328 10 Street N.W.
Calgary, AB T2N 1V8
(403) 237-6866
www.effectivehealth.ca

Intake Form for Men

Name ____ Date ___________________

Age ________ Birthdate ______________________ Blood type _________

Address ________________________________ City/Province ___________________ Postal Code ________

Phone (work) _____________________________ daytime or evening? (home)__________________________

Fax ____________________________________ E-mail address____________________________________

If we need to contact you, messages can be left at *(check all that apply)*: ڤ work ☐ home ڤ e-mail

Would you like to receive our clinic newsletter via e-mail? (*yes/no*)

Occupation ________________________________ (full/part time?) Employer ___________________________

Nearest Relative ____ Phone _____________________

what is his/her relationship to you

Who else can we reach in case of emergency?____________________________ Phone __________________

what is his/her relationship to you

How did you hear about my office? ____

If referred, please give us name of referee (so we can thank them)_______________________________________

Last physician or health practitioner seen? ________________________ When? ________________________

When was your last blood test? _______________________ What kind? _______________________________

Your Current Health Concerns

What is your **main** reason for coming in today? If you have a specific health condition, please describe in detail. When was the very first time you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation.

____
____
____

What are you willing to do to change this situation? ____

How long are you willing to work at it? ____

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List in order of importance other health concerns that are troubling you:

1. ______________________________ & length of time ______________
2. ______________________________ & length of time ______________
3. ______________________________ & length of time ______________
4. ______________________________ & length of time ______________
5. ______________________________ & length of time ______________
6. ______________________________ & length of time ______________

Other problems: ____
How long has your main concern been troubling you? ____
Is your current "main problem" getting *(better, worse, same)* and for how long?_________________________
What kind of treatment have you received and from whom? ______________________________________
____
Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current main health concern? *(yes/no)* or for any problem? *(yes/no)*
What was the therapy and what were the results?____
____

Your Health History

The general state of your health is (check one): excellent _____ good ____ avg ____ fair ____ poor ____
and on average, your energy level is best described on a scale of 1 to 10 (10 is highest, 1 is lowest) as ________
When during the day is your energy best?________________________________ worst? _______________________

What is your current approximate weight? ______ One year ago?_____ Ideal weight? _____ Height? ________

As an adult what has been your maximum ____________and minimum weight (excluding pregnancy)____________

Please list the 5 most significant stressful events in your life, from the most recent to the most distant

1. ____ Date ______________________________
2. ____ Date ______________________________
3. ____ Date ______________________________
4. ____ Date ______________________________
5. ____ Date ______________________________

Are any of these situations continuing to impact your life? *(yes/no) Please circle number*
Are you currently working with a professional counsellor, psychologist, social worker, pastor or other therapist? ________
Have you in the past?__________ If so, when? (please give dates)____
Are you currently working with a Doctor of conventional medicine (M.D.)? *(yes/no)* If so, whom? ___________________
Which of the following illnesses have you had? *Please indicate "n" for now or "p" for past*

	N	P		N	P		N	P		N	P
Allergies			Weight problems			Stroke			Venereal disease		
Asthma			Gallstones			Cancer			Syphilis		
Eczema			Gout			Epilepsy			Gonorrhea		
Psoriasis			Arthritis			Migraine			HIV		
Ear infections			Thyroid problems			Pneumonia			Varicose veins		
Strep throat			Anemia			Diabetes			Broken bones		
Hay fever			High blood press.			Malaria			Numbness/tingling		

Measles			Rheumatic fever			Tuberculosis			Cold hands/feet		
Mumps			Fainting			Small pox			Visual problems		
Chicken pox			Poor memory			Polio			Miscarriage		
Whooping cough			Balance problems			Gas/bloating			Mono		
Diphtheria			Speech problems			Hemorrhoids			Depression		
Scarlet fever			Ringing in ears			Parasites			Child abuse		
Sinusitis			Jaundice			Rectal bleeding			Physical abuse		
Canker sores			Hepatitis			Herpes			Sexual abuse		
Acne			Heart disease			Headaches			Emotional abuse		
Tonsillitis			Alcoholism			Warts			Rape		

Other: ____

Are there any of these from which you feel you have never been well since?______________________

Previous surgeries and hospitalizations (please give dates____

____

Have you had any major injuries? If so, what happened and when? ___________________________________

____

Do you have any allergies to any drugs, herbs, foods, animals or other? *(yes/no)* If so, what? ________________

Which of the following do you currently use?

	Amount (how often, how much & how long)		Amount (how often, how much & how long)
alcohol		tobacco	
hormones		coffee	
cortisone		laxatives	
sedatives		antacids	

other medications (please give full name and dosage and how long you have been taking the medication)

________________________/ ________________________ /________________________

________________________/ ________________________ /________________________

________________________/ ________________________ /________________________

________________________/ ________________________ /________________________

vitamins/herbs : ______________________________ / ___________________________ / ____________________

_________________________________/ ______________________________ /___________________________

_________________________________/ ______________________________ /___________________________

_________________________________/ ______________________________ /___________________________

Family History

Please indicate which of the following is found in your family with date of diagnosis if possible.

	Mother	Father	Sister/Brother	Grandparents
Cancer				
Tuberculosis				
Heart Disease				
Arthritis				
Diabetes				
High blood				
Asthma				
Kidney disease				
Depression				
Anemia				
Stroke				
Heart attack				
Ulcers				
Other				

When did you last use antibiotics? ______________________________________

Were you vaccinated? *(yes/no)* Did you have any adverse reactions (e.g. fever)? *(yes/no)*

Your currently live with? spouse ___ partner ___ parents ___ friends ___ children ___ alone ___

Are you? married ___ separated ___ divorced ___ widowed ___ single ___ in a supportive relationship ___

What is your current level of education? _____________________________ Are you satisfied with this? *(yes/no)*

Do you have any children? *(yes/no)* If so, how many? ______

Do they have any health problems?____

What is your weakest organ system and why? ____

____

Kidneys and Bladder

How much water do you drink daily? __________________________________

Have you had recurrent bladder infections? *(yes/no)* How were they treated? ______________________

How many bladder infections have you had in the last 3 years? _________________________________

Do you have any burning sensation during or after urination? *(yes/no, past or present)*

Is your urine *(dark yellow, bright yellow, cloudy, pale or clear)*?

Does your urine have a strong odor to it? *(yes/no)*

Do you have difficulty starting or stopping when urinating? *(yes/no)*

Do you have difficulty perspiring? *(yes/no)* Do you perspire when you exercise? *(lightly, moderately, heavily)*

Do you perspire at times other than when exercising? *(yes/no)* If yes, when? _______________

Does your perspiration have a strong smell? *(yes/no)*

Digestion and Elimination

Do you have any problems with gas, bloating or fullness after eating? (*yes/no*)

If so, how often? (*often, sometimes, never*) How severe? __________

Do you have gas in (*the upper part of the abdomen, the lower part, or both*)? How long have you had this problem? _________________________ How often do you have bowel movements? _____________________

Do you ever have any (*blood, mucus, undigested food, black*) stools? Any rectal itching? (*yes/no*)

Do your stools tend to be (*formed or loose*)? How often do you have diarrhea? ________________

Do you ever have alternating constipation and diarrhea? (*yes/no*)

Do you ever have yellow or light colored stools? (*often, sometimes, never*)

How often do your stools have a strong disagreeable odor? (*often, sometimes, never*)

Have you ever fasted? (*yes/no, juice or water*) If yes, how long have you fasted? __________________

How did you feel while you were fasting? ____

Have you traveled outside Canada in the last 5 years? (*yes/no*) If yes, where did you go? _____________

Reproductive Health

Are you currently sexually active? (*yes/no*) How often? _________Is this (*more or less*) than 1 year ago?

Sexual preference: Heterosexual _____ Bisexual _____ Homosexual ______ Transexual _____

Do you use birth control? (*yes/no*) What type of birth control do you currently use? _________________

How often do you get up at night to urinate? ____ Is this an increase in past few years? (*yes/no*)

Any problems with impotency (getting or maintaining an erection)? (*yes/no*)

Do you have any sores on penis? (*yes/no*) ____

Do you have any abnormal discharge from the penis? (*yes/no*)

Any prostate problems? (*yes/no*) Ever have your prostate examined? (*yes/no*) When? _______________

Personal Habits

What do enjoy most in your life? ____

Please rate your satisfaction with the following areas of your life on a scale of 1 to 10: (10 is highest, 1 is lowest)

Fun & recreation ______ Personal growth _____ Significant other/romance _____ Friends & Family ______

Health ______ Money ______ Physical Environment _____ Career _____

What are your main interests or hobbies? ____

What do you worry most about in your life? ____

Do you have any dietary restrictions? *(yes/no)* If yes, what? ____

Do you exercise? *(yes/no)* If yes, what kind, how much & how often? ___________________________________

Do you have a religious or spiritual practice? *(yes/no)* If yes, what? _____________________________________

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) ________

Do you have problems *(falling or staying)* asleep? _____ How many hours do you sleep at night? _____

Do you awaken at night? *(yes/no)* If yes, at what time(s) do you usually wake up? __________________

Do you ever sweat at night while sleeping? *(yes/no)* How frequently and how much do you sweat? ____
Do you wake up feeling refreshed? *(yes/no)* Do you nap or rest horizontally throughout the day? *(yes/no)*
If yes, how long and at what time usually? ____
What do you normally feel like temperature wise, compared to others? *(warmer, cooler, or average)*
What are the temperatures of your hands and feet generally? *(warmer, cooler, or average)*
Do you enjoy your work? *(yes/no)* Do you take vacations? *(yes/no)*
Are you currently in a happy satisfying relationship with someone? *(very, mostly, somewhat, not)*
How often do you get colds, flus, sore throat, yeast infections during the year? __________________
When you rise quickly from a sitting or lying position do you ever get dizzy? *(yes/no)*
If yes, how often? (daily, few times per week, once a week, twice a month, once a month, rarely)
How do you learn best? *I read* *I listen (lectures)* *Television* *Through stories* *Very visual*

Occupational/Household

How long have your lived at your present address? ____________________ Where have you lived previously?
(please describe location, if old or new place, if damp, moldy, etc.) ____________________________________
Do you have specialized air filtration at home? *(yes/no)* Do you live in a city? *(yes/no)*
Do you work in an office building? *(yes/no)* Do the windows open? *(yes/no)*
Do you have specialized air filtration at your work place? *(yes/no)*
Do you work in the presence of toxic fumes or chemicals? *(yes/no)*
Do any of your hobbies involve toxic materials? *(yes/no)*
Do you smoke? *(yes/no)* If yes, what and how much and how often? _______________________________
Are you currently exposed to second hand smoke? *(yes/no)*
What do you use for your drinking water? *(bottled, filtered, or tap water)*

Is there anything else you feel I should know about you?______________________________________
____
____
____
____
____
____

Thank you for taking the time to fill in this lengthy questionnaire.

It will be a valuable resource in assessing your health.

CARE AGREEMENT

Naturopathic medicine uses non-invasive methods for the assessment of bodily dysfunction and natural therapeutics for correction. The methods used in this clinic for assessment and therapeutics include clinical nutrition, homeopathy, botanical medicine, hydrotherapy, detoxification, acupuncture and lifestyle counseling.

Each person must sign this document before any treatment is rendered.

My signature acknowledges that:

1) I have been informed of and I understand that:

   i) The treatments that I receive at this office are different from those usually offered by a medical doctor or other licensed health care practitioner.

   ii) I understand that I am at liberty to seek or continue to seek medical care from a physician or surgeon or other licensed health care provider.

   iii) I confirm that Tasleem Kassam, N.D. nor anyone else has suggested that or recommended that I refrain from seeking or following the advice of another licensed health care provider.

2) I declare that I authorize and consent to treatment. I further understand and am informed that, as in all health care, in the practice of naturopathy, there are some very slight risks to treatment. I do not expect the doctor(s) to be able to anticipate and explain all the risks and complications; I wish to rely on the doctor's judgment during the course of treatment, based upon the facts then known, is in my best interest.

3) I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Therefore, all services rendered to me are charged to me directly and that I am personally responsible for payment. I am aware that these fees are not covered by provincial health care plans. I also understand that if I suspend or terminate my naturopathic care, any outstanding charges for consultation, labwork, supplements or other incidental fees arising from my treatment will be immediately due and payable.

Patient's Name: ____

Patient's signature X ______________________________ **Date** _________________________

OR

Guardian's signature X __________________________ Date_________________________