

DR. JEANNIE DOIG, ND
Family Natural Health Group, Port Alberni
Ph: 723-9888
Tofino & Ucluelet
Ph: 522-0033

drjeannedoig@gmail.com www.drjeannedoig.com

Intake Forms

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. _____

() _____ () _____ () _____

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.)?

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

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Tetanus booster; when?
_____ | <input type="checkbox"/> "Flu" | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Polio | <input type="checkbox"/> 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? _____

Diet

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) _____

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?

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
- 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

- Easy Bruising/Bleeding
- Varicose Veins
- Swelling of limbs
- Cold hands or feet

Date of last CBC (complete blood count):

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

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

- Emotional problems

Genito-Urinary:

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

DR. JEANNIE DOIG, ND

Family Natural Health Group

4711 Elizabeth St.

Port Alberni, BC

Ph: 250-723-9888 Email: drjeannedoig@gmail.com

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

NATUROPATHIC FEE SCHEDULE

VISIT	FEE
Initial consult adult 75 minutes	\$215
Initial consult child under 12 45 minutes	\$153
Follow up 45 minutes	\$153
Follow up 30 minutes	\$102
Follow up 15 minutes	\$50
Acupuncture 60 minutes	\$120
Acupuncture 30 minutes	\$60
Bowen Therapy 60 minutes	\$120
IV Myers vitamin drip	\$150

The seventy five minute initial consultation involves an assessment where personal health history and chief complaints are explored in depth and a physical exam is conducted. **Please be prepared to do a urine sample during the initial consult. Also, bring in any medications and supplements you are currently taking.**

Follow-ups are weekly, monthly, or bi-yearly depending on the type of treatment and condition of the patient.

Extended health care benefits do cover naturopathic treatment. Please check with your plan details or call your human resources.

Please note that there is a 4-hour cancellation policy. If 24 hours notice is not given, a \$30.00 missed appointment fee will be charged.

I acknowledge that I may purchase products prescribed by Dr. Jeannie Doig from her office or from another health food store or doctor.

Please sign that you have read the above and you acknowledge the fee schedule.

Signature of patient

Date