KIANI Naturopathic Clinic

Core Link Wellness Centre
2238 Caroline St., Burlington ON L7R 1M5
Tel: 905. 592.0095 Fax. 905.592.0106

New Adult Intake Form – History of Cancer

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care.

Name:_____ Today's Date:_____

Age:_____ Date of Birth (m/d/y):_____

Address:_____City:_____

Province:_____ Postal Code:_____

Phone:H:(_____)_____C: (_____)_____W(_____)_____

May we leave voicemails at the above phone numbers? If so, select which ones. □ Home □ Cell □ Work

Email address:_____

Occupation:_____Employer:_____

Gender: _____ Marital Status : _____

Do you have a health benefit plan? □Yes □No If Yes which company? _____

Emergency Contact:

Name:_____

Relationship: _____ Phone: (_____)_____

Where did you learn about this clinic?

□ Google
□ OAND/CAND
□ Seminar
□ Social Media
□ Other
□ Referral from: _____

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Please complete this to the best of your knowledge:

Cancer Type/Stage:_____
Date of Diagnosis:_____
Any Metastasis? Where? _____

******It will be of great assistance if you bring copies or original reports from diagnostic tests you have had i.e. biopsy report, CT, MRI, etc. You may also ask your doctors to fax them directly to us at (905)592-0106***

Health Priorities/ Chief Concerns
List your main health priorties/concerns in order of importance

1. _____

2. _____

3. _____

For the purposes of integrating your care and communicating with other healthcare practitioners, please list name of treating your treating doctors. ***We will not contact your doctors without your consent.***

	Name	Address and/or Location and/or Phone number	Permission to Contact	
Family Physician			Yes □	No □
Medical Oncologist			Yes □	No □
Surgeon			Yes □	No □
Radiation Oncologist			Yes □	No □
Other:			Yes □	No □

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Please list dates of your cancer surgeries:

Date of Surgery	Purpose of Surgery	Complications

Please list dates for your radiation therapy:

Site of Radiation	Start Date	End Date	Complications

Please list the dates and type of chemotherapy received:

Type of Chemotherapy	Start Date	End Date	Complications

Other than the cancer diagnosis, please list any other medical conditions, illnesses, surgeries, complications, or reasons for past hospitalizations

Other Medical Conditions	Date of Diagnosis	Is the condition still present?	Symptoms or Complications

Please list all ***current*** medications/supplements

Medications/Supplements	Dose	Prescribing Physician	Length of use

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Please list all *significant previous* medications/supplements you were on in the last 5 years

Medications/Supplements	Dose	Prescribing Physician	Length of use

Please indicate any allergies and/or food sensitivities

Allergy/Food sensitivity	Symptoms

Have you ever been infected with a Methicillin Resistant Organism (including MRSA)? _____

Have you had any adverse reactions to an antibiotics? _____

Have you had any adverse reactions from any vaccinations? _____

Do you use any of the following?

Type	Circle one	How much/How often/Form
Alcohol	Yes No	
Tobacco	Yes No	
Caffeine	Yes No	
Recreational Drugs	Yes No	
Aspirin	Yes No	
Laxatives	Yes No	
Antacids	Yes No	
Diet pills	Yes No	
Birth control	Yes No	

Please indicate which of the following screening tests do you receive (if known)

Test	Circle one	How often/Recent date
Breast exam	Yes No Never	
Mammogram	Yes No Never	
Bone Density scan	Yes No Never	
PAP test (women)	Yes No Never	
Digital rectal exam (men)	Yes No Never	
PSA (men)	Yes No Never	
Cholesterol	Yes No Never	
Blood Glucose	Yes No Never	
Other (X-Ray, ultrasound, EEG, ECG, CT scan, MRI etc.)	Yes No Never	

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Family History:

Indicate if any family member has had any of the following

Illness	Circle one	Family Member
Allergies	Yes No	
Asthma	Yes No	
Diabetes	Yes No	
Heart Disease	Yes No	
High Blood Pressure	Yes No	
Kidney Disease	Yes No	
Cancer	Yes No	
Depression	Yes No	
Other mental illness	Yes No	
Infertility	Yes No	
Other	Yes No	

Lifestyle:

Do you exercise?_____ How often? _____

Have you recently had a change in weight? □ Yes □ No If Yes, how much? _____↑ or ↓

Hobbies: _____

Is there anything that you feel is important that has not been covered?

_____

_____

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Review of Symptoms

	Current	Previous
General Symptoms		
Loss of consciousness	□	□
Numbness / tingling	□	□
Fever	□	□
Sweats	□	□
Fainting	□	□
Dizziness	□	□
Loss of sleep	□	□
Frequent colds / flus	□	□
Loss of weight	□	□
Head / Neck		
Headaches	□	□
Type _____		
Vision problems	□	□
TMJ concerns	□	□
Earaches	□	□
Decreased hearing	□	□
Sinus problems	□	□
Difficulty swallowing	□	□
Skin		
Rashes / Eczema	□	□
Itching	□	□
Bruise easily	□	□
Dryness	□	□
Boils / Hives	□	□
Contagious disease	□	□
Respiratory		
Chronic cough	□	□
Shortness of breath	□	□
Smoking	□	□
Breathing problems	□	□
Asthma / Bronchitis	□	□

	Current	Previous
Cardiovascular		
High blood pressure	□	□
Low blood pressure	□	□
Bleeding disorders	□	□
Chest pain	□	□
Stroke	□	□
Artery hardening	□	□
Varicose veins	□	□
Swelling of ankles	□	□
Poor circulation	□	□
Angina	□	□
Heart disease	□	□
Genitorurinary		
Trouble urinating	□	□
Blood in the urine	□	□
Kidney infections	□	□
Bed wetting	□	□
Prostate trouble	□	□
Gastrointestional		
Poor digestion	□	□
Indigestion	□	□
Excessive hunger	□	□
Belching or gas	□	□
Nausea / Vomiting	□	□
Abdominal pain	□	□
Constipation	□	□
Diarrhea	□	□
Hemorrhoids	□	□
Liver concerns	□	□
Gall bladder trouble	□	□
Bladder concerns	□	□
Ulcer	□	□
Diabetes	□	□

	Current	Previous
Infections / Illnesses		
Herpes	□	□
Hepatitis	□	□
Plantar warts	□	□
TB	□	□
HIV / AIDs	□	□
Cancer	□	□
Allergies	□	□
Muscles and Joints		
Stiff neck	□	□
Backache	□	□
Swollen joints	□	□
Painful tail bone	□	□
Foot trouble L / R	□	□
Shoulder pain L / R	□	□
Elbow pain L / R	□	□
Wrist pain L / R	□	□
Hip pain L / R	□	□
Knee pain L / R	□	□
Arthritis	□	□
Weakness/loss strength		□
Women's Health		
Painful menstruation	□	□
Excessive flow	□	□
Irregular cycle	□	□
Hot flushes	□	□
Cramps or backache	□	□
Vaginal discharge	□	□
Swollen breasts	□	□
Lumps in the breast	□	□
Are you pregnant Yes □ No □		
On birth control Yes □ No □		
# of pregnancies _____		
# of children _____		

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PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.
Our privacy policy states that: only necessary information is collected about you; storage, retention and destruction of your personal information complies with existing legislation and the privacy protection protocols of our regulatory body, the College of Naturopaths of Ontario.

This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns, provide health care, and advise you of treatment options
- To establish and maintain contact with you and follow-up with you for appointments
- To invoice goods and services, process payments including necessary credit card information and complete claims for insurance purposes when indicated
- To send you newsletters and other clinic updates as per your preference
- To communicate with other treating health-care providers when necessary with your consent
- To allow potential purchasers, practice brokers or advisors to conduct an audit

INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES

I, _____ acknowledge that I will be informed of the recommended therapeutic procedure(s)/ plan and will discuss any questions or concerns that may come up with the naturopathic doctor named below. I further acknowledge and confirm that I will be informed of and understand the therapeutic procedure(s)/plan with respect to the financial costs, expected benefits, potential risks and side effects, consequences of not having/following the procedure(s)/plan, and what alternative course(s) of action are available to me. As a result I do hereby voluntarily give my informed consent for the recommended therapeutic procedure(s)/plan and understand that I can change the status of my voluntary consent at any time.

PATIENT CONSENT

I have read and understand this form and consent to therapeutic care with a Naturopathic Doctor and the disclosure of my personal information as outlined above.

Signature_____ Print Name_____
Date _____Witness _____
Attending Naturopathic Doctor_____

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7 Day Diet Diary

Name: _____
Date:_____

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Breakfast							
Lunch							
Dinner							
Snacks							
Fluids							
Comments							