ImmuneND Nutritional and Complementary therapies for Immune 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 questionnaire below before coming to your visit, to ensure you get the best use of your time with the Doctor. Please do not rush through this step. The more detailed the information provided in your intake form, the less time will be required by Dr. Woodworth to obtain this information during your visit. This will allow more time for further assessment and treatment recommendations and options. If you are unable to fill out the forms before hand, Please arrive at least 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.

PATIENT CONSENT FORM

Privacy of your personal information is an important part of our clinic. We understand the importance of protecting your personal information while providing you with quality naturopathic care. We are committed to collecting, using and disclosing your personal information responsibly. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic is doing to ensure that:

- only necessary information is collected about you;
- your information will not be shared without your consent; and
- storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols in accordance with the privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

The collection, use and disclosure of your information by this clinic will be made for the following purposes:

- to assess your health concerns
- to provide health care, advise you of treatment options, and follow-up accordingly
- to establish and maintain contact with you, including information mailings to remind you of upcoming appointments
- to communicate with other treating health-care providers
- to collect payment for goods and services, including invoicing, credit card payments, and collecting on unpaid accounts
- to comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy, acting under the authority of the *Drugless Practitioners Act*
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this Patient Consent Form, I agree that I have given my informed consent to the collection, use and/or disclosure of my personal information as outlined above. I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information. I agree that **Dr. Scott Woodworth, ND** can collect, use and disclose personal information about me as set out above in the information about the clinic's privacy policies.

_____	_____	_____
Signature	Print name	Date

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ImmuneND.com Adult Intake Form

Please complete the following intake form and forward to the clinic BEFORE your visit. Please provide as much information as possible with respect to the questions answered. This will provide more time during your visit for more assessment and treatment recommendations/explanations by Dr. Woodworth.

Patient Name *

Patients Full Name (and Guardian if Application)

Birthdate *

MM DD YYYY

Date of First Visit / Assessment *

MM DD YYYY

Home Address *

Address

City State/Province

ZIP/Postal Code Country

Canada

Contact Phone Number *

Email *

Please, enter your email

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Physician's Name *

Physician's Contact Information

Address, Phone Number

Emergency Contact *

Name / Contact Info

Other Practitioners

Specialists, Complimentary Health Providers... (Please List)

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Chief Health Concerns and Medical History

Please list your primary health concerns and medical diagnoses (in point form). List the concerns/conditions you are seeking help for. Don't provide specific details here, Dr. Woodworth will question each item on your list for pertinent history and specific details.

Health Concern

Health Concern

Health Concern

Health Concern

Health Concern

Health Concern

Current Prescription Medications

These are Medications prescribed by your Physician or Conventional Medical Specialists.

List all prescriptions here

Current Supplements, Vitamins, Minerals, Nutraceuticals, Herbal Medicines

These are supplements and NON prescription medications you are currently taking.

List all supplements here

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Significant Medical History / Hospitalizations / Surgeries / Etc.

Please list any significant health history or events from Childhood to present day (in point form). Include Unusual diagnosis, surgeries, hospitalizations, accidents, etc.

Recent Diagnostic Tests, Blood Tests, X rays, etc.

Please indicate if you have any of the following testing procedures done recently, and if you have had any abnormal results from such

- ☐ Blood Tests (Cholesterol, Thyroid, Inflammation, Other)
- ☐ Urineanalysis
- ☐ Cardiac Testing (Stress Testing, EKG, Angiogram,etc)
- ☐ Xrays, Cat Scans, MRI's
- ☐ Colonoscopy
- ☐ Endoscopy
- ☐ Mammogram
- ☐ PAP Testing
- ☐ Other

Medical Condition History *

Please indicate if you have EVER been diagnosed with or suffered with any of the following conditions.

- ☐ Addictions
- ☐ Asthma
- ☐ Allergies
- ☐ Anemia
- ☐ Acne
- ☐ Abuse
- ☐ Arthritis
- ☐ Chronic Infections
- ☐ Cancer
- ☐ Cold Hands/Feet
- ☐ Depression
- ☐ Anxiety / Panic Attacks
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Eczema / Psoriasis
- ☐ Gallstones
- ☐ Kidney Stones
- ☐ Gout
- ☐ Chronic Headaches
- ☐ Migraines
- ☐ Chronic Bladder Infections
- ☐ Chronic Yeast Infections
- ☐ High Blood Pressure
- ☐ Angina
- ☐ Sexually Transmitted Diseases
- ☐ Mononucleosis
- ☐ Autoimmune Disease(s)
- ☐ Pneumonia / Bronchitis
- ☐ Chronic Sinus Issues
- ☐ Tonsillitis
- ☐ Strep Throat
- ☐ Thyroid Issues
- ☐ Eating Disorders
- ☐ Seasonal Allergies
- ☐ Food Sensitivities or Intolerances

Known Allergies

Indicate if you have any known history of allergies to medications, supplements, foods or other.

Childhood Health Issues

Did you suffer with any of the following conditions during your childhood or teen years.

- [ ] Recurrent Sore Throats, Strep Throat
- [ ] Tonsillitis
- [ ] Chronic Ear Infections
- [ ] Bronchitis / Pneumonia
- [ ] Asthma
- [ ] Colic
- [ ] Reflux / Indigestion
- [ ] Eczema
- [ ] Food Sensitivities or Intolerances
- [ ] Digestive Issues (Constipation / Diarrhea)

Digestive Function *

Please indicate if you have suffered with any of the following conditions either currently in anytime in the past

- [ ] Irritable Bowel Syndrome
- [ ] Recurrent Diarrhea
- [ ] Chronic Constipation
- [ ] Reflux, Indigestion, Heartburn, GERD
- [ ] Abdominal Pain, Cramping
- [ ] Gas and Bloating
- [ ] Blood in the Stool
- [ ] Crohns / Colitis
- [ ] Mucousy Stools
- [ ] Yellow Floating Stool
- [ ] Undigested Food Particles in the Stool
- [ ] Parasites or Worms
- [ ] Excessive Upper or Lower Gass
- [ ] Other

Genito-Urinary System *

Please indicate if you are currently or have in the past, suffered with any of the following conditions or symptoms. Please provide details in the Notes section if applicable.

- [ ] Recurrent Bladder or Kidney Infections
- [ ] Recurrent Kidney Stones
- [ ] Blood in the Urine
- [ ] Difficulty initiating flow
- [ ] Increased urinary frequency
- [ ] Dribbling, weak urine stream
- [ ] Incontinance
- [ ] Discomfort during urination
- [ ] Recurrent Yeast Infections
- [ ] Other

Other

Women's Health

Please indicate if you currently or have in the past suffered with any of the following

- ☐ Menstrual Difficulties
- ☐ Menstrual Irregularities
- ☐ Periods longer than 10 days
- ☐ Breast Tenderness
- ☐ Significant Cramping
- ☐ Significant PMS Symptoms, Mood Swings
- ☐ Heavy Periods
- ☐ Light Periods
- ☐ Infertility, Miscarriages
- ☐ Acne associated with Cycle
- ☐ Endometriosis
- ☐ Polycystic Ovarian Syndrome
- ☐ Fibrocystic Breasts
- ☐ Abnormal Mammogram
- ☐ Abnormal PAP tests

Notes (Urinary)

Please indicate details of any of the above symptoms / conditions if applicable.

How many pregnancies / live births?

Age at First Menstrual Cycle ?

Age at Menopause ?

Please indicate if natural or surgical (hysterectomy)

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Family Medical History

Please indicate if you or any direct blood relative (sibling, parent, grand parent, aunt, uncle, child, etc) have ever suffered with or been diagnosed with any of the following. This history is VERY important, so if you need to check with other family members to confirm any of this information please do so.

- [ ] Irritable Bowel Syndrome
- [ ] Crohn's / Colitis / Ulcerative Colitis
- [ ] Diverticulitis / Diverticulosis
- [ ] Ulcers
- [ ] Colon Cancer
- [ ] Eczema, Psoriasis, Skin Disorders
- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis
- [ ] Fibromyalgia
- [ ] Type I Diabetes (Insulin)
- [ ] Type II Diabetes
- [ ] Kidney Disorders / Stones
- [ ] Gout / Gallstones
- [ ] Thyroid Disorders
- [ ] Multiple Sclerosis
- [ ] Lupus / Scleroderma
- [ ] Other Autoimmune Disorders
- [ ] Breast Cancer
- [ ] Skin Cancer
- [ ] Other Cancers
- [ ] Other

Notes to Family History

If you indicated yes to any of the conditions above, please indicate which family suffered with each condition above. This is very important information so please be thorough.

Other conditions / Concerns

Please indicate if you currently or in the past have suffered with any of the following symptoms or conditions. If so, please provide details of each in the notes section below.

- [ ] Fatigue, Exhaustion
- [ ] Lack of Endurance
- [ ] Poor Focus, Concentration, Brain Fog
- [ ] Muscle Weakness
- [ ] Restless Leg Syndrome
- [ ] Muscle Cramps
- [ ] Anxiety, Worry
- [ ] Anxiety Attacks, Panic Attacks
- [ ] Oversensitive, Overwhelmed Easily
- [ ] Edgy, Irritable, Over Reactive
- [ ] Palpitations, Shortness of breath episodes with Anxiety
- [ ] Lack of Motivation, Will, Drive, Ambition, Apathy
- [ ] Salt, Sugar, Caffeine Cravings
- [ ] Sleep Issues (Falling Asleep, Staying Asleep, Waking up unrefreshed
- [ ] Low Libido
- [ ] Cold hands and Feet
- [ ] Dry Skin, Brittle nails
- [ ] Thinning hair and eyebrows
- [ ] Sleepy after meals
- [ ] Other

Dietary Assessment and Review

Breakfast

Please indicate some of your common breakfast food choices and options. Include drinks as well (water, juice, caffeinated beverages)

List most common breakfast food and drink options

Lunch

Please indicate some of your common Lunch food choices and options. Include drinks as well (water, juice, caffeinated beverages)

List most common Lunch food and drink options

Supper

Please indicate some of your common Supper food choices and options. Include drinks as well (water, juice, caffeinated beverages)

List most common Supper food and drink options

Snacks

List common between meal snack options from mid morning to bedtimes

Other Dietary Behaviours

Please indicate if you eat, drink or use any of the following regularly, and indicate frequency in the notes section if applicable.

- [ ] Caffeinated Beverages (Hot or Cold)
- [ ] Alcoholic Beverages
- [ ] Tobacco Products
- [ ] Marijuana
- [ ] Other Recreational Drugs
- [ ] Sodas

Notes (to above)

Dairy Products *

Please indicate if any of the following are consumed on a daily to weekly basis.

- [ ] Milk / Cream products
- [ ] Cheese
- [ ] Yogurt
- [ ] Ice Creams
- [ ] Butter / Margarine
- [ ] Goats Milk Products
- [ ] Lactose Free Milk Products
- [ ] Other Dairy Products

Notes (Dairy)

Grain Products *

Please indicate if any of the following are consumed on a daily to weekly basis.

- [ ] Wheat / Flour Products
- [ ] Rice Products
- [ ] Gluten Free flour products
- [ ] Whole Grain Products
- [ ] Muffins, Cookies, Baked Goods
- [ ] Wheat Pastas
- [ ] Corn Products (Popcorn, Corn Chips, Whole Corn

Notes (Grains)

Egg Products *

- [ ] Whole Eggs
- [ ] Mayonnaise
- [ ] Muffins / Cookies

Notes (Eggs)

Nuts, Seeds *

- [ ] Peanuts
- [ ] Almonds
- [ ] Cashews
- [ ] Pecans
- [ ] Walnuts
- [ ] Other Nuts
- [ ] Sunflower Seeds
- [ ] Sesame Seed (includes Tahini in Hummus)
- [ ] Flax / Chia Seed
- [ ] Pumpkin Seed
- [ ] Hemp Seed Products
- [ ] Other Seeds

Fruits

- [ ] Banana
- [ ] Blueberry, Cranberry
- [ ] Strawberry
- [ ] Raspberry
- [ ] Lemon
- [ ] Orange
- [ ] Grapefruit
- [ ] Other Citrus (Mandarin, Tangerine, etc)
- [ ] Pineapple
- [ ] Melon (Watermelon, Honeydew, Canteloupe, etc)
- [ ] Papaya
- [ ] Mango
- [ ] Dried Fruits
- [ ] Avocado

Notes (Fruit)

Latex Food Sensitivity

Are there any fruits, nuts or seeds with cause unusual or immediate reactions in the mouth or anywhere else in your body when consumed. (for example, pineapple or kiwi causing a funny sensation on the tongue or throat, fruits that cause cold sores or irritation in the mouth, etc.)

Indicate any such reactions here

Vaccinations *

Do you (or have you recently) any regular vaccinations (Influenza, Hepatitis, Shingles, other) If so, please indicate which below.