ImmuneND Nutritional and Complementary Therapies for Immune System and Related Disorders

What to expect from your visit with a Naturopathic Doctor…

Before your visit…

Your Naturopathic Doctor spends a minimum of 1 hour and possibly more with you on your first visit. This time is spent doing a thorough medical history and intake and may include some basic physical exam procedures relating to your health concerns. Be prepared to run a little late and don't worry, they don't charge overtime. Please bring with you any medical reports, information or references that may be pertinent to your health concerns as well as lists of all current medical prescriptions and nutritional supplements. Naturopathic doctors are extensively trained in laboratory analysis and would find blood results, x-rays, scans, etc. very helpful in diagnosing and providing treatments.

Your First Visit…

Please fill out the attached questionnaire before coming to your visit, to ensure you get the best use of your time with the Doctor.

If you are unable to fill out the forms before hand, Please arrive 20 minutes early to fill out your intake form and some questionnaires. Should you not be able to complete these forms prior to your visit, you may take them with you and return them at your convenience.

Your Second Visit…

Depending on your health concerns, some treatments may begin during the first visit but generally more than one visit is necessary to provide a complete protocol. Information obtained during the first visit will be researched and further recommendations offered at the second visit subsequent to this research. This provides time to assess the initial treatments and to further steer subsequent treatments. The second and subsequent visits will be approximately 30 - 45 minutes in length.

Follow Up Visits…

The scheduling of follow up visits will vary according to the nature of your health concerns and treatments implemented. For basic health promotion and supplemental protocols, follow up visits would be scheduled at least every three to six months following establishment of your basic protocol as your bodies needs and supplemental requirements often change during the course of treatment (what is good for you now may not be necessary in six months and vice versa!) General health promotion visits are ideally scheduled every six months for monitoring of current health concerns and for support of your body systems requiring seasonal support. (ie. Immune system, Adrenal system, Detoxification systems)

Congratulations on taking the first step towards a healthier lifestyle.

Naturopathic Intake Form

Please fill out this form BEFORE coming to your visit. Please fill out in as much detail as possible.
This will ensure the most efficient use of your time with the practitioner.

Patient Information

Consultation Date

(Please Print)

Full Name	
Date of Birth / Age	
Address	
Phone:	
Work Phone:	
Cell Phone:	
Emergency Contact:	
Emergency Contact Phone:	
Click to edit	

Current Health Professionals

Please provide Name and Contact Information

Family Physician:	
Specialist:	
Naturopathic Physician:	
Osteopathic Practitioner:	
Chiropractor:	
Other:	

Chief Complaints / Health Concerns

Please outline in point form, your main health concerns and reasons for your visit/consult)

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

Current Prescription Medications

Please list all of your current prescriptions medications and dosages here

Past Pescription Medications

Please list any medications prescribed in the past that you aren't currently taking

Current Nutritional Supplements

Vitamins, Herbal Medicines, Homeopathics, Nutraceuticals, Other

Medical History

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations (along with approximate dates) from childhood to present.

Please indicate if you have had any of the following medical testing procedures done recently

Blood Test	Urine Test	Blood Pressure	Cholesterol	X-Ray	Bone Density	CT Scan	MRI
☐	☐	☐	☐	☐	☐	☐	☐
Colonoscopy	**Endoscope**	**Angiogram**	**Mammogram**	**PAP**	**Prostate**	**Thyroid**	**Other**
☐	☐	☐	☐	☐	☐	☐	☐

Medical Conditions

Please CIRCLE any of the conditions below that you have ever experienced or been diagnosed with.

Abscesses
Abuse
Acne
Addictions
Allergies
Anemia
Arthritis
Asthma
Cancer
Chronic Infections
Cold Hands/Feet
Depression
Diabetes
Ear Infections
Eczema
Fainting
Frequent Colds
Gallstones
Genital Herpes
Gout
Hay Fever
Headaches
Heart Disease
Hemorrhoids
Hepatitis
High Blood Pressure
HIV
Jaundice
Kidney Disease
Low Blood Pressure
Migraines
Mononucleosis
Multiple Sclerosis
Mumps
Nerve Problems
Parasites
Pneumonia
Poor Memory
Psoriasis
Rectal Bleeding
Rheumatic Fever
Rubella
Scarlet Fever
Sinusitis
Strep Throat
Sexually Transmitted Disease
Tonsillitis
Thyroid problems
Tuberculosis
Varicose Veins
Venereal Disease
Visual problems
Warts
Weight Difficulties
Whooping Cough

Allergies

Please indicate if you have any KNOWN allergies to Medications, Supplements, Foods or otherwise

Diet Assessment

Please provide examples of typical dietary choices for the day outlined below. Include beverages

Breakfast	
Mid A.M. Snacks	
Lunch	
Mid P.M. Snacks	
Supper	
Evening Snacks	

Please indicate your consumption of the following and indicate if it Daily, Weekly, Monthly and approximate amounts of each (This information is kept completely confidential)

Alcoholic Drinks	
Caffeinated Beverages (Coffee, Tea, Colas, Etc.)	
Tobacco Products	
Marijuana (Medical/Other)	
Recreational Drugs	

Environmental Assessment

Please provide the following environmental information as indicated.

Occupation(s)	
Hobbies	
Exercise & Frequency	
Toxin exposure at work?	
Types of toxins (work)	
Toxin exposure at home?	
Types of toxins (home)	

Stress Environment

Please rate your stress level at home and at work in the following chart

	No Stress	Mild	Moderate	Severe
At Home	☐	☐	☐	☐
At Work	☐	☐	☐	☐
With Spouse/Partner	☐	☐	☐	☐
With Children	☐	☐	☐	☐
With Extended Family	☐	☐	☐	☐
With Co-workers	☐	☐	☐	☐
Other (please indicate below)	☐	☐	☐	☐

Digestion

Please indicate if you have experienced or been diagnosed with any of the conditions / symptoms below and the timing of the condition or symptoms

	Regularly	Past Month	Past Year	Ever
Recurrent loose stool or diarrhea	☐	☐	☐	☐
Constipation, Difficulty moving bowels	☐	☐	☐	☐
Excessive upper gas, belching	☐	☐	☐	☐
Excessive lower gas, flatulance	☐	☐	☐	☐
Gas and Bloating	☐	☐	☐	☐
Indigestion, heartburn, reflux	☐	☐	☐	☐
Abdominal pain, cramping	☐	☐	☐	☐
Blood in the stool	☐	☐	☐	☐
Mucousy stool	☐	☐	☐	☐
Parasites, worms	☐	☐	☐	☐
Undigested food in stool	☐	☐	☐	☐

How often do you have bowel movements?

Genito-Urinary

Please CIRCLE any of the conditions or symptoms below that you have been diagnosed with or have experienced.

Bladder Infections	*Discomfort Urinating*	*Malodorous Urine*	*Blood in Urine*	*Kidney Stones*
Incontinence	*Dribbling*	*Malodorous Perspiration*	*Kidney Infections*	*Kidney Pain*

Male Health

Please indicate below if you have ever been diagnosed with or experienced any of the symptoms / conditions outlined below, and indicate frequency as outlined.

	Currently	Past Month	Past Year	Ever
Frequent Urination at night	☐	☐	☐	☐
Dribbling at end of Urination	☐	☐	☐	☐
Decrease force of Urination	☐	☐	☐	☐
Erectile weakness difficulties	☐	☐	☐	☐
Prostate Examinations	☐	☐	☐	☐

Women's Health

Please provide information as indicated.

Age at first Menstrual Cycle?	
Age at Menopause (cessation of periods)	
Have you had a hysterectomy?	
Number of pregnancies?	
Number of births?	
Length of Period? (days)	
Length of Menstrual cycle? (days)	
Is your cycle regular?	
Do you take Birth Control or Hormone Replacement Therapy? (if so, how long?)	

Pre-menstrual Symptoms

Please indicate if you experience any of the following pre-menstrual symptoms OR you did when you were having menstrual cycles.

Mood Swings	Irritability	Emotional	Cramping	Breast Tenderness	Heavy periods	Long periods	Light periods
☐	☐	☐	☐	☐	☐	☐	☐

Food cravings	Water Retention	Acne	Migraines	Ovulatory pain	Short periods	No periods
☐	☐	☐	☐	☐	☐	☐

Other

Do you have regular PAP screening?	
Have you had abnormal PAP results in the past?	
Do you have regular Mammograms?	
Have you had abnormal Mammogram results in the past?	
Do you experience regular yeast infections now, or have you in the past?	

Please indicate any blood relative who you know has been diagnosed with any of the following conditions.
Beside each check mark, indicate if the relative was Maternal or Paternal

	Personal	Parent	Grandparent	Aunt/Uncle	Sibling	Child
Crohn's or Colitis	☐	☐	☐	☐	☐	☐
Diverticulitis	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐
Other Digestive issues	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐
Type I Diabetes (Insulin Dependent)	☐	☐	☐	☐	☐	☐
Type II Diabetes (Adult onset)	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐
Scleroderma	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐

Childhood Health History

Please indicate if you were diagnosed or experienced any of the following conditions or symptoms as an infant of child

Ear infections	Sore throats	Strep throat	Tonsillitis	Colic	Reflux	Eczema	Digestive issues	Mononucleosis	Asthma	Food allergies
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Dietary Intake

Please indicate the on the chart below, the frequency of which you eat the following foods and food groups

	Daily	Weekly	Monthly	Yearly	Never
Milk, cream	☐	☐	☐	☐	☐
Cheese (any form)	☐	☐	☐	☐	☐
Yogurt (any form)	☐	☐	☐	☐	☐
Ice cream	☐	☐	☐	☐	☐
Butter	☐	☐	☐	☐	☐
Eggs (whole)	☐	☐	☐	☐	☐
Bread, Grains, Cereals	☐	☐	☐	☐	☐
Pasta	☐	☐	☐	☐	☐
Baked goods, cookies, etc	☐	☐	☐	☐	☐
Rice	☐	☐	☐	☐	☐
Corn, nachos, tortillas	☐	☐	☐	☐	☐
Berries (straw, blue, cran)	☐	☐	☐	☐	☐
Bananas	☐	☐	☐	☐	☐
Pineapple	☐	☐	☐	☐	☐
Citrus (orange, lemon)	☐	☐	☐	☐	☐
Melon	☐	☐	☐	☐	☐
Avocado	☐	☐	☐	☐	☐
Almonds	☐	☐	☐	☐	☐
Peanuts	☐	☐	☐	☐	☐
Sesame	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
Beans, Peas	☐	☐	☐	☐	☐

Please indicate any of the following symptoms or conditions you have experienced in the past or are currently experiencing

	Current	Past Month	Past Year	Ever
Fatigue, Exhaustion	☐	☐	☐	☐
Poor Focus , Concentration	☐	☐	☐	☐
Lack of Endurance	☐	☐	☐	☐
Muscle weakness	☐	☐	☐	☐
Restless Legs	☐	☐	☐	☐
Muscle cramping	☐	☐	☐	☐
Anxiety, worry	☐	☐	☐	☐
Oversensitive	☐	☐	☐	☐
Overwhelmed easily	☐	☐	☐	☐
Irritable, edgy	☐	☐	☐	☐
Anxiety attacks	☐	☐	☐	☐
Palpitations	☐	☐	☐	☐
Short of breath episodes	☐	☐	☐	☐
Lack motivation, ambition	☐	☐	☐	☐
Crave salt, sugar, caffeine	☐	☐	☐	☐
Disturbed sleep patterns	☐	☐	☐	☐
Difficulty falling asleep	☐	☐	☐	☐
Wake in middle of night	☐	☐	☐	☐
Wake unrefreshed	☐	☐	☐	☐
Low libido	☐	☐	☐	☐
Sleepy after meals	☐	☐	☐	☐
Frequent colds and flus	☐	☐	☐	☐
Shingles	☐	☐	☐	☐
Cold hands, feet	☐	☐	☐	☐
Thinning hair, eye brows	☐	☐	☐	☐
Brittle nails, hair	☐	☐	☐	☐