2019 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 all of your 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, traumas or hospitalizations with approximate dates:

_____

_____

_____

Family physician's name:_____ City:_____

Approximate date of last 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 - please list any health conditions:

Mother	
Father	
Siblings	
Grandparents	
Children	

Lifestyle

Circle the amount of stress you're dealing with: Minimal Moderate Significant Unbearable

What are your main stressors?_____

_____

How do you cope with stress?_____

_____

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

Have you ever received counselling or psychotherapy? YES NO

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

For how many hours do you sleep?_____Do you work shift work? YES NO

Occupation:_____

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

Hobbies and interests:_____

Who do you live with?_____

Do you have 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 level of physical fitness? YES NO

If NO please explain where you see room for improvement:_____

_____

How tall are you?_____ What is your approximate weight?_____

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 use of the following substances:

	What and how much?	How often?
Caffeine		
Soft drinks		
Artificial sweeteners/“Diet” products		
Candy/Sweets/Sugar		
Alcohol		
Tobacco		
Cannabis		
Other recreational drugs		
Pain killers		
Antacids		
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

Candida or BV

masses/sores

STIs

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:

mood swings

memory loss

nervousness

anxiety

worry

depression

trauma/grief

thought of self-harm

thoughts of suicide

eating disorder

substance abuse

What To Expect

Our work together begins with me listening attentively and with compassion to your story - usually over a cup of tea. This will feel different from interactions you've had with other doctors. I take the time to perform a thoughtful, thorough assessment of *all* your health concerns in the context of your lifestyle, diet and eating habits, environment, genetics and mental/emotional factors.

My diagnostic workup includes conventional blood tests as well as more sophisticated, functional medicine tests used to identify underlying problems related to your digestion, microbiome, hormones, immune system and environmental exposures. By taking the time to ask the right questions, perform the right tests and *really think about you*, I gain the necessary insight to create your personalized care plan.

Treatment is often initiated during your initial visit. When dependent upon the results of laboratory testing, treatment options will be discussed and implemented in your second visit after I review and explain your results.

I will recommend treatment options that are integrative, evidence based, generally safe and well tolerated. I will inform you of both the anticipated benefits as well as any known risks such as aggravation of pre-existing symptoms, known side effects and the potential for drug interactions. I will also advise you of any associated costs and alternative courses of action so that you feel confident in making an informed decision about your care every step of the way.

It is important that you return for occasional progress visits so I may effectively monitor your response to treatment, make necessary adjustments to your care plan and support you in maintaining your results.

Privacy Policy

1) 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 in writing at any time for an administrative fee of $0.25 per page. Please allow 5-10 business days for such requests to be met.

2) Lab results will only be released once we have reviewed them together. After that time I am happy to share copies with you and members of your health team and there is no charge for this.

3) To ensure your privacy and the effective delivery of care, discussion about your health concerns and treatment must take place during visits. If something arises between scheduled visits please contact my office to schedule a visit so I may properly attend to your concern.

4) My office may contact you from time to time for the purpose of scheduling progress visits. Please inform us of any changes to your contact information and how you prefer to be contacted.

Financial Policy

1) **Payment**: Payment for visits is due in full at the end of each visit. You will be presented with an itemized invoice for your visit fee and any lab work to be performed. You can pay by debit, credit card or cash.

2) **Insurance**: I do not direct bill insurance companies at the present time; however, I will provide you with itemized official receipts which you may easily submit to your insurance provider. Please consult

your policy to learn about your coverage. If you do not have coverage you may instead claim my fees as a medical expense deduction on your income tax return.

3) **Visit lengths**: Aside from your *Initial Visit* (90 or 120 minutes) and *Second Visit* (usually 60 minutes) your subsequent *Progress Visits* vary in length depending on the complexity of your health concerns, what you wish to accomplish and how recently we last met. If I haven't seen you in 3 months I'll generally ask you to book 60 minutes. If visits end early I will automatically reduce the fee. Likewise if your visit runs significantly longer than what was booked, as may be possible when my schedule permits, I will automatically increase the fee.

4) **Visit fees**:

2019 Fees for Adults

Visit type	*Duration*	*Fee*
Initial Visit (Standard)	90 min	$225
Initial Visit (Extended)	120 min	$300
Second visit	60 min	$150
Progress visits (in office or by phone)	30 min	$90
	45 min	$120
	60 min	$150
	75 min	$188
	90 min	$225

5) **Cancellations**: A significant amount of resources are allocated to your visits and the high level of care I maintain for my patients. Missed visits and last minute cancellations greatly impact my ability to sustain high overhead costs and earn a living. Please provide me with at least 24 hours notice if you need to cancel or reschedule to avoid being billed for the cost of the scheduled visit. While you must attend your initial visit in person, subsequent visits may be arranged by phone if you cannot make it to our office.

6) **Dispensary**: For your convenience you may purchase natural health products from my office as long as you remain actively under my care. Please don't share or buy for other people; what is safe and effective for you may be harmful to someone else. Only unopened product may be returned for credit within 30 days of purchase.

Acknowledgement

By signing below you acknowledge that you have read and understand what to expect, including my Privacy Policy and Financial Policy outlined above. You agree to inform me of all health conditions and symptoms you're experiencing as well as prescription and over the counter drugs and natural health products you're taking. You agree to notify me if your condition, medication or natural health product use changes while under my care. You provide informed consent to receiving naturopathic care which you may withdraw at any time.

_____

Name

_____

Signature

_____

Date