Intake Form
Adults (16+)

Aranka Jones
naturopathic medicine

be well
COLLINGWOOD

Name:_____ Date of birth:_____ Gender:_____

Address:_____

City:_____Postal Code:_____

Home Phone:_____ Mobile/Work:_____

Email:_____

Marital status:_____ Spouse/Partner's name:_____

Emergency Contact:_____ Phone Number:_____

How did you hear about Dr. Jones?_____

Describe your general state of health: Excellent Good Fair Poor

Please list your chief health concerns and goals for treatment:

_____

_____

_____

_____

_____

_____

If not included in the above list, please tell me about any current or past medical conditions, serious illnesses, injuries or hospitalizations with approximate dates:

_____

_____

_____

Family physician:_____ City:_____

Date of last physical and/or blood work:_____

Other practitioners you see:_____

Current medications including prescription or over the counter drugs & natural health products:

Medication	Why you take it	Dose	Taken since

How many times have you taken antibiotics in the last year?_____

List any drug allergies:_____

Family History

Mother	
Father	
Siblings	
Grandparents	
Children	

Lifestyle

Describe the level of stress in your life: Minimal Moderate Significant Unbearable

List the main stressors:_____

_____

_____

Have you ever received counselling or psychotherapy? YES NO

Do you have emotionally supportive friends or family members? YES NO

How do you cope with stress?_____

_____

_____

Rate your energy level (0-10 with 10 being excellent): 0 1 2 3 4 5 6 7 8 9 10

Do you have difficulty sleeping? YES NO Do you wake rested? YES NO

How many hours do you sleep?_____ Do you work shift work? YES NO

Occupation:_____

Do you enjoy it?_____ When and where was your last vacation?_____

Hobbies and interests:_____

Who do you live with?_____

Do you have any children? YES NO How old are they?_____

Do you have any pets?_____

Describe your physical activity/exercise habits (what and how often):_____

_____

_____

_____

Are you happy with your weight, body composition and level of physical fitness? YES NO

Weight:_____ Height:_____ Fitness goals:_____

Describe what you eat in a typical day:

Meal	Time of day	What and how much
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Dessert/night time eating?		

Describe your consumption of the following:

	How much?	How often?
Coffee or Black Tea		
Soft drinks		
Artificial sweeteners		
Candy/Sweets/Sugar		
Alcohol		
Smoking		
Recreational drugs		
Pain killers		
Antacids		
Diet pills		
Laxatives		

Review of body systems - Please circle all that apply:

General:

unexplained weight loss

unexplained weight gain

change in appetite

fatigue

fever or chills

night sweats

trouble sleeping

Skin:

rashes

itching

burning

dryness

hair or nail changes

mole changes

Head & neck:

head injury

headache

migraines

neck pain/stiffness

lumps/masses

thyroid problems

Eyes:

visual changes

eye pain

redness

double vision

blurry vision

flashing lights

cataracts

glaucoma

Ears, nose, throat, mouth:

hearing loss

ringing in ears

earache

vertigo

sinus congestion

sinus pain

nasal discharge

nosebleeds

hay fever

frequent sore throat

hoarseness

sore tongue

dry mouth

bad breath

thrush

non-healing sores

dental infections

bleeding gums

cold sores

Cardiovascular:

chest pain

tightness in chest

heart palpitations

dizziness

fainting spells

shortness of breath with activity and/or waking you up

difficulty breathing if lying down

ankle swelling

leg cramping

calf pain with walking

Immunologic:

hives

allergies

infections

Hematological:

easy bruising/ bleeding

anemia

swollen glands

Endocrine:

hair loss

heat intolerance

cold intolerance

excessive sweating

excessive thirst

change in appetite

Respiratory:

dry cough

wet cough

productive cough

coughing up blood

shortness of breath

wheezing

painful breathing

Gastrointestinal:

difficult/painful swallowing

heartburn/reflux

nausea/vomiting

changes in bowel habits

bowel movements per day:_____

constipation

diarrhea

yellow eyes/skin

abdominal pain

bloating/gas

black/bloody stool

rectal bleeding

hemorrhoids

incontinence

Urinary:

pain

burning

frequency

urgency

leaking

incontinence

blood in urine

dribbling

decreased flow

incomplete voiding

bladder infections

Females:

sexual orientation:

_____

age of first period:_____

irregular periods

painful periods

heavy bleeding

PMS

fertility concerns

pregnancies:____

childbirths:_____

currently pregnant

breastfeeding

menopause

hot flashes

vaginal dryness

pain with sex

loss of sex drive

abnormal PAP(s)

vaginal discharge

vaginal itching

masses

sores

STI(s)

Males:

sexual orientation:

_____

erectile dysfunction

premature ejaculation

penile discharge

pain with sex

loss of sex drive

hernia

prostate issues

masses

sores

STI(s)

Breasts:

breast lumps/ masses

nipple discharge

breast pain

dimples/skin changes

Musculoskeletal:

physical trauma

muscle pain/ stiffness

cramping

restless legs

back pain

joint pain

joint stiffness

joint swelling

joint redness

Neurological:

dizziness

fainting

seizures

weakness

numbness

tingling

tremor

Psychiatric:

stress

mood swings

memory loss

nervousness

anxiety

depression

thought of self-harm

thoughts of suicide

eating disorder

substance abuse

trauma/grief

What To Expect:

Naturopathic medicine is a distinct system of primary healthcare integrating standard medical diagnostics with complementary and alternative therapies. A naturopathic doctor (ND) considers how diet, lifestyle, the environment, personal relationships and mental/emotional factors influence your health and well-being.

During your initial consultation your ND will conduct a thorough assessment of your health concerns and answer your questions. Your ND will communicate her findings, suggest lab testing when relevant and recommend a course of treatment. She will explain the anticipated benefits, possible risks, side effects and associated costs of her recommended course of action.

Naturopathic therapies are generally safe and well tolerated. As with any medical intervention results are not guaranteed and there may be health risks associated with certain treatments including but not limited to aggravation of pre-existing symptoms and allergic reactions.

In order to ensure safety it's essential that you inform your ND of all health conditions and symptoms you're experiencing as well as all prescription and over the counter drugs and natural products you're taking. Notify us if your condition or medication use changes during the course of therapy.

Privacy Policy:

All personal and medical information is kept strictly confidential and will not be released to anyone without your written consent. You may request a copy of your records at any time for an administrative fee of $0.25 per page.

Booking Policies:

1) I operate on a fee for service basis and receive no compensation if you don't show up for scheduled appointments. Same day cancellations, last minute requests to reschedule and no shows add up to a substantial amount of lost income each year. Please provide me with at least 24 hours notice if you need to cancel or reschedule; failure to do so will result in being billed for the full cost of the missed visit.

2) Any discussion about your treatment must take place during a scheduled visit or by consultation over the phone. **Please reserve email for scheduling purposes only.** If a new concern arises please schedule an appointment or phone consultation.

3) Initial consultations for adults run 75 or 120 minutes. If you have complex health concerns* please schedule an Extended Care initial visit to allow sufficient time to address your concerns.

*Complex health concerns include but are not limited to hormonal health issues (menopause, menstrual irregularities, fertility and/or IVF support) mental health disorders (depression, anxiety, bipolar, schizophrenia) Lyme disease, chronic infections, immune system disorders, oncology and chronic pain. Extended care visits are strongly recommended for any patients taking more than 6 prescription drugs and/or any patients presenting with multiple health concerns.

4) Follow up visits vary in length depending on the time needed to address your health concerns and monitor response to treatment. Patients with complex and/or multiple health concerns are asked to schedule longer visits; if less time is actually required your fees will be adjusted accordingly.

5) Adult Fee Schedule:

Initial visit - General visit for uncomplicated health concerns	75 min	$180
Initial Visit - Extended Care for complex health concerns*	120 min	$216
*Complex health concerns include but are not limited to hormonal health issues (menopause, menstrual irregularities, fertility and/or IVF support) mental health disorders (depression, anxiety, bipolar, schizophrenia) Lyme disease, chronic infections, immune system disorders, oncology and chronic pain. Extended care visits are strongly recommended for any patients taking more than 6 prescription drugs and/or any patients presenting with multiple health concerns.		
Adult follow-up visits vary in length depending on individual needs:		
	90 min	$174
	75 min	$155
*Standard second visit	60 min*	$125
	45 min	$105
	30 min	$80
	15 min	$55
Phone call/email discussing your care	15 min	$25

6) Naturopathic medicine is not covered by OHIP. Payment is due in full at the conclusion of each visit and official receipts are provided. The clinic accepts payment by Debit, Visa and MasterCard.

Acknowledgement of Informed Consent:

By signing below I acknowledge that I have read and understand what to expect including the important policies and fees outlined above. I provide informed consent to receive naturopathic care, including assessment, treatment and follow up with Dr. Aranka Jones ND. I understand that I will have the opportunity to discuss the anticipated benefits and associated risks of the recommended assessment and treatment. I understand that I may withdraw my consent at any time.

Patient name: _____

Signature: _____

Date signed: _____