience PMS, which symptoms?

☐ Pain or cramping ☐ Headaches

☐ Mood Swings ☐ Breast Tenderness

☐ Bloating ☐ Cravings

Do you experience any of the following?

☐ Hot flashes ☐ Low libido

☐ Disrupted sleep ☐ Pain during intercourse

☐ Poor memory ☐ Vaginal itching

☐ Changes in mood ☐ Vaginal dryness

Are you sexually active? Yes No ☐ Form of contraception _____

Male reproductive

Please, indicate if any of the following applies to you:

☐ Impotence	☐ Testicular Pain
☐ Sexually Transmitted Disease	☐ Infertility/Low Sperm Count
☐ Sores on Genitals	☐ Hernia
☐ Discharge	☐ Prostate Condition
☐ Testicular mass	

Are you sexually active? Yes ☐ No ☐ Form of contraception _____

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

General
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Change in thirst
- ☐ Cravings
- ☐ Weight gain
- ☐ Weight loss
- ☐ Poor sleep
- ☐ Chills or fever
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes

Skin and Hair
- ☐ Dryness
- ☐ Rash
- ☐ Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Recent moles
- ☐ Hives/allergic reactions
- ☐ Loss of hair
- ☐ Thinning hair
- ☐ Dandruff
- ☐ Other skin problem(s)

Eyes Ears Nose & Throat
- ☐ Eye pain
- ☐ Eye strain
- ☐ Blurry vision
- ☐ Impaired vision
- ☐ Cataracts
- ☐ Ear aches
- ☐ Ear infections
- ☐ Ringing in ears
- ☐ Vertigo or dizziness
- ☐ Sinus infections
- ☐ Nasal obstruction
- ☐ Post nasal drip
- ☐ Nosebleeds
- ☐ Loss of smell/taste
- ☐ Tonsillitis
- ☐ Sores in mouth
- ☐ Mercury fillings
- ☐ Jaw pain or clicks
- ☐ Recurrent sore throat
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Facial pain/tics
- ☐ Headaches

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Irregular heartbeat
- ☐ Pacemaker
- ☐ Artificial heart valve
- ☐ Fainting
- ☐ Varicose veins
- ☐ Deep leg pain
- ☐ Cold hands or feet
- ☐ Anemia
- ☐ Easy Bruising

Respiratory
- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Wheezing
- ☐ Coughing blood
- ☐ Phlegm in throat

Muscle Bone & Joints
- ☐ Neck pain
- ☐ Back pain
- ☐ Arthritis
- ☐ Bursitis
- ☐ Joint pain or stiffness
- ☐ Artificial joint
- ☐ Muscle pain
- ☐ Muscle weakness

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Reflux or heartburn
- ☐ Constant hunger
- ☐ Ulcer
- ☐ Gall stones
- ☐ Constipation
- ☐ Diarrhea
- ☐ Chronic laxative use
- ☐ Rectal burning/pain
- ☐ Hemorrhoids
- ☐ Blood in stool

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Irritability
- ☐ Emotional problems
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Dizziness
- ☐ Seizures/Epilepsy
- ☐ Concussion
- ☐ Lack of coordination
- ☐ Extremity numbness
- ☐ Extremity tingling
- ☐ Paralysis

Infections
- ☐ Strep throat
- ☐ Mononucleosis
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ HIV/AIDS

Urinary
- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Incontinence
- ☐ Pain on urination
- ☐ Wake at night to urinate
- ☐ Urinary tract infection
- ☐ Blood in urine
- ☐ Kidney stones

Signature

I attest that the information provided is true and accurate to the best of my knowledge.

Signature _____ Date _____

DECLARATION AND CONSENT TO TREATMENT

Naturopathic Practitioners minimize the risk of harmful side effects, by supporting the body's own capacity to heal and by using the least invasive procedures for diagnosis and treatment whenever possible. However, even the gentlest therapies have potential for complications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease, or in specific patient populations such as pregnant or lactating women, very young children, or patients taking multiple medications. It is very important that you inform your Naturopathic doctor immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture or blood draws
- Fainting or puncturing of an organ with acupuncture needles

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my Naturopathic Practitioner will answer any questions that I have to the best o his/her ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Practitioner to be able to anticipate and explain all risks and complications. I will rely on the Naturopathic Practitioner to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known.

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

If I am unable to make my appointment I must provide advance notification within 48 hours in which case no charge will be applied.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

I. Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving from another licensed health care provider, or may receive in the future;

II. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in New Zealand;

III. No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;

IV. The treatment and therapies rendered or recommended by this Clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, as well as other applicable fees. I understand that there is a fee for completing forms, letter writing, and telephone consultations greater than 10 minutes and emails that take greater than 10 minutes to answer. Notice of 48 hours is required for appointment cancellation, otherwise you will be charged an administrative fee of $35.00.

Patient's Full Name: _____

Date of Consent: _____

Signature of Patient: _____

Notes: