STEPHANIE PELTZ
NATUROPATHIC DOCTOR

ADULT INTAKE FORM

Please fill in the following form to the best of your ability. If you have questions, please make a note.

Name: _____ Date: _____ Care Card Number: _____
Address: _____ City: _____ Postal Code: _____
Home #: _____ Work #: _____ Cell #: _____
Date of Birth (m/d/y): _____/_____/_____ Age: _____ Occupation: _____
Legal Gender: ☐ female ☐ male ☐ other Gender Identity: _____
Email Address: _____

Are you: ☐ Single ☐ Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Living with: ☐ Alone ☐ Partner ☐ Parents ☐ Friends ☐ Children ☐ Relatives
Number of Children: _____ Husband / Wife's / Significant other's name: _____

Person to Contact in Emergency:
Name _____ Relationship _____
Home #: _____ Alternate #: _____
How did you hear about Dr. Peltz? _____

Names of Other Healthcare Providers:
MD (Medical Doctor) _____
ND (Naturopathic Doctor) _____
Chiropractor/ Acupuncturist _____
Other _____

List your main health concerns in order of importance:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past Medical History: Please check and date (year) if any of these apply to you.
☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ Seizures
☐ Heart Disease ☐ Rheumatic Fever ☐ Thyroid Disease ☐ Venereal Disease
☐ Other _____
Surgeries/Hospitalizations_____
Significant Trauma (auto accidents, falls, etc.) _____
Your Birth (Prolonged labor, forceps delivery, etc.) _____

Current History
Height _____ Weight _____ Weight 1Yr ago _____ Max Weight_____
Smoker: ☐ Y ☐ N Smoked: _____years Amount/day: _____ Years stopped: _____
Drink coffee/cola/tea: ☐ Y ☐ N ____cups/day Use alcohol /drugs: ☐ Y ☐ N Amount: _____
Exercise: Types_____ Duration _____ Frequency _____
Allergies (food, drug, environmental): _____
Are any of these known life threatening allergies?_____

Food groups you restrict / avoid (due to religion, ethics, preference, etc.) _____
_____
Current medications (prescription / over the counter)? ☐ Y ☐ N If so please list _____
Current vitamins/supplements?_____

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Family History

Please indicate if any of these apply to you or your family

☐ Glaucoma	☐ Diabetes	☐ Kidney disease	☐ High blood pressure	☐ Anemia
☐ Heart disease	☐ Seizures	☐ Tuberculosis	☐ Depression	☐ Arthritis
☐ Schizophrenia	☐ Dementia	☐ Osteoporosis	☐ Liver disease	☐ Stroke
☐ Thyroid issues	☐ Allergies	☐ Asthma	☐ Hayfever	☐ Hives

☐ Cancer (type_____) ☐ Other_____

Review of Systems

Indicate any symptoms that are current or recurring concerns. If there are any additional problems please describe them in the margin.

General

☐ sudden energy change	☐ strong thirst	☐ night sweats	☐ tremors	☐ bleed easily
☐ bruise easily	☐ fatigue	☐ poor balance	☐ fever	☐ chills
☐ hypoglycemia	☐ cravings	☐ localized weakness	☐ weight/gain	☐ sweat easily
☐ change in/poor appetite	☐ poor sleep	☐ thyroid problems	☐ seasonal depression	

Skin and Hair

☐ rashes	☐ ulcerations	☐ hives	☐ itching	☐eczema dry/scaling skin	☐ dandruff
☐ loss of hair	☐ acne	☐ recent moles			

Head, Eyes, Ears, Nose and Throat

☐ dizziness	☐ glasses/contacts	☐ sinus problems	☐ spots in front of eyes	☐ sore throats
☐ concussions	☐ nose bleeds	☐ poor hearing	☐ swollen glands	☐ loss of smell
☐ headaches	☐ recent vision change	☐ ringing in ears	☐ cavities	☐ hayfever
☐ migraines	☐ blurred vision	☐ earaches	☐ copious saliva	☐ facial pain
☐ cataracts	☐ colour blindness	☐ grinding teeth	☐ jaw clicks	☐ night blindness
☐ eye pain	☐ eye strain	☐ canker sores	☐ sore lips/tongue	☐ cold sores
☐ hoarseness	☐ sensitive to light	☐ frequent colds		

Cardiovascular

☐ high blood pressure	☐ low blood pressure	☐ heart murmurs	☐ chest pain	☐ swelling of feet
☐ swelling of hands	☐ irregular heart beat	☐ rheumatic fever	☐ fainting	☐ blood clots
☐ palpitations	☐ cold hands/feet	☐ difficulty breathing	☐ difficulty giving blood	

Respiratory

☐ cough	☐ coughing blood	☐ production of phlegm	☐ pneumonia	☐ asthma
☐ pleurisy	☐ wheezing	☐ bronchitis	☐ shortness of breath at night	

Gastrointestinal

☐ nausea	☐ vomiting	☐ ulcers	☐ indigestion	☐ diarrhea
☐ constipation	☐ belching/gas	☐ black in stools	☐ gallbladder disease	☐ bad breath
☐ rectal pain	☐ haemorrhoids	☐ repeated laxative use	☐liver disease	☐ ulcers

How often do you have a bowel movement?_____ Is this a change? ☐ Y ☐ N

Genitourinary

☐ pain on urination	☐ frequent urination	☐ urgency to urinate	☐ blood in urine
☐ inability to hold urine	☐ decrease in urine flow	☐ kidney stones	☐ frequent infections

Do you wake to urinate? ☐ Y ☐ N (how often)?_____ colour/odour of urine? _____

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Male

☐ hernias ☐ testicular pain ☐ premature ejaculation ☐ discharge or sores ☐ impotency
☐ herpes ☐ testicular masses ☐ low sperm count ☐ prostate disease ☐ low libido
Are you sexually active? ☐ Y ☐ N ☐ sexually transmitted infection (type)_____
Do you practice birth control? ☐ Y ☐ N What type and for how long? _____
Have you had difficulty conceiving? ☐ Y ☐ N

Female

Age of 1st menses_____ Date of last pap_____
History of abnormal pap ☐ Y ☐ N if so, when_____ Are you sexually active? ☐ Y ☐ N
☐ sexually transmitted infection (type)_____
Do you practice birth control? ☐ Y ☐ N What type and for how long? _____
Have you had difficulty conceiving? ☐ Y ☐ N
☐ low libido ☐ pain during intercourse ☐ ovarian cysts ☐ vaginal sores ☐ endometriosis
# of pregnancies_____ # of births_____ # of miscarriages_____ # of abortions_____
☐ breast lumps ☐ self breast exams ☐ nipple discharge

If you have not yet entered menopause:
Date of last menses: _____ length of cycle (i.e. 28d) _____ duration of menses (i.e. 5d)_____
☐ heavy menses ☐ irregular periods ☐ painful periods ☐ bleeding between periods
☐ clots in menses ☐ abnormal bleeding ☐ vaginal discharge ☐ light menses
☐ perimenopausal ☐ PMS

If you are menopausal:
Date and age of last menses:_____ Vaginal bleeding since menopause? ☐ Y ☐ N
Menopausal symtoms? ☐ Y ☐ N if so, what type:_____

Musculoskeletal

☐ neck pain/stiffness ☐ shoulder pain ☐ hip pain ☐ knee pain ☐ hand/wrist pain
☐ foot/ankle pain ☐ muscle weakness ☐ muscle pain ☐ back pain ☐ sciatica
☐ arthritis ☐ broken bones

Neurological

☐ seizures ☐ poor memory ☐ susceptible to stress ☐ tingling ☐ depression
☐ concussions ☐ loss of balance ☐ quick temper ☐ anxiety ☐ irritable
☐ paralysis ☐ numbness ☐ lack of coordination ☐ nervousness

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

What expectations do you have from this visit with me? _____
_____

What long-term expectations do you have for working with me? _____
_____

Thank you for filling out this form. I look forward to helping you in any way I can.

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As a naturopathic physician my treatments involve gentle, typically non-invasive techniques to stimulate the body's inherent healing capacity. As your naturopathic doctor I will take a thorough case history, may do a relevant screening physical examination, and if required evaluate blood, urine, saliva, or stool samples. It is important that you inform me of any change in your health status while under my care, as this may necessitate changes to your naturopathic treatment plan such as any new disease process or diagnosis, if you are prescribed a new medication or over the counter drug, or if you become pregnant or are breastfeeding. There are some slight health risks to treatment by naturopathic medicine.

These include but are not limited to:
• Aggravation of pre-existing symptoms.
• Allergic reactions to supplements, herbs or intravenous therapy contents.
• Pain, bruising and injury from venipuncture or acupuncture.
• Dizziness, lightheadedness or nausea from IV therapy and acupuncture.

I understand that a confidential health record will be kept of the health services provided to me. This record will not be released to others unless so directed by myself or required by law. If appropriate (and with my explicit consent) I understand that you, as my naturopathic doctor, may discuss my case with other healthcare providers. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications.

Cancellation policy - I understand that if I fail to appear for my scheduled appointment or cancel with less than 24 hours notice (one business day) I will be charged a Missed Appointment Fee of the full cost of my missed visit.

I understand that opened remedies and lab tests prescribed are non-refundable. I understand that I am responsible for payment at the time services are rendered. Dispensary items must be paid for in full before leaving the office.

I hereby consent to receive Dr. Stephanie Peltz's quarterly email newsletter, which contains information about clinic events, health conditions, current health news, and healthy recipes
☐ Yes ☐ No

I hereby consent to email communication with Dr. Stephanie Peltz as needed
☐ Yes ☐ No

I intend this consent form to cover the entire course of my treatment and understand that I am free to withdraw my consent at any time. With this knowledge, I voluntarily consent to naturopathic care with Dr. Stephanie Peltz:

Patient Name: (Please Print)_____
Signature of Patient or Parent/Guardian (if under 19 yrs):_____
Date: _____