Dr. Melissa Bradwell, ND

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ADULT INTAKE FORM

Please complete the following questionnaire to the best of your ability.
All information is kept *confidential*. Please ask if you have any questions. Thank you.

Date: _____ PHN: _____

First Name: _____ Last Name: _____

Male ☐ Female ☐ Date of Birth (D/M/Y): _____/_____/_____ Age: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____Ext:_____

Cell Phone: _____

E-mail: _____ Occupation: _____

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Children (Names & Ages): _____

Emergency Contact Name: _____ Phone #: _____

Relationship: _____

Health Concerns: (Please list your current health concerns/complaints and when they first began.)

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

Current Medications: (Please include all prescription medications, non-prescription medications, vitamins, herbs, etc.)

_____

_____

_____

Past Medical History: (Please check and date the conditions that pertain to YOU personally)

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Alcohol Abuse
- ☐ Drug Addiction
- ☐ Parkinson's
- ☐ Seizures
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ STI (sexually transmitted infection)
- ☐ Thyroid Disease
- ☐ Hepatitis

Hospitalizations/Surgeries (Procedure/Date):_____

_____

Occupational Exposure to Toxins:_____

_____

Allergies: (Medications, environmental, food, etc)_____

_____

Family Medical History: (Blood relatives, NOT including yourself. Please check condition & circle F for father's side or M for mother's side.)

☐ Cancer	F / M	☐ Allergies	F / M
☐ Diabetes	F / M	☐ Arthritis	F / M
☐ Stroke	F / M	☐ Tuberculosis	F / M
☐ Heart Disease	F / M	☐ Addiction	F / M
☐ Seizures / Epilepsy	F / M	☐ Gout	F / M
☐ High Blood Pressure	F / M	☐ Obesity	F / M
☐ Pregnancy/Labour Problems	F / M	☐ Hepatitis	F / M
☐ Asthma	F / M		

Notes:_____

_____

_____

Please check if the following symptoms are current or recurring:

General:

- ☐ Weight-loss
- ☐ Weight-gain
- ☐ Fevers
- ☐ Chills
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Significant drop in Energy/Time of day? _____
- ☐ Fatigue
- ☐ Anemia
- ☐ Bleed or Bruise easily
- ☐ Heat or Cold Intolerance
- ☐ Unusual tastes or smells

Skin & Hair:

- ☐ Rashes
- ☐ Itching
- ☐ Eczema or Psoriasis
- ☐ Dryness
- ☐ Change in hair or skin texture
- ☐ Loss of hair
- ☐ Dandruff
- ☐ Changes in moles
- ☐ Ulcers
- ☐ Acne

Head/Eyes/Ears/Nose/Throat:

- ☐ Headaches
- ☐ Neck masses
- ☐ Hay fever
- ☐ Eye pain/strain
- ☐ Blurry vision
- ☐ Floaters
- ☐ Cataracts
- ☐ Blindness (Colour/Night)
- ☐ Corrected vision
- ☐ Ear aches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Facial pain
- ☐ Frequent colds/flu's
- ☐ Sinus problems
- ☐ Frequent nose bleeds
- ☐ Jaw pain
- ☐ Tooth pain
- ☐ Mercury fillings # _____
- ☐ Mouth pain or sores

Heart & Circulation:

- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Varicose veins
- ☐ Fainting / Dizziness
- ☐ Cold Hands/Feet
- ☐ Swelling in Hands/Feet
- ☐ Blood clots

Respiratory:

- ☐ Difficulty breathing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Phlegm / Colour? _____

Digestion:

- ☐ Indigestion/Heartburn
- ☐ Gas/Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Parasite infection
- ☐ Poor/Excess appetite
- ☐ Change of appetite
- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Food in stool

Genito-Urinary:

- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Sores on genitals
- ☐ Blood in urine
- ☐ Increased urgency
- ☐ Decrease in flow
- ☐ Kidney stones
- ☐ Impotence
- ☐ Prostate problems

Musculoskeletal:

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand / Foot pain
- ☐ Joint pain/stiffness (ankle, wrist, hip, knee)
- ☐ Joint swelling
- ☐ Muscle pain or weakness
- ☐ Bone pain

Neurological/Psychological:

- ☐ Numbness
- ☐ Dizziness
- ☐ Poor memory
- ☐ Seizures
- ☐ Loss of balance
- ☐ Stress
- ☐ Depression
- ☐ Anxiety
- ☐ Difficulty concentrating
- ☐ Mood swings
- ☐ Eating disorder
- ☐ Addiction
- ☐ Suicide (thoughts/attempts)
- ☐ Quick temper/irritability

Women's Health:

Date of last period (first day): _____ Date of last PAP exam: _____

Any concerns regarding your period? ☐ Yes ☐ No _____

Any Abnormal PAP results? ☐ Yes ☐ No Monthly Self Breast exams? ☐ Yes ☐ No

Birth control use? If so, what type and for how long? _____

pregnancies: _____ # births: _____ # miscarriages: _____ # abortions: _____

Personal:

Alcohol Consumption: ☐ Yes ☐ No Type & Amount (per week) _____

Smoker: ☐ Yes ☐ No How long have you smoked? _____ How much? _____

Recreational Drug Use: ☐ Yes ☐ No Type & How often? _____

Do you exercise regularly? ☐ Yes ☐ No Type & How often? _____

CONTEXT OF CARE

(Please read the following questions carefully and answer them to the best of your ability)

1. What made you choose to come to this clinic? _____
2. What do you know about our approach (naturopathic medicine)? _____
3. What 3 expectations do you have from THIS VISIT?
   i. _____
   ii. _____
   iii. _____
4. What long-term expectations do you have from working with our clinic? _____
5. What expectations do you have of me personally as your physician? _____
6. What is your present level commitment to address any underlying causes of your signs and symptoms?

(Rate from 0 – 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

7. What behaviours or lifestyle habits do you currently engage in regularly that you believe ***support your health***?

_____

_____

8. What behaviours or lifestyle habits do you currently engage in regularly that you believe are ***self-destructive lifestyle habits***?

_____

_____

9. What potential obstacles do you foresee preventing you from adhering to the therapeutic protocols provided to you?

_____

_____

10. Who do you know that will support you consistently with the beneficial lifestyle changes you will be making?

_____

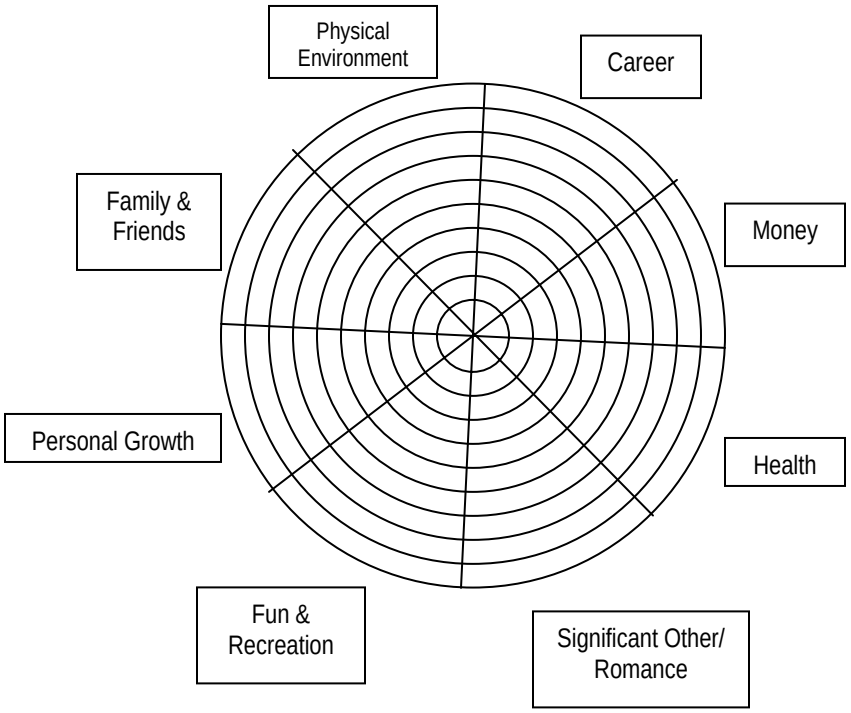
_____

11. What do you LOVE to do? _____

_____

WHEEL OF HEALTH

(Please shade in your level of satisfaction in each pie section, starting from the inside out, the first small circle being 10% and the outside circle being 100%)



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CONSENT FORM

Full Name (please print): _____

As a patient of Dr. Melissa Bradwell, I understand that the form of medical care that I will receive is based on naturopathic principles, practices, and therapies. These may include, but not limited to: IV therapy, nutritional counseling, botanical medicine, traditional Chinese medicine (acupuncture, herbs, cupping), homeopathy, hydrotherapy, and counseling. As with any therapy, including conventional medicine, I understand that no treatment is guaranteed to be successful. I also understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless it is requested by law. Though naturopathic therapies are proven safe when used correctly, I recognize the potential risks that include, but are not limited to: aggravation of pre-existing symptom, allergic reactions to supplements or herbs, pain, fainting or bruising from IV therapy, venipuncture or acupuncture, inconvenience or lifestyle changes.

I have read and understand the above statement, accept the risk and thereby consent to treatment.

I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial, or federal agency attempting to gather information without stating.

I accept full responsibility for any fees incurred during care and treatment.

Signature:_____ Date:_____

Witness:_____ Date:_____

Parent/guardian's name (please print): _____

Signature of parent/guardian: _____