Julie McKeen B.Sc., ND
Doctor of Naturopathic Medicine
781 Prospect Street
Fredericton NB

Adult Intake

Please complete this form. All information that you disclose is confidential and will not be released without your permission.

Completed forms may be emailed to juliemckeen.nd@gmail.com or brought with you on your first visit. Please being copies of current tests and blood work.

Name:_______________________________________ **Date:** ____________________

Date of birth: ___/___/___ **Age:** _____

Address: _______________________________________

____

____

Phone (Home): _______________ (**Work**): _______________ Email:_____________

Occupation: _________________

May we leave messages relating to your visits? Y / N

How did you hear about our Clinic: ____

Other health care providers you are seeing:

1. ____________________ **2.**______________________ **3.**______________________

______________________ ______________________ ____________________

(_________)_____________ (_________)_____________ (_________)_____________

HEALTH PRIORITIES AND CHIEF CONCERNS

Complaint	Since	Possible Cause(s)

HEALTH HISTORY

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, hospitalizations, or surgery.

Condition/Surgery	Date	Complications/ Long Term Effects

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics)

Medication/Vitamin	Since	Reason	Complications/ Side effects

Please list any previous medications / vitamins taken for more than 3 months.

Medication/Vitamin	Since	Reason	Complications/ Side effects

Were you ever on antibiotics for an extended period of time? Please explain when and for how long.____

ALLERGIES AND/OR SENSITIVITIES (FOOD, DRUG, ENVIRONMENTAL)

Allergy	Details of Reaction

Do you get regular screening tests done by your family physician? (PAP, blood test, etc.) YES NO

Date of last physical exam:

Immunizations up to date? Y/N   Adverse reactions to vaccines? ________________

Please inform your Naturopath if any of the following apply to you:

Hemophiliac Y/N
Wear a pacemaker Y/N
Heart Condition Y/N
Asthma Y/N
Surgery Scheduled Y/N
Anticoagulant Medication Y/N
Epilepsy Y/N
Fainting Y/N
Pregnant/Nursing Y/N

HABITS AND LIFESTYLE

Do you use any of the following? Please circle

Aspirin / laxatives / antacids / diet pills / birth control pills or HRT / implants / cortisone /artificial sweetener / alcohol / sweets and candy / excess salt / fried food / processed food

Please outline a typical day's diet:

Breafast	lunch	dinner	snack

Do you have any food allergies/intolerances? _________________________________

How many cups of the following do you drink on an average day?
Water:____ Coffee:_____ Tea:_____ Fruit / Veg juice:____ Soft drinks:_____

Cravings: sugar / chocolate / dairy / salty foods / other:

Do you exercise regularly? Y/N   type: Frequency:

Rate your stress level (circle): Low / Average / High / Unbearable

Which factors most contribute to your stress? Health / Career / Family / Financial / Other:

How do you manage stress? ____

How many hours sleep do you get per night, on average? _____ Do you sleep well? Y/N
Do wake up feeling well-rested? Y/N

Are you exposed to significant tobacco smoke? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

Are you regularly exposed to toxic chemicals, solvents, sprays, pesticides, heavy metals (lead, mercury, cadmium, arsenic) at work, home, or traveling? Please describe.

FAMILY MEDICAL HISTORY

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		**Who?**
Allergies		**Depression**	
Asthma		**Cancer**	
Heart disease		**High Cholesterol**	
High blood pressure		**Stroke**	
Liver or kidney disease		**Other significant illness**	
Diabetes			

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

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108 Queen St, Fredericton, NB

INFORMED CONSENT

I would like to take this opportunity to welcome you to my practice. I utilize the principles and practices of Naturopathic Medicine and other supportive therapies to assist your body's own ability to heal and to improve the quality of life and health through natural means.

During your visit I will conduct a thorough case history. Sometimes a physical exam and specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. Privacy and confidentiality of your personal information is an important part of our office. Any personal information or records collected during your visits will not be released without your consent unless required by law.

Statement of Acknowledgement

Printed name ___________________________________

As a patient of this clinic I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in those individuals on multiple medications; therefore, the information I provide is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; and pain, fainting, or bruising from venipuncture or acupuncture.
I accept full responsibility for any fees incurred during care and treatment.

___________________________	________________	____________________
SIGNATURE	DATE	WITNESS