Date:_____

Dr. Alan Cranton D.C., N.D.
Practice of Chiropractic & Naturopathic Medicine
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# Naturopathic Adult Intake Form

## Personal Information

Patient's Name:_____ Sex: Male___Female___

Date of Birth: _____ Place of Birth (country): _____

Religion (Optional): _____ Ethnicity:(Optional) _____

Address: _____City: _____ Province:_____ Postal Code:_____

Phone (home):_____(office): _____ (other):_____

**E-mail Address**:_____

In Case of Emergency, Contact:

Name: _____ Relationship to Patient:_ _____

Address: _____

Phone (home):_____ (office): _____ (other):_____

Other Health Care Providers:

1._____ 2. _____ 3. _____

How were you referred to Dr. Cranton? (eg., friend, family, co-worker)_____

Chief Health Concerns (In order of Importance):

1. _____
2. _____
3. _____
4. _____
5. _____

## Medical History

Height _____ Current weight _____ Any noticeable weight **gain** or **loss**? If YES, how much?_____

**Current Medications / Supplements / Herbs / etc:**

_____

_____

_____

_____

_____

Do you frequently use any of the following? (circle)

Aspirin Laxatives Antacids Diet pills Birth control pills / implants / injections

Alcohol – how many drinks per day / week? _____

Caffeine – form and amount per day _____

Recreational drugs – what form and how often? _____

**Relevant Diagnoses** (present and/or past):

- ❑ Acne
- ❑ Alcohol or Drug Addiction
- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes Mellitus
- ❑ Drug Sensitivity
- ❑ Gastrointestinal Disorder
- ❑ Eczema
- ❑ Epilepsy
- ❑ Heart Disease/Defect
- ❑ Hearing Impairment
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Insomnia
- ❑ Kidney Disease
- ❑ Learning Disorder
- ❑ Pre-menstrual syndrome
- ❑ Psoriasis
- ❑ Sinusitis
- ❑ Thyroid Problems
- ❑ Trauma
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Visual Impairment
- ❑ Warts
- ❑ Other:

_____

_____

_____

Past Surgeries / Hospitalizations / Illnesses (include approximate dates):

_____

_____

_____

## Family History

Please List Family Illnesses: ❑ Family History not known

Mother: _____

Father: _____

Sister(s): _____

Brother(s): _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

## Lifestyle Factors

Describe a Typical Day's Diet (including drinks):

. Breakfast: _____

. Mid-Morning Snack: _____

. Lunch: _____

. Afternoon Snack: _____

. Dinner: _____

. Evening Snack: _____

Do You Exercise Regularly? Yes No What Form? _____

Do You Eat Three Meals a Day? Yes No

Do You Average 6-8 Hours of Sleep? Yes No

Do You Enjoy Your Work? Yes No

**Smoking History** Are you a smoker? Yes No

How long have you been smoking? _____ How many cigarettes per day? _____

Are there other people with whom you live that smoke? Yes No ; If YES, who? _____

Have you ever tried to quit smoking before? Yes No ; If YES, how many times? _____

When was the last time you quit smoking? _____

What is the longest period of time that you have gone without smoking? _____

Did you experience any symptoms when you tried to quit smoking? _____

_____

Are you exposed to significant tobacco smoke (work, home, etc.) Yes No

Is There Anything You Feel Is Important That Has Not Been Covered?

_____

_____

## Review of Systems

**Please Check those that Apply (mark with a "✓" for a present condition and a "P" for a past condition):**

*Skin*
- ❑ rashes
- ❑ acne
- ❑ lumps
- ❑ colour change
- ❑ change in mole
- ❑ dryness/moistness
- ❑ itching

*Head*
- ❑ headache
- ❑ head injury
- ❑ dizziness
- ❑ hair loss

*Eyes*
- ❑ impaired vision
- ❑ double vision
- ❑ blurred vision
- ❑ floaters
- ❑ eye pain
- ❑ redness
- ❑ discharge
- ❑ dry eyes
- ❑ blind spot
- ❑ itching
- ❑ glaucoma
- ❑ cataracts

*Ears*
- ❑ impaired hearing
- ❑ ringing in the ears
- ❑ earache
- ❑ discharge
- ❑ hearing aids

*Nose/Sinuses*
- ❑ frequent colds
- ❑ nose bleeds
- ❑ nasal discharge
- ❑ hay fever
- ❑ sinus problems
- ❑ diminished sense of smell

*Mouth/Throat*
- ❑ frequent sore throat
- ❑ sore tongue/mouth
- ❑ gum problems
- ❑ hoarseness
- ❑ dental amalgams/fillings
- ❑ loss of taste

Do you visit your dentist regularly?___

*Neck*
- ❑ lumps
- ❑ swollen glands
- ❑ goiter
- ❑ stiff neck

*Respiratory*
- ❑ cough
- ❑ sputum (discharge)
- ❑ spitting up blood
- ❑ wheezing
- ❑ difficulty breathing
- ❑ pain on breathing
- ❑ shortness of breath (SOB)
- ❑ SOB upon lying down
- ❑ asthma
- ❑ bronchitis
- ❑ pneumonia
- ❑ pleurisy
- ❑ emphysema
- ❑ tuberculosis

*Cardiovascular*
- ❑ palpitations
- ❑ heart murmur
- ❑ swelling in ankles
- ❑ blue/purple lips
- ❑ chest pain
- ❑ angina
- ❑ heart disease
- ❑ high blood pressure
- ❑ rheumatic fever

*Blood*
- ❑ anemia
- ❑ easy bleeding or bruising
- ❑ blood transfusions

*Gastrointestinal*
- ❑ trouble swallowing
- ❑ heartburn
- ❑ nausea
- ❑ vomiting
- ❑ vomiting blood
- ❑ belching or passing gas
- ❑ bowel movements: How often:
- ❑ blood in stool
- ❑ rectal bleeding
- ❑ hemorrhoids
- ❑ black, tarry stool
- ❑ constipation
- ❑ diarrhea

- ❑ jaundice (yellow skin)
- ❑ liver disease
- ❑ gallbladder disease
- ❑ hernia
- ❑ ulcer
- ❑ indigestion
- ❑ abdominal pain
- ❑ food allergy / sensitivity

***Peripheral Vascular***
- ❑ deep leg pain
- ❑ leg cramps
- ❑ varicose veins
- ❑ cold hands/feet
- ❑ numbness of extremities
- ❑ ulcers

***Musculoskeletal***
- ❑ joint pain or stiffness
- ❑ joint swelling
- ❑ arthritis
- ❑ broken bones
- ❑ muscle weakness
- ❑ muscle spasm or cramps
- ❑ back pain
- ❑ gout

***Neurological***
- ❑ fainting
- ❑ seizures/convulsions
- ❑ involuntary movement
- ❑ paralysis
- ❑ numbness/tingling
- ❑ muscle weakness
- ❑ loss of balance
- ❑ loss of memory
- ❑ speech problems

***Endocrine***
- ❑ heat or cold intolerance
- ❑ thyroid problems
- ❑ excessive thirst
- ❑ excessive hunger
- ❑ excessive urination
- ❑ excessive sweating
- ❑ night sweats
- ❑ hypoglycemia
- ❑ diabetes
- ❑ hormone therapy

***Urinary***
- ❑ pain on urination
- ❑ blood in urine
- ❑ foul smelling urine
- ❑ increased frequency
- ❑ frequency at night
- ❑ inability to hold urine
- ❑ dribbling
- ❑ hesitancy (can't get started)
- ❑ frequent infections
- ❑ kidney stones

***Reproductive***
- ❑ sexual difficulties
- ❑ low sex drive
- ❑ sexually transmitted disease
- ❑ sexual preference: _____

*Male*
- ❑ hernia
- ❑ testicular mass
- ❑ testicular pain
- ❑ discharge

*Female* (check or fill in blank)

Age menses began:_____

Duration of menses: _____

Length of cycle:_____ (from day 1 to day 1)
- ❑ bleeding between periods
- ❑ irregular cycles
- ❑ pain during intercourse
- ❑ painful menses
- ❑ excessive flow
- ❑ blood clots
- ❑ PMS (premenstrual syndrome)
- ❑ vaginal itching
- ❑ vaginal discharge

Number of pregnancies:_____

Number of live births: _____

Birth control method:_____

Last PAP:_____

***Emotional***
- ❑ depression
- ❑ mood swings
- ❑ anxiety or nervousness
- ❑ tension
- ❑ phobias:_____
- ❑ insomnia
- ❑ alcohol/drug abuse

Dr. Alan Cranton D.C., N.D.
3-701 Memorial Ave, Thunder Bay, Ontario, P7B3Z7

# *Informed Consent to Naturopathic Care*

Patient Name:_____ Date of Birth:_____

Address:_____

City/Town:_____ Province:_____ Postal Code:_____

Naturopathic Medicine offers a comprehensive approach to improving health and treating illness in patients of all ages. It incorporates the art & science of disease diagnosis, treatment and prevention through the use of natural substances and natural therapies including: ***Naturopathic Physical Medicine (Manipulation/Mobilization & Therapeutic Modalities), Acupuncture (Needle, Electronic & Laser), Botanical (Herbal) Medicine, Homeopathic Medicine, Laser Therapy, Clinical Nutrition and Lifestyle Counselling.***

Following consultation, your Naturopathic Doctor will determine the best approach in addressing your health concerns and establishing a treatment plan. Additionally, referral to other health care professionals may be recommended. Naturopathic therapies can complement conventional medical treatments or be used effectively alone. Be advised that although naturopathic treatments are generally safe, gentle, and effective, individual responses to treatment may vary. Patients are encouraged to discuss their responses to treatment during regular follow-up visits to evaluate their progress and modify treatment if necessary. Please note that non-compliance and self-prescribing, while undergoing naturopathic treatment, may compromise your overall progress. Additionally, naturopathic medical consultation cannot be provided through e-mail.

I, _____, consent to the therapeutic procedures/plan as outlined by **Dr. Alan Cranton D.C., N.D.** I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic procedures/plan and have discussed to my satisfaction this and any request for related information. I further acknowledge and confirm that I have been informed and understand the therapeutic procedures/plan with respect to the financial costs, expected benefits, and potential risks and side effects, the likely consequences of not following the procedure/plan and what alternative course(s) of action are available to me.

As a result, I do hereby voluntarily consent to the recommended therapeutic procedures/plan as specified above. I also understand that I may alter the status of my informed consent at any time, including the decision to halt a procedure/procedures.

Signature of Patient:_____

Signed on the _____ day of _____ year_____

Doctors Signature:_____