



New Patient Intake Form - Adult

Welcome! Please complete this questionnaire as thoroughly and clearly as possible. Mark anything you don't understand with a question mark. All information contained in these pages is completely confidential.

Name _____ Today's Date _____

Age _____ Date of birth _____ Gender M / F

Home Phone _____ Work or Mobile _____

Address _____

City _____ Province BC _____ Postal Code _____

Email address _____

Check: Married _____ Separated/Divorced _____ Widowed _____ Single _____ Partnership _____

Live with: Spouse/Partner _____ Parents _____ Children (#) _____ Friend _____ Alone _____

Occupation _____ Hours per week _____

Emergency Contact: Name _____

Relationship & Phone Number _____

Referred by/How did you hear about our office? _____

What expectation/goal(s) do you have for this visit?

What long-term expectations do you have for working with Dr. Wiens?

Allergies/Intolerances

Are you hypersensitive or allergic to...Any drugs? _____

Any foods? _____

Any environmental (pollens/pets) or chemical sensitivities? _____

Do you have any known contagious diseases at this time? Y / N

If yes, please list. _____



Other practitioners you are currently seeing or have recently seen (MD, DC, RMT):

Name	Type of Practitioner	Treatment
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

Please list all surgeries/major procedures you've had:

Procedure	Year	Reason

Please list your health concerns **in order of importance**:

Complaint	Since	Possible Cause(s)

Females Only (P = significant past problem)

Age of first menses? _____
 Age of last menses? (if menopausal) _____
 Length of monthly cycle? _____ days
 Duration of menses/bleeding? _____ days
 Date of last PAP exam _____
 Abnormal PAP? Y N P
 Are you sexually active? Y N P
 Are you currently breastfeeding? Y N

Are cycles regular? Y N
 Bleeding between cycles? Y N P
 Number of pregnancies: _____
 Number of live births: _____
 Number of miscarriages: _____
 Number of abortions: _____
 Birth control? Y N P Type? _____

Males Only (P = significant past problem)

Prostate disease? Y N P Testicular pain? Y N P
 Testicular masses? Y N P Discharge or sores? Y N P
 Are you sexually active? Y N P Difficulty urinating? Y N P
 Erection difficulty? Y N P Low sex drive? Y N P



Review of Symptoms *please circle any present or significant past concerns (mark with P if past)*

Skin Rash, eczema, itching, pigmentation, changes in hair growth, nail changes, cold sores

Head Headaches, vertigo, lightheadedness, injury

Vision vision changes, tearing, blind spots, pain, dry eyes, degeneration

Nose Bleeding, recurrent colds, obstruction, discharge, sinus infections, inhalant allergies

Dental Extensive dental work, gingival bleeding, dentures, root canal

Neck Stiffness, pain, whiplash, masses in thyroid

Cardiovascular Pain/angina, palpitations, hypertension, heart murmurs, varicosities, stroke

Respiratory Pain, shortness of breath, cough, respiratory infections, asthma

Gastrointestinal

Low appetite, indigestion, abdominal pain, heartburn, burping, nausea, vomiting, constipation, diarrhea, abnormal stools, flatulence, hemorrhoids, hepatitis, parasites, gallstones, bloating

Genitourinary Urgency, frequency, unusual color of urine, KI stones, infections, discharge

Musculoskeletal Joint pain, swelling, decreased motion, weakness, cramps

Neurologic/Psychiatric

Convulsions, paralysis, tremor, incoordination, numbness, difficulties with memory, anxiety, depression, previous psychiatric care, OCD, bipolar

General Anemia, bleeding tendency, intolerance to heat or cold, night sweats, diabetes, cancer

Any other conditions not listed above?

Family History (Please check all that apply)

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer type: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Eczema/skin diseases | |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid disease | |

Any other relevant family history? _____

Current Medications

Please list everything you are currently taking (Prescription, over the counter, supplements, vitamins, minerals).

Medication/supplement	Since	Dose & Reason



Physical Exam Questions

Height: _____ Weight: _____ Weight 1 year ago: _____
Highest weight? _____ When _____
When was the last time you had a complete physical exam? _____

Typical Food Intake

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Liquids/Drinks _____

Do you eat three meals a day? Y / N Drink coffee? Y / N How often do you eat out? _____

Do you know your blood type? A / B / O / AB

Lifestyle questions

Interests and hobbies _____

Exercise type: _____ How often _____

Please indicate using a Y, N, or amount as applicable:

Average 7-9 hours of sleep? _____ Sleep well? _____

Enjoy your work? _____ Take vacations? _____ Spend time outside? _____

Have a supportive relationship? _____ History of physical or emotional abuse? _____

Any major traumas (physical or emotional)? _____ At what age(s)?

How many hours of TV / week? _____ Use recreational drugs in past or present? _____

Drink alcoholic beverages? Y / N How many per week? _____

Use tobacco? Y / N How many per day? _____ Smoked previously? Y / N

Do you have a religious or spiritual practice, and what is it? _____

Is there anything else you would like to add that might be relevant to your health care?

**Thank you for your time and effort.
We look forward to providing you with the best possible care.**



Informed Consent for Naturopathic Treatment

Naturopathic treatment may include the following modalities:

- Botanical medicine
- Hydrotherapy
- Clinical nutrition
- Homeopathy & Bach Flower Essences
- Lifestyle and Psychological counselling
- Traditional Chinese Medicine (TCM) including acupuncture and eastern herbs
- Physical treatments such as Chiropractic style adjustments, Bowen therapy, muscle energy technique, massage, Craniosacral therapy or joint play.
- Prescription Medicine

The following diagnostic procedures may be used:

- Physical exam including ears, eyes, respiratory, cardiac, abdominal, lymph, nervous systems.
- Orthopedic assessment of spine and other joints.
- TCM pulse and tongue diagnosis
- In office testing such as urinalysis or blood glucose via fingerstick
- Specimen collection using saliva, urine, stool, or blood to be sent to external labs.
- Breast, gynecological, genital, rectal, or prostate exams as necessary

Even the gentlest therapies may cause complications in certain physiological conditions, such as pregnancy, lactation, very young children, or those taking multiple medications. Some therapies must be used with caution in certain diseases including but not limited to diabetes, heart, liver and kidney disease. Fully inform the doctor of your current condition.

There are some slight health risks associated with Naturopathic Medicine, including but not limited to:

1. Aggravation of pre-existing symptoms
2. Allergic reactions to supplements or herbs
3. Pain, possible bruising or injury from venipuncture, fingerstick or acupuncture
4. Muscle or joint pain from alignment techniques.

All payments are due when services are rendered.

Please ensure that you give 24 hours notice to change or cancel appointments to avoid a missed appointment fee.

I _____ hereby authorize Dr. Jese Wiens to perform specific procedures as deemed necessary to facilitate my diagnosis and treatment. I understand that I am free to withdraw my consent and discontinue my treatment at anytime. I understand that Dr. Wiens will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications.

Signature _____ (parent/guardian if under 18) **Date:** _____