Lia Sonnenburg
Doctor of Naturopathic Medicine

ADULT INTAKE FORM

First Name:_____ Last name:_____ Gender: M / F

Address:_____ City:_____ Postal Code:_____

Please list only the numbers where you would like to be contacted:

Phone (Home):_____ Phone (Work):_____

Email:_____ Cell Phone:_____

Date of Birth: _____ Age:_____ Occupation:_____

Marital Status:_____ Number in Household?

_____ Emergency Contact:_____

Phone:_____

Other health care providers:

Name:_____ Designation:_____ Phone:_____

Name:_____ Designation:_____ Phone:_____

Name:_____ Designation:_____ Phone:_____

How did you hear about our Naturopathic medical services? _____

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN SECURE ELECTRONIC FORM. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON, EXCEPT FOLLOWING YOUR WRITTEN AUTHORIZATION. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

What is the chief health concern(s) that brings you to us?

_____

_____

Please list any other health concerns (physical, emotional and/or mental) that you would like to address, duration of the concern (i.e. how long you have had the concern), and who made the diagnoses:

1.

_____

2. _____

3.

_____

4. _____

5. _____

What specialists have you seen? (Indicate the year of consultation, if possible)

_____

_____

If you are female, are you currently pregnant? YES NO

MEDICATIONS:

Please list all **CURRENT prescribed medications you are taking**. Indicate the name of the drug, dosage, duration of use, and reason for use:

_____

_____

_____

Please list all **PAST prescribed medications that you have taken for longer than 3 months**:

_____

_____

_____

Have you ever had an adverse reaction to any medication? Indicate the drug name and reaction experienced:

_____

How many times have you been treated with antibiotics in the past 5 years? _____

Please list any **over the counter medications you are presently taking** (e.g. Aspirin, Tums) **and the frequency of use:**

_____

_____

Please list any **vitamins/minerals, herbs or homeopathic remedies that you take on a regular basis**:

_____

_____

FAMILY MEDICAL HISTORY:

Relation	Age	Health problems	Cause, if deceased
Father			
Mother			
Grandparents			
Siblings			
Children			

MEDICAL HISTORY:

Date of last physical exam: _____
Reason for the exam? _____

Do you have regular SCREENING TESTS done by another doctor? (Pap, blood tests, etc.) YES NO
Please list: _____

Blood Type (circle one, if known): A B AB O Negative Positive

PERSONAL HEALTH HABITS:

Height:_____ Current weight: _____ Weight 1 year ago: _____ Max weight:_____ Year:_____

Smoker? YES NO Amount/day?_____# Years smoked?_____ Year stopped? _____

Are you exposed to second hand smoke? YES NO Where? _____

Alcohol use? YES NO Type: _____ Frequency: _____

Recreational drug use? YES NO Type: _____ Frequency: _____

Caffeine use (coffee, tea, pop)? YES NO Type: _____ Frequency: _____

Amount of fluids/day: _____ Amount of water/day: _____

Are there any food groups that you avoid? YES NO If yes, please list what and why

_____

_____

Please list any foods that you crave: _____

How many meals do you eat in a day? 1 2 3 4 More than 4

Are you frequently exposed to animals? YES NO Type? _____

Are you regularly exposed to toxins or other hazards? YES NO Kind?_____
_____

List all known allergies (food, environmental, seasonal, etc.):
_____
_____
_____

Please describe a typical day's diet:
Breakfast_____
Lunch_____
Dinner_____
Snacks, including drinks _____

Do you exercise regularly? YES NO Type: _____ Frequency: _____

How many hours of sleep do you get per night? _____ Do you wake rested? YES NO

Do you have problems falling or staying asleep? _____

How many hours do you work each day? _____ Is it shift work? YES NO

Please rate your satisfaction with each of the following areas of your life: (4 = highest satisfaction)

HEALTH	0	1	2	3	4
DIET	0	1	2	3	4
LIFESTYLE	0	1	2	3	4
WORK	0	1	2	3	4
FAMILY	0	1	2	3	4
RELATIONSHIPS	0	1	2	3	4

Rate your stress level: Low Average High Very high Unbearable

What areas of your life contribute the most to your stress (please circle)?
Work Health Family Money Marriage Other: _____

What do you do to deal with stress? _____

When was your last vacation? _____ How often do you take a vacation? _____

CHRONOLOGICAL HEALTH HISTORY:

This portion of the health history helps to establish patterns in your life that may be relevant to your present health concerns. Please indicate any accidents, broken bones, falls, illnesses, hospitalizations, surgeries, and/or any emotional stresses or traumas (deaths, loss of job, divorce, etc.)

Age 0-4 _____
Age 5-9 _____
Age 10-15 _____
Age 16-20 _____
Age 21-25 _____
Age 26-30 _____
Age 31-35 _____
Age 36-40 _____
Age 41-45 _____
Age 46-50 _____
Age 51-55 _____
Age 56-60 _____
Age 61-65 _____
Age 66-70 _____
Age 71 + _____

What are your short-term health goals? _____
_____

What are your long-term health goals? _____
_____

Please list any other relevant health/ personal information that you feel is missing: _____

INFORMED CONSENT

I would like to take this opportunity to welcome you to the services of Lia Sonnenburg, Naturopathic Doctor. This practice utilizes the principles of Naturopathic Medicine to assist the body's own ability to heal and thrive. A number of different approaches may used: Clinical nutrition and nutritional supplements, Botanical Medicine, Homeopathy, Traditional Chinese Medicine and Acupuncture, Physical Medicine and Lifestyle Counseling.

A thorough case history will be conducted by Lia Sonnenburg, ND including a complaint-oriented physical exam and any pertinent laboratory reports may be requested/used as part of the treatment work-up (as deemed necessary after a comprehensive intake).

Statement of Acknowledgement

Printed name _____

As a patient of this clinic, I understand that the form of medical care is based on Naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies have potential complications in conditions such as diabetes, heart, liver or kidney disease, during pregnancy and lactation, in children and while using other conventional/prescribed medications. Therefore, it is very important that the information provided is complete and inclusive of all health concerns including risk of pregnancy and all medications being used simultaneously, including prescribed medications, over the counter drugs, herbs and nutritional supplements. The slight health risks of some Naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms or conditions, allergic reaction to supplements or herbs and pain, fainting, bruising or injury from acupuncture.

As a patient of Lia Sonnenburg, ND, I am at liberty to seek or continue medical care from a medical doctor or other health care provider licensed to practice in Ontario. This consent form is intended to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that results are not guaranteed. I understand that treatment advice will not be given over the phone or via e-mail unless directly relating to specifics discussed during a clinic visit. I accept full responsibility for any fees incurred during care and treatment. I also understand that the Cancellation policy requires me to cancel and/or reschedule a booked appointment 24 hours prior to a given, scheduled appointment. Failure to do so will incur a charge of 50% of the scheduled office visit fee that must be paid prior to the next visit.

_____ _____ _____

SIGNATURE DATE WITNESS