"Supporting Optimal Health & Well-being for Women"

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PATIENT INTAKE FORM

Today's Date: _____

Name: _____ **Age:** _____ **Date of Birth:** ____/_____/____ **Sex:** F/M
day month year

Address: _____ **City:** _____ **Prov:**_____ **Postal Code** _____

Home Telephone: _____ **Work Telephone:** _____

E-mail: _____ **Fax #:** _____

Occupation: _____ **Full or Part Time:** _____

Employer: _____

Address: _____ **City:** _____ **Prov:** _____

Referred by: _____ **Care Card Number:** _____

For MSP purposes, are you on premium assistance or a treaty status Indian ? _____

Married ☐ Separated ☐ Divorced ☐ Single ☐ Cohabitating ☐

Live with:

Spouse ☐ Partner ☐ Parents ☐ Relatives ☐ Friends ☐ Pets ☐ Alone ☐

Next of kin (or emergency name):

Relationship: _____

Address: _____ City: _____Province_____Postal Code_____

Home Telephone: _____ Work Telephone: _____

☐ **Check here if you are interested in receiving information about upcoming lectures & workshops. If YES,**

Circle one: Contact home phone, e-mail, work phone, or by mail.

CHECK ALL THAT YOU ARE CURRENTLY EXPERIENCING

☐ Heavy bleeding ☐ Sore breasts ☐ Anxiety/Irritability
☐ Water retention ☐ Weight gain ☐ PMS
☐ Heavy bleeding ☐ Hot flashes/flushes ☐ Migraine headaches
☐ Bloatedness (along waistline) ☐ Fibrocystic breasts
☐ Endometriosis

☐ Foggy thinking ☐ Dry vagina ☐ Itching around the vagina
☐ Frequent urination ☐ Urinary leakage ☐ Depression
☐ Night sweats ☐ Mood swings/tearfulness ☐ Disturbing memory lapses
☐ Painful intercourse ☐ Crawly skin ☐ Dry eyes
☐ Insomnia/weird dreams ☐ Waking early hours of the morning

☐ Drowsiness ☐ Breast swelling ☐ Yeast infections
☐ Short cycles ☐ Heart palpitations

☐ Facial hair ☐ Acne ☐ Hair loss
☐ Loss of muscle mass ☐ Decreased sexual desire/response ☐ Lack of sexual interest

☐ Sleep disturbances ☐ Weight gain IN WAIST
☐ Skin wrinkles/thinning ☐ Fatigue ☐ Aching joints
☐ Onset of new allergies ☐ Salt Cravings ☐ Sugar Cravings

☐ Sudden outbursts of anger ☐ Lightheadedness/dizzy spells ☐ Nausea
☐ Indigestion/flatulence ☐ No symptoms
☐ Other(s):

_____

CURRENT HEALTH CONDITION

What are your most important health concerns?

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Which of the above problems are of most immediate concern? _____

CURRENT MEDICAL CONDITION

Do you have any of the following—indicate P for past, or C for current:

☐ Lupus ☐ Asthma ☐ Fibroids ☐ Endometriosis ☐ Sore/Lumpy breasts
☐ Phlebitis ☐ Liver disease ☐ High triglycerides ☐ Raynaud's syndrome

☐Diabetes ☐Seizures ☐Arthritis ☐Pancreatitis ☐Unexplained vaginal bleeding

☐Heart disease ☐Migraines ☐Breast Cancer ☐Gallbladder disease ☐Edometrial cancer within 5 years

CURRENT MEDICATIONS

Do you take or use:

☐HRT ☐Thyroid medication ☐Cortisone ☐Birth control pills

☐ERT ☐Pain relievers ☐Antibiotics ☐Nasal decongestants

☐Laxatives ☐Antidepressants ☐Antacids ☐Fosamax/Calcimar/Didrocal/Evista

☐Cholesterol-lowering drugs ☐NSAIDS

List any prescription drugs &/or hormones you are taking: _____

Please list any prescription or over-the-counter medications, vitamins or other supplements you are taking:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9._____
5. _____ 10._____

GENERAL INFORMATION

Weight: _____ Ibs. Smoking? Y/N Number per day? _____How many years?_____

Weight 1 year ago: _____lbs. Live with a smoker? Y/N

Maximum weight: _____lbs. Alcohol? Y/N Number of drinks per week? _____

Height:_____ feet ____ inches

Coffee/soda: Y/N How many per day?_____

Exercise? Y/N Times per week: _____ What kind?_____

FAMILY HISTORY

	Grandparent	Mother	Father	Sisters	Brothers
Ages (if living)					
Health					
Age at death					
Cause of death					

Check those applicable:					
Cancer					
(type)					

Heart Disease					
High Blood					
Pressure					
Stroke					
High cholesterol					
Diabetes					
Thyroid problem					
Anemia					
Asthma/Hayfever					
Arthritis					
Kidney Disease					
Alzheimer's					
Depression					
Osteoporosis					

HOSPITALIZATION AND SURGERY

What hospitalizations or surgies have you had? _____

LAB RESULTS

Last blood test results:_____

Hormone tests: Blood, saliva or urine? _____ When: _____ Results: _____

Last PAP smear results: _____

History of Abnormal PAP? _____When? _____ Results: _____

Bone Density Test? Y/N

What type? DEXA/DXA: ____ Ultrasound: _____ Other: _____ Date: _____Results: _____

Mammogram: Y/N When: _____ Results: _____

Breast Ultrasound: Y/N When: _____ Results: _____

Clinical Breast Exam: Y/N When :_____ Results:_____

MENSTRUAL HISTORY

Age at first period: _____
Date of Last Period: _____
No period? Y/N How long? _____
Days between cycles (i.e. days between periods): _____

Has there been a change in your cycle length? Y/N
Has it ☐increased or ☐decreased?
Are your cycles:
☐Regular ☐Irregular ☐Clots
 # Days of bleeding (i.e. length of menses): _____ Is this an ☐ Increase or ☐Decrease?
Cramps-- ☐Mild ☐ Moderate ☐Severe:

Birth Control: Y/N

☐ The pill	How long: _____
☐ Depo provera	Last injection: _____
☐ IUD	Date removed: _____
☐ Diaphragm/cervical cap	How long: _____
☐ Norplant	Date of last implant: _____
☐ Condoms	
☐ Natural family planning	

PREGNANCY HISTORY

Infertility problems? Y/N
Treatment: _____

Number of pregnancies: _____ Number of births: _____ Miscarriages: _____
Problems during pregnancy? _____

Breast feeding: Y/N How long? _____

GYNECOLOGICAL HISTORY

Hysterectomy? Y/N Date: _____ Reason: _____
Ovaries removed? Y/N Date: _____ Reason: _____
Did you begin Hormone Replacement immediately after surgery? Y/N Type: _____

Do you have a history of:

- ☐ Endometriosis
- ☐ Fibroids
- ☐ Fibrocystic breasts
- ☐ Ovarian cysts
- ☐ Irregular bleeding
- ☐ Thyroid problems
- ☐ Vaginal infections Type: _____

BREAST CANCER RISK EVAUATION

Personal history of breast cancer or precancer? Y/N
When? _____ Type: _____ Estrogen positive? Y/N
Treatment: _____
Tamoxifen: Y/N When? _____
Radiation: Y/N
Chemotherapy: Y/N Type? _____ Other treatments?

Family history of breast cancer: Y/N
Who: _____ Age: _____ Type: _____ Estrogen positive? Y/N
Family history of ovarian, uterine or colon cancer: Y/N
Who? _____ Age: _____ Type: _____

Check all that apply:

- ☐ First period before age 12
- ☐ Last period after age 55
- ☐ Never had children
- ☐ Never breast fed
- ☐ Smoking
- ☐ Second hand smoke exposure
- ☐ Alcohol use
- ☐ Overweight after menopause
- ☐ Lack of exercise
- ☐ Birth Contol pill
- ☐ Diet low in vegetabes & fruits
- ☐ Took DES during pregnancy
- ☐ Use of ERT/HRT >5yrs
- ☐ Shift work

OSTEOPOROSIS RISK EVALUATION

Family history of osteoporosis/ broken bones: Y/N
Who? _____ What type? _____
Personal history of osteoporosis/broken bones: Y/N
When? _____ What type? _____
Diagnosis of ostoporosis: Y/N
When? _____ How? _____

Check all that apply:

☐Asian ☐Caucasian ☐Thin/under 120 lbs ☐Fair skin
☐Late start of periods ☐Early hysterectomy ☐Both ovaries removed
☐Menopause before age 40 ☐Lost more than 1.5" in height
☐When younger had no periods for a while
☐Excessive dental carries/peridonal gum disease
☐Long term use of:
☐Steroids, heparin, lithium, thyroid medication , asthma inhalers, seizure medication, heparin/warfin

Diagnosis of:
☐Anorexia ☐Amenorrhea ☐Multiple sclerosis ☐Rheumatoid arthritis ☐Crohn's/Peptic ulcer/Celiac
High intake of:
☐coffee ☐soda pop ☐animal protein ☐alcohol ☐smoker
☐Lack of exercise ☐Diet low in calcium ☐Back pain

HEART DISEASE RISK EVALUATION

Family history of:

☐heart attack ☐high blood pressure ☐high cholesterol ☐diabetes
Who? _____ What age? _____

Personal history of high blood pressure: Y/N

Current blood pressure: _____ Last measured on: _____
☐High cholesterol Date: _____ Reading: _____
☐High triglycerides Date: _____ Reading: _____
☐High blood suger Date: _____ Reading: _____ Treatment: _____
☐Smoking Packs/day: _____ Number of years: ____
☐Alcohol
Amount per week: _____
Blood pressure medication:
What type (s) _____ How long? _____

Check all that apply:

☐Indo-Asian Canadian ☐African Canadian ☐Hispanic ☐Post menopausal
☐Sedentary lifestyle ☐Polycystic ovaries ☐High-Stress ☐Diabetic
☐More than 20lbs overweight ☐Surgical menopause before 40

ALLERGIES

Are you hypersensitive or allergic to:

- ☐ Any drugs: _____
- ☐ Any foods: _____
- ☐ Any chemicals or environmental toxins: _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

YOUR VALUES

In attempt to help you sort out your values, please check all statements that apply to you.

- ☐ I hate pills and would rather tough it out. [1]
- ☐ I don't care what it takes, I just want it to get better, and fast. [3
- ☐ I have always favored natural remedies. [2]
- ☐ I don't have time to exercise or change my diet—just give me a pill. [3]
- ☐ I have always thought that herbs were useless. [3]
- ☐ I go to the doctor because she or he is the expert, so I'll do what the doctor says. [3]
- ☐ It's important to me to be actively involved in all my own decisions about health care. [1]
- ☐ I am willing to experiment with other ways of seeking health care to get rid of my symptoms. [2]
- ☐ I am willing to experiment with different approaches to get rid of my symptoms. [2]
- ☐ I don't care what the studies say: women on hormones look younger to me. [3]
- ☐ I think menopause almost always includes unpleasant symptoms that need treatment. [3]
- ☐ I don't have time for menopause. [3]
- ☐ I couldn't take anything that came from horse urine. [2]

THANK YOU!

DR. TASNIM ADATYA
OFFICE POLICY REGARDING FEES AND INSURANCE COVERAGE

OUR FEE POLICY IS A REFLECTION OF THE SPECIALISED PROCEDURES INCORPORATED IN THIS OFFICE AND ALLOWS US TO GIVE WHAT WE FEEL TO BE THE HIGHEST QUALITY OF NATUROPATHIC CARE.

Fees

Payment for naturopathic services is expected at the time of treatment.

B.C. Medical

The provincial government removed MSP coverage for naturopathic services on January 1, 2002. Partial re-imbursement from the government is no longer available. Those on premium assistance or who are treaty status Indian may qualify for partial re-imbursement.

Extended Medical

With the provincial government change on January 1, 2002, more extended healthcare plans will permit the subscriber to claim the full cost of naturopathic services and therefore receive a larger re-imbursement. You will need to check your contract with your insurance company. This office does not deal directly with private insurance companies.

ICBC

For ICBC cases the patient is responsible for the fee at the time of treatment and can then submit the receipt to their adjuster for reimbursement.

Cancellation and missed appointment

This office requires a minimum of **forty-eight (48) hours** notice to cancel any appointment. **A 50% appointment fee will be charged for missed or rescheduled appointments with insufficient notice.**

BC residents are required to sign the agreement below:

I have been informed of the billing procedures of this office and agree to pay the full office fee for services rendered by Dr. Tasnim Adatya. I understand that upon submission of the appropriate claim forms that I will be reimbursed by the Medical Services Plan of BC at an established rate and that this rate is of a lesser amount than the office fee.

_____ _____

Date PATIENT'S SIGNATURE (parent or guardian)