"Supporting Optimal Health & Well-being for Women"

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PATIENT INTAKE FORM

Today's Date: ____________________________

Name: ____ **Age:** _____ **Date of Birth:** ____/______/____ **Sex:** F/M
day month year

Address: ________________________________ **City:** ________________ **Prov:**______ **Postal Code** _______

Home Telephone: ____________________________ **Work Telephone:** __________________________________

E-mail: _________________________________ **Fax #:** __________________________________

Occupation: ______________________________ **Full or Part Time:** ________________________

Employer: ________________________________

Address: ________________________________ **City:** _______________ **Prov:** _____________

Referred by: ______________________________ **Care Card Number:** ____________________________________

For MSP purposes, are you on premium assistance or a treaty status Indian ? __________

Married ☐ Separated ☐ Divorced ☐ Single ☐ Cohabitating ☐

Live with:

Spouse ☐ Partner ☐ Parents ☐ Relatives ☐ Friends ☐ Pets ☐ Alone ☐

Next of kin (or emergency name):

Relationship: ______________________________

Address: __________________________________ City: _____________Province__________Postal Code________

Home Telephone: ___________________________ Work Telephone: _______________________________________

☐ **Check here if you are interested in receiving information about upcoming lectures & workshops. If YES, Circle**

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CHECK ALL THAT YOU ARE CURRENTLY EXPERIENCING

☐ Heavy bleeding
☐ Water retention
☐ Heavy bleeding
☐ Bloatedness (along waistline)
☐ Endometriosis
☐ Sore breasts
☐ Weight gain
☐ Hot flashes/flushes
☐ Fibrocystic breasts
☐ Anxiety/Irritability
☐ PMS
☐ Migraine headaches

☐ Foggy thinking
☐ Frequent urination
☐ Night sweats
☐ Painful intercourse
☐ Insomnia/weird dreams
☐ Dry vagina
☐ Urinary leakage
☐ Mood swings/tearfulness
☐ Crawly skin
☐ Waking early hours of the morning
☐ Itching around the vagina
☐ Depression
☐ Disturbing memory lapses
☐ Dry eyes

☐ Drowsiness
☐ Short cycles
☐ Breast swelling
☐ Heart palpitations
☐ Yeast infections

☐ Facial hair
☐ Loss of muscle mass
☐ Acne
☐ Decreased sexual desire/response
☐ Hair loss
☐ Lack of sexual interest

☐ Sleep disturbances
☐ Skin wrinkles/thinning
☐ Onset of new allergies
☐ Weight gain IN WAIST
☐ Fatigue
☐ Salt Cravings
☐ Aching joints
☐ Sugar Cravings

☐ Sudden outbursts of anger
☐ Indigestion/flatulence
☐ Other(s):
☐ Lightheadedness/dizzy spells
☐ No symptoms
☐ Nausea

____

CURRENT HEALTH CONDITION

What are your most important health concerns?

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

Which of the above problems are of most immediate concern? ______________________

CURRENT MEDICAL CONDITION

Do you have any of the following—indicate P for past, or C for current:

☐Lupus ☐Asthma ☐Fibroids ☐Endometriosis ☐Sore/Lumpy breasts
☐Phlebitis ☐Liver disease ☐High triglycerides ☐Raynaud’s syndrome

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☐Diabetes ☐Seizures ☐Arthritis ☐Pancreatitis ☐Unexplained vaginal bleeding
☐Heart disease ☐Migraines ☐Breast Cancer ☐Gallbladder disease ☐Edometrial cancer within 5 years

CURRENT MEDICATIONS

Do you take or use:

☐HRT ☐Thyroid medication ☐Cortisone ☐Birth control pills
☐ERT ☐Pain relievers ☐Antibiotics ☐Nasal decongestants
☐Laxatives ☐Antidepressants ☐Antacids ☐Fosamax/Calcimar/Didrocal/Evista
☐Cholesterol-lowering drugs ☐NSAIDS

List any prescription drugs &/or hormones you are taking: ______________________________

Please list any prescription or over-the-counter medications, vitamins or other supplements you are taking:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

GENERAL INFORMATION

Weight: ______ Ibs. Smoking? Y/N Number per day? ________How many years?_____

Weight 1 year ago: ______lbs. Live with a smoker? Y/N

Maximum weight: ______lbs. Alcohol? Y/N Number of drinks per week? ___________________

Height:_____ feet ____ inches

Coffee/soda: Y/N How many per day?_______

Exercise? Y/N Times per week: _________ What kind?__________________________

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FAMILY HISTORY

	Grandparent	Mother	Father	Sisters	Brothers
Ages (if living)					
Health					
Age at death					
Cause of death					

Check those applicable:					
Cancer & type					
Heart Disease					
High Blood Pressure					
Stroke					
High cholesterol					
Diabetes					
Thyroid problem					
Anemia					
Asthma/Hayfever					
Arthritis					
Kidney Disease					
Alzheimer's					
Depression					
Osteoporosis					
Other					

HOSPITALIZATION AND SURGERY

What hospitalizations or surgies have you had? ______________________________

LAB RESULTS

Last blood test results:______________________________

Hormone tests: Blood, saliva or urine? __________ When: ______________ Results: ____________________

Last PAP smear results: ______________________________

History of Abnormal PAP? ____________When? ______________ Results: ______________________

Bone Density Test? Y/N

What type? DEXA/DXA: ____ Ultrasound: ______ Other: ______________ Date: ________Results: ______________

Mammogram: Y/N When: ______________ Results: ______________________________

Breast Ultrasound: Y/N When: ______________ Results: ______________________________

Clinical Breast Exam: Y/N When :______________ Results:______________________________

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MENSTRUAL HISTORY

Age at first period: ______________________________

Date of Last Period: ______________________________

No period? Y/N How long? ______________________________

Days between cycles (i.e. days between periods): ______________________________

Has there been a change in your cycle length? Y/N

Has it ☐increased or ☐decreased?

Are your cycles:

☐Regular ☐Irregular ☐Clots

 # Days of bleeding (i.e. length of menses): ______ Is this an ☐ Increase or ☐Decrease?

Cramps-- ☐Mild ☐ Moderate ☐Severe:

Birth Control: Y/N

- ☐ The pill — How long: _______________
- ☐ Depo provera — Last injection: ____________
- ☐ IUD — Date removed: ____________
- ☐ Diaphragm/cervical cap — How long: _______________
- ☐ Norplant — Date of last implant: _______
- ☐ Condoms
- ☐ Natural family planning

PREGNANCY HISTORY

Infertility problems? Y/N

Treatment: __________________________

Number of pregnancies: _______________ Number of births: ________ Miscarriages: _________

Problems during pregnancy? ___________

Breast feeding: Y/N How long? _______

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GYNECOLOGICAL HISTORY

Hysterectomy? Y/N Date: ___________ Reason: ___________
Ovaries removed? Y/N Date: ___________ Reason: ___________
Did you begin Hormone Replacement immediately after surgery? Y/N Type: _____________

Do you have a history of:

- ☐Endometriosis
- ☐Fibrocystic breasts
- ☐Irregular bleeding
- ☐Vaginal infections Type: ___________
- ☐Fibroids
- ☐Ovarian cysts
- ☐Thyroid problems

BREAST CANCER RISK EVAUATION

Personal history of breast cancer or precancer? Y/N
When? ___________________ Type: ______________ Estrogen positive? Y/N
Treatment: ________________
Tamoxifen: Y/N When? _____________
Radiation: Y/N
Chemotherapy: Y/N Type? ______________ Other treatments?

Family history of breast cancer: Y/N
Who: _____________________ Age: ________ Type: ______________ Estrogen positive? Y/N
Family history of ovarian, uterine or colon cancer: Y/N
Who? ____________________ Age: ________ Type: ______________

Check all that apply:

- ☐ First period before age 12
- ☐ Last period after age 55
- ☐ Never had children
- ☐ Never breast fed
- ☐ Smoking
- ☐ Second hand smoke exposure
- ☐ Alcohol use
- ☐ Overweight after menopause
- ☐ Lack of exercise
- ☐ Birth Contol pill
- ☐ Diet low in vegetabes & fruits
- ☐ Took DES during pregnancy
- ☐ Use of ERT/HRT >5yrs
- ☐ Shift work

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OSTEOPOROSIS RISK EVALUATION

Family history of osteoporosis/ broken bones: Y/N
Who? ___________________________ What type? _____________________
Personal history of osteoporosis/broken bones: Y/N
When? __________________________ What type? _____________________
Diagnosis of ostoporosis: Y/N
When? __________________________ How? __________________________

Check all that apply:

- Asian
- Caucasian
- Thin/under 120 lbs
- Fair skin
- Late start of periods
- Early hysterectomy
- Both ovaries removed
- Menopause before age 40
- Lost more than 1.5” in height
- When younger had no periods for a while
- Excessive dental carries/peridonal gum disease
- Long term use of:
- Steroids, heparin, lithium, thyroid medication , asthma inhalers, seizure medication, heparin/warfin

Diagnosis of:

- Anorexia
- Amenorrhea
- Multiple sclerosis
- Rheumatoid arthritis
- Crohn’s/Peptic ulcer/Celiac

High intake of:

- coffee
- soda pop
- animal protein
- alcohol
- smoker
- Lack of exercise
- Diet low in calcium
- Back pain

HEART DISEASE RISK EVALUATION

Family history of:

- heart attack
- high blood pressure
- high cholesterol
- diabetes

Who? ________________ What age? ________

Personal history of high blood pressure: Y/N

Current blood pressure: _______ Last measured on: ___________

- High cholesterol — Date: __________ Reading: __________
- High triglycerides — Date: __________ Reading: __________
- High blood suger — Date: __________ Reading: __________ Treatment: ________
- Smoking — Packs/day: ______ Number of years: ____
- Alcohol — Amount per week: ______

Blood pressure medication:
What type (s) __________ How long? ___________

Check all that apply:

- Indo-Asian Canadian
- African Canadian
- Hispanic
- Post menopausal
- Sedentary lifestyle
- Polycystic ovaries
- High-Stress
- Diabetic
- More than 20lbs overweight
- Surgical menopause before 40

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ALLERGIES

Are you hypersensitive or allergic to:

- ☐ Any drugs: ___________________
- ☐ Any foods: ___________________
- ☐ Any chemicals or environmental toxins: _______________________

TYPICAL FOOD INTAKE

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

YOUR VALUES

In attempt to help you sort out your values, please check all statements that apply to you.

- ☐ I hate pills and would rather tough it out. [1]
- ☐ I don’t care what it takes, I just want it to get better, and fast. [3
- ☐ I have always favored natural remedies. [2]
- ☐ I don’t have time to exercise or change my diet—just give me a pill. [3]
- ☐ I have always thought that herbs were useless. [3]
- ☐ I go to the doctor because she or he is the expert, so I’ll do what the doctor says. [3]
- ☐ It’s important to me to be actively involved in all my own decisions about health care. [1]
- ☐ I am willing to experiment with other ways of seeking health care to get rid of my symptoms. [2]
- ☐ I am willing to experiment with different approaches to get rid of my symptoms. [2]
- ☐ I don’t care what the studies say: women on hormones look younger to me. [3]
- ☐ I think menopause almost always includes unpleasant symptoms that need treatment. [3]
- ☐ I don’t have time for menopause. [3]
- ☐ I couldn’t take anything that came from horse urine. [2]

THANK YOU!

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DR. T ADATYA
OFFICE POLICY REGARDING FEES AND INSURANCE COVERAGE

OUR FEE POLICY IS A REFLECTION OF THE SPECIALISED PROCEDURES INCORPORATED IN THIS OFFICE AND ALLOWS US TO GIVE WHAT WE FEEL TO BE THE HIGHEST QUALITY OF NATUROPATHIC CARE.

Fees
Payment for naturopathic services is expected by the time of treatment.

B.C. Medical
The provincial government removed MSP coverage for naturopathic services on January 1, 2002. Partial re-imbursement from the government is no longer available. Those on premium assistance or who are treaty status Indian may qualify for partial re-imbursement.

Extended Medical
With the provincial government change on January 1, 2002, more extended healthcare plans will permit the subscriber to claim the full cost of naturopathic services and therefore receive a larger re-imbursement. You will need to check your contract with your insurance company. This office does not deal directly with private insurance companies.

ICBC
For ICBC cases the patient is responsible for the fee at the time of treatment and can then submit the receipt to their adjuster for reimbursement.

Cancellation and missed appointment
This office requires a minimum of **forty-eight (48) hours** notice to cancel any appointment. **A 50% appointment fee will be charged for missed or rescheduled appointments with insufficient notice.**

BC residents are required to sign the agreement below:

I have been informed of the billing procedures of this office and agree to pay the full office fee for services rendered by Dr. Tasnim Adatya. I understand that upon submission of the appropriate claim forms that I will be reimbursed by the Medical Services Plan of BC at an established rate and that this rate is of a lesser amount than the office fee.

______________ ____

Date PATIENT'S SIGNATURE (parent or guardian)

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