Dr. Jeannie Doig, HBSc, ND
Naturopathic Physician

www.drjeanniedoig.com
Port Alberni (250) 723-9888
Tofino & Ucluelet (250) 522-0033

Intake Form

This record of your medical history is confidential. Information it contains will not be released to any person unless you authorize me to do so.

Name: ____ **Date:** ______________________

Date of birth: ___________________________ (M/D/Y) **Sex M F**

Address:____
____
____
____

E-mailAddress:____

Telephone number: Home:_______________________ **Work**:____________________________

May I leave messages relating to your visits? Y / N

Marital Status:____________________ **# of Children**: ______________________

Occupation: ______________________ **How did you hear about my practice?**
____
____

Emergency contact: Name: ____

Phone number:____________________ **Relation**:______________________________________

Other health care providers you are seeing:

1. _______________________
____
____
(_____)__________________

2. _______________________
____
____
(_____)__________________

3. _______________________
____
____
(_____)__________________

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What are your health concerns, in order of importance to you:

1. ____
2. ____
3. ____
4. ____
5. ____

If you are female are you currently pregnant? Yes No (Please circle one)

Medical history

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations, along with approximate dates.

____
____

Which of the following conditions do you currently experience or have had in the past?

Abuse Alcoholism Asthma Cancer Chicken pox Cold sores Depression Diabetes
Emphysema Endometriosis Epilepsy Gall stones Gonorrhea Gout Hay Fever
Heart Disease Hemorrhoids Hepatitis Herpes Influenza HIV Kidney Disease
Malaria German Measles Mononucleosis Mumps Parasites Peritonitis Pleurisy
Pelvic Inflammatory Disease Pneumonia Psoriasis Prostatitis Rheumatic Fever
Scarlet Fever Skin Cancer Strep throat Sinusitis Stroke Syphilis Thyroid Problems
Tuberculosis Typhoid Fever Warts Whooping cough Worms

Do you have any allergies (medicines, environmental, etc.)?

____
____
____
____

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Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

____
____
____

Please list past prescription medications.

____
____-__________
____
____
____
____

How many times (approx) have you been treated with antibiotics? _________________________

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/implants/injections
Cortisone / Tranquilizers / Pain relievers / Appetite suppressants / Thyroid medication
Sleeping pills

Alcohol—how much/day or week ____
Tobacco—form and amount/day____
Caffeine—form and amount/day____
Recreational drugs—what and how often____

Please indicate what immunizations you have had

☐ **DPT (diphtheria, pertussis, tetanus)**	☐ **Haemophilus influenza B**	☐ **Hepatitis A**
☐ **Tetanus booster; when?** ____________________________	☐ **"Flu"**	☐ **Hepatitis B**
☐ **MMR (measles, mumps, rubella)**	☐ **Polio**	☐ **Smallpox**

Other ____

Please indicate if any caused adverse reactions:

____
____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y / N

Have you gained or lost any weight lately? ________ How many pounds? __________________

How often do you have a bowel movement? ____

<u>Diet</u>

Do you have any food allergies or intolerances? Please list.

____
____
____
____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____
____
____
____

Describe a typical day's diet:

Breakfast____
Lunch____
Dinner____
Snacks____
Beverages (and total quantity)_________+____

Comments:

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Family history

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies/Hay Fever		**Depression**	
Asthma		**Other mental illness**	
Heart disease		**Drug abuse/alcoholism**	
High blood pressure		**Kidney disease**	
Cancer		**Autoimmune Disease (MS, RA, Lupus, etc.)**	
Diabetes		**Psoriasis**	

☐ **I don't know my family medical history**

Environment

Hobbies ____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

____

____

____

____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N
Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?

____

____

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Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

____
____
____
____

How would you describe the emotional climate of your home?

____
____
____
____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

____
____

What are your treatment goals and expectations?

____
____
____

What expectations do you have of me personally as your physician?

____
____

Please check if you are experiencing the following symptoms or write "P" beside the box if you have experienced these symptoms in the past.

General:

- ❑ Poor appetite
- ❑ Change in appetite
- ❑ Headaches
- ❑ Weight gain
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Chills and Fever
- ❑ Easy Bruising/Bleeding
- ❑ Varicose Veins
- ❑ Swelling of limbs
- ❑ Cold hands or feet

Date of last CBC (complete blood count):

____

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- ❑ Night sweats
- ❑ Excessive sweating
- ❑ Cravings
- ❑ Intense hunger
- ❑ Intense thirst

Skin and Hair:

- ❑ Rashes
- ❑ Itching
- ❑ Eczema
- ❑ Acne, boils
- ❑ Loss of hair
- ❑ Nail changes
- ❑ Dandruff
- ❑ Recent moles
- ❑ Dryness
- ❑ Hives or allergy reaction
- ❑ Colour change
- ❑ Other problems

Cardiovascular:

- ❑ High Blood pressure
- ❑ Low Blood pressure
- ❑ Irregular Heart Beat
- ❑ Dizziness
- ❑ Fainting
- ❑ Chest pain
- ❑ Angina
- ❑ Anemia

Eyes, Ears, Nose and Throat:

- ❑ Impaired Hearing
- ❑ Earaches
- ❑ Ear infections
- ❑ Ringing in the ears
- ❑ Ear wax build up
- ❑ Sinus infections
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Recurrent sore throats
- ❑ Frequent colds
- ❑ Tonsillitis
- ❑ Nasal obstruction
- ❑ Post-nasal drip
- ❑ Nose bleeds
- ❑ Eye sensitive to sun
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Night blindness
- ❑ Colour blindness
- ❑ Near/Far sighted
- ❑ Cataracts
- ❑ Itchy/Red eye
- ❑ Blind spots
- ❑ Facial pain/tics
- ❑ Jaw pain or clicks
- ❑ Mercury fillings
- ❑ Sores in mouth
- ❑ Loss of taste

Muscle, Bone and Joints:

- ❑ Back pain
- ❑ Muscle spasms/cramps
- ❑ Muscle weakness
- ❑ Arthritis
- ❑ Joint pains/stiffness
- ❑ Bursitis

- ❑ Emotional problems

Genito-Urinary:

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Pain on urination
- ❑ Recurrent urinary tract infections

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Gastrointestinal:

- ❑ Indigestion
- ❑ Gas and burping
- ❑ Bad breath
- ❑ Heart burn
- ❑ Constipation
- ❑ Diarrhea
- ❑ Incomplete bowel movement
- ❑ Abdominal pain/cramps
- ❑ Nausea
- ❑ Vomiting
- ❑ Chronic laxative use
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Blood in stool (black or red stool)
- ❑ Bloating
- ❑ Ulcers
- ❑ Hernias
- ❑ Intestinal worms
- ❑ Liver disease
- ❑ Gallbladder disease
- ❑ Jaundice

Neurological:

- ❑ Depression
- ❑ Irritability
- ❑ Poor memory
- ❑ Anxiety
- ❑ Phobias
- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Seizures
- ❑ Concussion
- ❑ Numbness of Feet

- ❑ Wake at night to urinate
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Kidney infection
- ❑ Sores on genitals
- ❑ Blood in urine

Female:

- ❑ Irregular periods
- ❑ Heavy flow
- ❑ Light flow
- ❑ Blood clots
- ❑ Painful periods
- ❑ Using birth control pills
- ❑ Pain during intercourse
- ❑ Vaginal discharge
- ❑ Yeast infections
- ❑ STD's
- ❑ Vaginal sores
- ❑ Vaginal itching
- ❑ Sore breasts
- ❑ Do self breast exams

Date of Last Pap: ____________________

Age of first menstruation: ______________

Menopausal? Y N

Age of last menstruation: ______________

Pregnant? Y N

Number of:

Pregnancies ________

Abortions __________

Miscarriages ________

Births ______________

Male:

- ❑ Testicular masses
- ❑ Do testicular self exams
- ❑ Testicular pain
- ❑ Impotence
- ❑ STD's
- ❑ Prostate problems
- ❑ Discharge/Sores

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CONSENT FORM

INFORMED CONSENT TO NATUROPATHIC TREATMENT

Naturopathic medicine is the art and science of preventing and treating disease by natural means. Naturopathic Doctors assess the whole person, including physical, mental, and emotional aspects of the individual. Naturopathic Doctors use a variety of therapeutic approaches either alone, or in combination. These include nutritional and lifestyle changes, counseling, botanical medicine, nutritional supplementation, Asian medicine and acupuncture, homeopathy, and physical medicine.

This is to acknowledge that I have been informed and I understand that:

1) Any treatment or advice provided to me as a patient of Dr. Jeannie Doig is not mutually exclusive of any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider.
2) I may at liberty seek or continue medical care from a physician or surgeon or other health care provider qualified to practice medicine.
3) Dr. Jeannie Doig will not suggest or recommend to me to refrain from seeking or following the advice of another health care provider.
4) The treatment and therapies rendered or recommended by Dr. Jeannie Doig may be different from those usually offered by a medical doctor or other licensed health care provider.
5) There are some risks, however rare, to Naturopathic Medicine. These include but are not limited to:
    - Aggravation of pre-existing symptoms
    - Allergic reaction to supplements or herbs
    - Pain, bruising or injury from acupuncture
    - Fainting or puncturing with acupuncture needles

I declare that I have received a full and complete explanation of the treatment or services that I may receive by Dr. Jeannie Doig and hereby authorize and consent to treatment by Dr. Jeannie Doig, ND. I intend this consent to apply to all my present and future care.

______________________________ ______________________________
Signature of patient Date

______________________________ ______________________________
Name of patient (printed) Doctor's signature