DR. JENNIFER BRIX BSc, ND
106-1851 Kirschner Road, Kelowna BC, V1Y 4N7
p. 778-436-9366 f. 778-436-9367 www.freshhealth.ca

NATUROPATHIC INTAKE FORM – ADULT Today's Date_____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized to do so. Please complete this intake form thoroughly and to the best of your knowledge. It is understood that you may not recall all relevant information at this time and this is not intended to be a complete record of your medical history.

Name _____ Age _____ Date of Birth _____ Sex ___
Health Card # _____ Extended Coverage _____
Address_____ City_____ Province_____ Postal code_____
Phone (home)_____ Ph.(work)_____ OK to leave messages re: appointments? Y / N
Email_____ Would you like to receive email notifications of appointments: Y / N
Occupation_____ □ Full-time □ Part-time □ Retired □ Student □ Unemployed □ Other
Emergency contact_____ Relation_____ Phone_____

How did you hear about our clinic?_____
Would you like to receive anything in the mail/email including newsletters? Y / N

If you are under 18 years of age, please list the name, relationship, and contact information of the person who is legally responsible for you: _____

Do you have an outstanding WCB or ICBC claim? Y / N

I understand that I am required to give a minimum of 24 hours notice if I am unable to make my appointment. In the event that I miss an appointment without sufficient notice, I may be charged the full cost of the missed appointment. Signature: _____ Date: _____

What is the major health concern that has brought you to this office today? Please describe it in detail including when you first noticed this condition and describe any factors that you suspect may be playing a role.
_____
_____
_____

Please list any other health concerns (physical, mental or emotional) in order of importance:
_____
_____

Personal Health Habits

Height _____ Current weight _____ Weight 1 year ago _____

Are you a smoker? Y / N □ current □ past For how many years? _____ Amount per day_____
Do you drink alcohol? Y / N What? _____ Frequency? _____
Do you use recreational drugs? Y / N What? _____ Frequency? _____
Do you engage in regular exercise? Y / N Type? _____ Frequency? _____

Current/Recent Heath Care Providers (Conventional and Complimentary)
Name Dates Care Provided
_____
_____
_____
_____

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Supplements and Medications

Please include all current supplements (vitamins, minerals, herbs, homeopathic remedies, etc.) and medications (prescription and over-the-counter):

Supplement/Herb	Brand name	Potency (mg, IU etc)	Dose	Frequency

Medication	What it's for	For how long?	Strength	Dose	Frequency

Approximately how many times have you taken antibiotics? _____
Have you ever had an adverse reaction to any medications or supplements? Y / N

Medical History

Please indicate if you have had any of the following childhood illnesses (CIRCLE):

Asthma	Measles	Rheumatic fever
Chicken pox	Mumps	Diphtheria
Scarlet fever	Mononucleosis	Tuberculosis
Eczema	Polio	Whooping cough
Frequent ear infections/colds	Rubella (German measles)	Other: _____

Please list any serious conditions, illnesses, injuries, accidents, and/or hospitalizations with their approximate dates. _____
_____
_____

Immunizations (CIRCLE all that apply)

DPT	Tetanus Booster	Chicken pox
MMR	Flu shot	Small pox
Polio	Hepatitis A	Other: _____
Haemophilus Influenza B	Hepatitis B	

Have you had any adverse reactions to vaccinations? Please describe. _____
_____

Blood Type

□ A □ B □ AB □ O
□ Rh- □ Rh+
Have you had recent blood work or other lab testing done? Y / N

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Lifestyle Factors

Please list any dietary preferences/restrictions (vegan, vegetarian, etc.) and food avoidances (gluten, dairy, etc.) _____
_____

Sample of day's menu:
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Fluids _____

Do you drink coffee/other caffeinated drinks? Y / N What? _____ Frequency? _____

To the best of your knowledge, have you ever been exposed to pesticides, heavy metals, toxic chemicals, radiation, or other toxins beyond those encountered in daily life?
_____
_____

Are you frequently exposed to animals? Y / N Are you exposed to molds in your home dwelling? Y / N

Please list all allergies (medications, foods, pollens, animals etc)_____
_____

What is your travel history like? Please list any countries you have visited:_____
_____

Please rate the following and write in any comments:

Sleep	POOR	FAIR	AVERAGE	GOOD	EXCELLENT	Number of hrs per night? ___
Energy Level	POOR	FAIR	AVERAGE	GOOD	EXCELLENT	_____
Appetite	POOR	FAIR	AVERAGE	GOOD	EXCELLENT	_____
Digestion	POOR	FAIR	AVERAGE	GOOD	EXCELLENT	_____
Mood	POOR	FAIR	AVERAGE	GOOD	EXCELLENT	_____

Please rate your current stress level: LOW AVERAGE HIGH UNBEARABLE

Which of the following factors most contributes to your stress? (CIRCLE)
HEALTH MONEY WORK FAMILY MARRIAGE/RELATIONSHIP OTHER_____

Please list the 5 most significant stressful events in your life, from the most recent to most distant. Are any of these situations continuing to impact your life? (If so, place a star next to the event)
1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____
5. _____ Date _____

What do you do for recreation and relaxation? _____

Relationship status: _____ Number of children: _____

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Female Reproduction

Are you currently pregnant? Y / N Do you get regular PAP smears? Y / N
Date of last PAP (month/year) _____/_____ Have you ever had an abnormal PAP? Y / N

Age of first period _____ Date of last period _____ Length of cycle _____ Length of period _____
Is your period: Light? _____ Heavy? _____ Does it contain clots? _____ Colour of blood? _____
Menstrual cramps? Y / N; if yes, which days? _____ Do you have irregular bleeding/spotting? Y / N

Number of pregnancies _____ Births? _____ Miscarriages? _____ Abortions? _____
Have or are you currently experiencing any difficulties in conceiving? Y / N

Do you experience PMS? Y / N
Please CIRCLE relevant PMS symptoms:

Bloating	Depression	Headaches	Mood swings
Breast tenderness	Food cravings	Irritability	Other: _____

Are you menopausal? Y / N If yes, age of last period _____
Please describe any symptoms of menopause you experience:_____

Are you sexually active? Y / N If no, have you been sexually active in the past? Y / N
Current forms of contraception: _____
Do you have any sexual problems or concerns? Y / N If yes, please explain:_____

Have you ever had a sexually transmitted disease/infection? Y / N Specify if Yes _____

Do you experience vaginal/yeast infections? (CIRCLE) NEVER RARELY FREQUENTLY
Do you experience bladder infections? (CIRCLE) NEVER RARELY FREQUENTLY

Have you had any of the following? (CIRCLE)

Hysterectomy	Fibroids	Interstitial cystitis
Ablation	Tubal ligation	Vaginal Dryness

Do you do self breast exams regularly? Y / N
Have you ever had any of the following concerning your breast? (CIRCLE)
Pain Lumps Infections Cysts Nipple Discharge Lump/Mastectomy

Male Reproduction

Do you have regular screening tests done? (blood work, prostate examination) Y / N
Date of last prostate examination: _____

Are you sexually active? Y / N If no, have you been sexually active in the past? Y / N
Current forms of contraception: _____
Do you have any sexual problems or concerns? Y / N If yes, please explain:_____
Have you ever had a sexually transmitted disease/infection? Y / N Specify if Yes _____

Do you have difficulties with urination (pain, difficulty stopping/starting, frequent urination)? Y / N
How many times to you get up from sleep to urinate? _____

Have you had any of the following? (CIRCLE)
Testicular pain Hernia Discharge Skin Lesions Other _____

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Family History: Please indicate if any of the following pertain(ed) to blood relatives NOT including yourself:

Condition	Relative	Condition	Relative
Alcohol/substance abuse		Heart condition	
Allergies (hay fever, food)		High blood pressure	
Alzheimer's disease		Infertility	
Arthritis		Kidney problems	
Asthma		Liver disease	
Autoimmune disease		Mental illness/Depression	
Bleeding disorders		Obesity	
Cancer (indicate type)		Osteoporosis	
Diabetes (Type I or II)		Stroke	
Eating Disorder(s)		Thyroid condition	
Epilepsy		Other:	
Glaucoma			

Review of Systems

Please **CIRCLE** if YOU are experiencing any of the following currently, OR write a **P** next to those symptoms that you have experienced in the past.

General
Fatigue/Low energy
Fever
Chills
Sweats (day or night)
Change in thirst or appetite
Easy Weight gain or Loss
Intolerance to heat or cold
Thyroid problems
Blood sugar problems
Autoimmune disease
Allergies (Seasonal/Food)

Digestion
Bloating
Gas (Flatulence)
Belching
Nausea/Vomiting
Food cravings
Poor appetite
Bad breath
Difficulty swallowing
Indigestion/Heartburn
Abdominal pain/cramps
Constipation
Diarrhea
Irritable Bowel Syndrome
Crohn's disease
Ulcerative Colitis
Liver/Gallbladder problems
Hemorrhoids/rectal pain
Blood or mucus in stool
History of parasites

Eyes/Ears/Nose/Throat
Cataracts
Glaucoma
Eye pain, tearing or dryness
Vision problems
Earaches/infections
Ear discharge
Poor hearing
Ringing in ears
Nose bleeds
Sinus congestion/infection
Nasal discharge
Sore throat/Tonsillitis
Mouth sore (cold/canker sore)
Gum or dental problems
Silver mercury dental fillings
Grinding teeth
Swollen glands
Frequent colds/flu

Neuropsychological
Sleep disturbances
Poor memory
Numbness or tingling
Depression
Anxiety/Irritability
Seizures
High stress levels
Headache/Migraine
Head injury
Difficulty concentrating
Loss of balance
Eating disorder

Cardiovascular
Blood pressure problems
Chest pain
Previous stroke
Heart disease
Palpitations, flutter, irreg beat
Dizziness/Fainting
Cold hands or feet
Easy bruising/bleeding
Blood clots
Varicose veins
Poor circulation
Swelling of hands/feet
Anemia

Lung Health
Cough
Bronchitis or pneumonia
Asthma
Pain on breathing
Shortness of breath
Positive TB test

Kidneys & Reproduction
Frequent/Painful urination
Inability to control/hold urine
Blood or pus in urine
Bladder or Kidney infection
Kidney stones
Prostate inflammation
Genital lesions
Erectile dysfunction
Infertility

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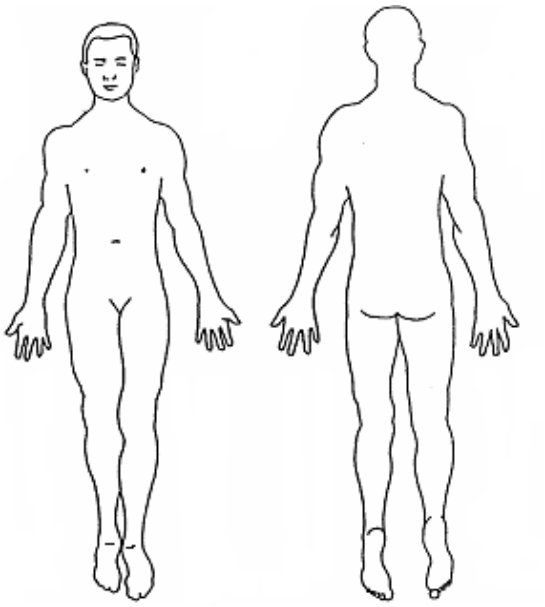
Skin and Hair
Change in mole(s)
Growth(s)
Hives or allergic reaction
Acne or skin eruptions
Itching
Dry skin or dandruff
Eczema
Rashes or infections
Loss of hair
Hair/nail changes

Muscle and Joint
Neck pain
Muscle cramps/spasms
Back pain
Stiffness
Muscle weakness
Fracture/dislocation
Swollen/painful joints
Hernia
Arthritis
Jaw clicking

Please indicate painful or distressed areas:



Please list any other symptoms of concern that you are experiencing or have experienced in the past:
_____
_____

If you are in a clinical trial or experimental protocol, please provide details:
_____

What are your Treatment Goals and Expectations?
_____
_____
_____

Clinical Research
For the purposes of research and continuing education, it is occasionally helpful for practitioners to review case files and to discuss cases with colleagues, or to publish specific information in professional journals where there are important lessons to be learned form a case. I would like to ask your permission to potentially use selected information from this file for such purposes. At all times identifying features will be kept private and no confidential information will be divulged. This is strictly for the purposes of learning and teaching.

Please **initial** whether or not you give permission. To be completed by parent/guardian if under 18 years of age.
__ I give my permission for selected information in this file to be used for continuing learning purposes.
__ I do not give my permission for selected information in this file to be used for continuing learning purposes.

Thank you very much for taking the time to complete this form. It will greatly assist in the formulation of a treatment protocol specific to your healthcare needs.

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Naturopathic Patient Disclosure & Informed Consent

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors (NDs) assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are used in order to stimulate the body's inherent healing capacity. Your ND will take a thorough case history and conduct a screening physical examination as needed. This may include a breast, gynecological, rectal, or prostate exam, as well as taking blood, saliva and urine samples as required. Treatment may involve such interventions as botanical medicine, traditional Chinese medicine and acupuncture, bony manipulations, massage, supplementation, naturopathic injections, hydrotherapy, nutritional and lifestyle counseling, laser or PEMT treatment for pain, psychological counseling, homeopathy, and medication prescription.

I understand that I must inform the ND immediately of any disease process that I may be suffering from or have suffered from, if I am on any medication or over the counter drugs, if I am pregnant, suspect I may be pregnant or breast feeding.

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. 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 unless law requires it. I understand that the physicians at this clinic are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. 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 fees are payable at the time of appointment, including fees for services, prescriptions, and laboratory tests. I understand that 48 hours' notice is required for appointment cancellation; otherwise, I will be responsible for the cancellation fee.

In the event that your appointment is Telemedicine using audio and/or video, signing this consent form provides the clinic with your permission to communicate with you via telemedicine. If you choose to communicate with Dr. Jennifer Brix using telemedicine, you should be aware that:

- it may not be secure. The clinic cannot guarantee the security of any information given over telemedicine.
- there may be technical difficulties such as low/no WIFI connection, delay in sound or video, and potentially minor delays relating to the above.

I understand that I can change my consent to telemedicine at any time. I understand that I may need to confirm my identity during telemedicine appointment(s) by stating my personal health number, or visually showing my photo identification, or I agree that Brix Wellness Centre stores an up-to-date photograph of me, and of my choice, to confirm my identity during a video telemedicine appointment.

I understand that the results are not guaranteed. I do not expect the ND will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

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

I understand that if I am a minor (under the age of 19) a parent or legal guardian must give their consent for treatment.

Patient Signature	Date (mm/dd/yyyy)
Signature of parent or guardian	Name of Guardian if patient is a minor