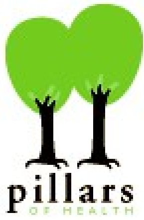

An Introduction to Naturopathic Medicine

Naturopathic Medicine is the art and science of diagnosis, treatment, and prevention of disease using natural therapies with a focus on optimizing health and well-being through individualized patient care and public education. We work with you to get to the root cause of illness with a focus on prevention and wellness.

PRINCIPLES OF NATUROPATHIC MEDICINE

- ***Primum non nocere*** – First do no harm. The most effective health care with the least possible risk.
- ***Vis medicatrix naturae*** – The healing power of nature respects and promotes self-healing.
- ***Tolle causum*** -Treat the cause, identify and remove obstacles to health while avoiding suppression of symptoms.
- ***Docere*** - Doctor as teacher. Educate patients, inspire and encourage self-responsibility.
- ***Treat the whole person*** – Acknowledge the individual and treat using a holistic paradigm.
- ***Health promotion is the best prevention*** - The focus of Naturopathic Medicine is as much on wellness as it is on treating disease.

BEFORE YOUR FIRST APPOINTMENT

Please fill out the intake form and complete the 4-day diet diary. Bring this to your first appointment.

If you've had any recent bloodwork or other testing done, please try to obtain a copy to bring with you. If this isn't possible, we can send a request to your MD for this information.

If you have questions about our fees, location and parking in downtown Dartmouth please refer to our website: www.pillarsofhealth.ca

If you have any questions about your appointment, or need to reschedule please call 902.444.3303 or email reception@pillarsofhealth.ca. Please note that we have a 24-hour cancellation policy in effect.

We look forward to meeting you and helping you achieve your best health!

Dr. Jennifer Salib Huber, B.Sc (Hons), P.Dt., N.D
Dr. Samanda Verdun, B.Sc., ND
10 Portland Street – Suite 101
Dartmouth, NS B2Y 1G9
Tel: (902)444-3303 Fax: (902)444-3853
www.pillarsofhealth.ca

ADULT INTAKE FORM

Please complete this form and return it on your first visit

Name:________________________________ Date: _____________

Address: ____

____

Telephone numbers: (h)______________ (w)___________________

May we leave messages for you at these numbers? ____YES ____NO

E-mail: ____

Referred by: ____

Family Medical Doctor _____________________________________

Other Primary Care Givers___________________________________

Emergency Contact______________________________________

____

THE FOLLOWING INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT YOUR WRITTEN PERMISSION

PERSONAL HEALTH PROFILE

A note to patients: Naturopathic, holistic and preventative health care is only possible when the doctor has a complete picture of the patient physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire. Consider making a copy for your own records.

Age:_________ Date Of Birth:______ Sex:_______
Marital Status:________________ Name of spouse/partner:________________________________
Number of children (if applicable):_________
Occupation:___________________________ No. of work hours/week:________________________
Are you fulfilled in your current position? If not, please explain:

Last physician or health care practitioner seen?_________________ When? _____________

When was your last physical exam? ________Blood tests done? Yes/No Blood Type_____

What is your primary health concern:____

How long have you had this condition?____
Do you have a medical diagnosis for this condition?__________________________________
If yes, name of physician who made the diagnosis:__________________________________
When was this diagnosis made:____
How have you been treated to date:____

Additional Health Concerns and Goals

List health concerns in order of importance to you. Please list any health goals that you would like to achieve. When possible, indicate the month and year that the health condition started and present treatments.

	Health Concern/Goal	Month/Year	Treatments/Comments
1			
2			
3			
4			
5			
6			
7			

Have you ever seen a: Naturopathic Doctor Chiropractor Acupuncturist Massage Therapist Osteopath Other______

How would you describe the general state of your health?
Excellent___ Good___ Average___ Fair___ Poor___

Height____ Current weight ____ One year ago____ Ideal weight_____

How long has it been since you have experienced excellent health?
____
____

Please list the 5 most significant, stressful events in your life:

1)____Date_____________
2)____Date_____________
3)____Date_____________
4)____Date_____________
5)____Date_____________

Are any of these situations continuing to impact your life? Yes/no (please circle number)

Please list any prescription medication you are **currently** taking.

Prescription	Prescribed for	Dosage

In the past 5 years, how often have you been prescribed antibiotics?__________________

Do you take any of the following on a regular basis? Circle all that apply.

Aspirin Tylenol Laxative Antacids Muscle relaxants Sleeping pills

Do you have any **allergies** to medications? ____Yes ____No
If so, please list:____

Please list any vitamins/herbs that you are **currently** taking**.**

Supplement	Taking for	Dosage

Past Health History

Please list and describe any surgeries and/or hospitalization.

Surgery/Hospitalization	Date	Comments

Immunizations: check all that apply.

- MMR
- DPT
- Polio
- Meningitis
- Small Pox
- Flu
- Hib
- Hepatitis
- Typhoid
- Other:

Have you had any reactions to vaccinations? Yes/No If yes, please describe:

____

Childhood illness: check all that apply

- Measles
- Mumps
- Rubella
- Rubeola
- Whooping cough
- Asthma
- Rheumatic Fever
- Chicken Pox
- Scarlet Fever
- Other:_______

Health Conditions: check all that apply.

Condition	Now	Past	Never	Condition	Now	Past	Never
Anemia	○	○	○	Hypoglycemia	○	○	○
Arthritis	○	○	○	Allergies	○	○	○
Asthma	○	○	○	Emphysema	○	○	○
Alcoholism	○	○	○	Migraines	○	○	○
Bleeding	○	○	○	Pneumonia	○	○	○
Cancer	○	○	○	Bronchitis	○	○	○
Colitis	○	○	○	Tuberculosis	○	○	○
Heart disease	○	○	○	Rheumatism	○	○	○
High blood pressure	○	○	○	Hypothyroidism	○	○	○
Injury	○	○	○	Hyperthyroidism	○	○	○
Kidney disease	○	○	○	Eczema	○	○	○
Liver disease	○	○	○	Psoriasis	○	○	○
Obesity	○	○	○	Canker Sores	○	○	○
Ulcers	○	○	○	Fainting	○	○	○
Diabetes	○	○	○	Balance Problems	○	○	○
Depression	○	○	○	Jaundice	○	○	○
Epilepsy	○	○	○	Hepatitis	○	○	○
Gas/Bloating	○	○	○	Cold hands/feet	○	○	○

Are there any of these from which you feel you have never been well since?

____

Family History

Please list ages and if deceased, what they died from and at what age.

Mother____________________________ Father_________________________________

Grandmother________________________Grandmother___________________________

Grandfather_________________________Grandfather____________________________

Siblings____

Have any of your family members (including aunts, uncles, etc.) had any of the following conditions?

- Alcoholism
- Allergies
- Anemia
- Arthritis
- Asthma
- Cancer
- Depression
- Diabetes
- Drug Addiction
- Epilepsy
- Headaches
- Heart Disease
- Hypertension
- Kidney Disease
- Mental Illness
- Stroke
- Tuberculosis
- Other?

Lifestyle Factors

Do you use tobacco products? ___Yes ___No How often?________________________

Are you exposed to tobacco products in your home or workplace? ___Yes ___No

Do you consume alcohol? ___Yes ___No How often?___________________________

Do you use recreational drugs? ___Yes ___No How often?_________________________

Do you exercise regularly? ___Yes ___No How often?____________________________

What types of activities do you do to relax?_______________________________________

____

____

____

You currently live with? Spouse___Partner___Parents___Friends___Children___Alone__

How would you describe the emotional climate of your home?______________________

____

____

____

Personal Habits

What do you enjoy most in life?_______________________________________
What do you worry about most in life?__________________________________
What nurtures you?____
Do you have a religions/spiritual practice? Yes/No
On a scale of 1-10, how would you rate the quality of your sleep?____________
How many hours of sleep do you get?___________Do you wake refreshed?____
How is your body temperature compared to other? Warmer Cooler Average
How often do you get colds, flus, sore throats in a year?___________________

Reproductive

Are you sexually active? Yes/No Is this more or less than one year ago?____

Do you use birth control? Yes/No What type?____________________________

Female

Age of first menses_____ If periods have stopped, at what age did they stop?___
Are your cycles regular? Yes/No Periods begin every____days, and last ____days
Are your periods **heavy, medium, light**? What is the color of the blood?_______
Are there any clots? Yes/No Any cramps with your period? Yes/No
Do you have spotting/bleeding between periods? Yes/No Every month?_______

Do you have any premenstrual symptoms? **Water retention irritability depression headaches anger breast tenderness mood swings crying bloating acne cravings other?__________________________**

Number of pregnancies____ Number of abortions____ Number of miscarriages____
Number of live births____ Any problems getting pregnant?_____________
Do you get regular pap smears? Yes/No Any abnormal pap's? Yes/No
Do you do regular breast self exams? Yes/No

Male

How often do you get up in the night to urinate?_____Has this increased lately?_____
Do you have trouble achieving/maintaining an erection? Yes/No
Do you have any sores or discharge from your penis? Yes/No
Have you had your prostate examined? Yes/No When?_____

Kidney and Bladder

Have you had a bladder infection? Yes/No How often?____ Treatment?_____
Do you have a burning sensation during or after urination? Yes/No
Is your urine **dark yellow bright yellow cloudy pale/clear strong odour**
Do you have any difficulty starting/stopping when urinating?

Perspiration

Do you have any difficulty perspiring? Yes/No Any strong odour? Yes/No
Do you perspire when exercising? **Lightly** **Moderately** **Heavily**

Digestion and Elimination

Do you have any problems with gas, bloating or fullness after meals? Yes/No
How often is this a problem? **Often** **Sometimes** **Never**
How long have you had this problem?____________________________________
How often do you have bowel movements?________________________________
Do you ever have any **blood** **mucous** **undigested food** **black stools**
Any rectal itching? Yes/No
Are you stools **formed or loose** Any diarrhea?___________________________
Ever have alternating constipation and diarrhea Yes/No How often?__________
Do you ever have yellow or light coloured stools? Yes/No
Do you ever have to strain to pass stools? Yes/ No How often?______________
Do you pass gas frequently? Yes/No Do you burp frequently? Yes/No
Do your stools ever have a strong, disagreeable odour? Yes/No

Please use the space below to add any additional information that has not been covered in this questionnaire.

Diet Diary and Food Frequency Questionnaire

Please record all foods eaten over a 4-day period, including 1 weekend day. If any symptoms occur after eating a food or meal, please make note in the space below

Breakfast	Lunch	Supper	Snack

Notes:____

____

____

____

Do you have any food allergies or food sensitivities?

Are there any foods that you avoid because they make you feel sick or unwell?

Do you follow any specific type of diet – ie. Vegetarian, Diabetic, Grain-Free?