

#### Adult intake form

*www.TruMed.ca* 14620 Stony Plain Road T5N 3S2 780 757 8378

Thank you for taking the time to fill out this form. It is highly detailed with the intention of understanding your past and present health so that we can choose an appropriate direction to take you.

If possible please bring relevant medical records (labs, scans, reports) with you to your first visit. Please contact your healthcare provider and have them fax the records to 1 855 455 4235

Please print off and complete these forms and bring them to your first visit.

Date			
First name	Last name _		
Date of birth	(M/D/Y)		
Age Sex M / F (circle	)	Marital status	
Current weight		Home Telephone I	Number
Address		Work	
		Cell	
E-mail		Emergency contac	ct:
Alberta Health #:		Name	
		Phone number	

How did you hear about us	s?		
	Other health care provide	rs you are seeing:	
1.Name:	2.Name:	3.Name:	
Type(eg.GP):	Туре	Туре:	
In orde	r of importance: What are	e your health concerns?	
1. (the most important con			
2.			
Goal:			
3.			
Goal:			
4.			
Goal:			

Please list any current diagnoses or diseases you have that were not mentioned above:

#### Medical History

If you are female are you currently pregnant? Y / N

Please indicate any serious conditions, illnesses or injuries and any hospitalizations, along with approximate dates.

Please list all current medications and dose (prescription, over-the-counter)	Please list all supplements, herbs, vitamins, homeopathics you're currently on.
Do you have any allergies (medicines,	Please list past prescription medications as
environmental, FOODS?)	well as supplements, herbs, etc.
Do you get regular screening tests done by another	her doctor? (pa <mark>p, b</mark> lood tests, etc.)? <mark>Y</mark> N
Results and date:	Fecal blood
Рар	Colonoscopy
Breast Exam	Prostate exam
Mammogram	PSA
Bone density	Other
Date of last physical exam	

#### Describe a typical day's diet:

Breakfast	Lunch	Dinner
Snacks	Beverages	Water
Alcohol—how much/day or wee	ekTobacco—ar	mount/day
Coffee or tea—form and amou	nt/day	
Recreational drugs-what and	how often	
	Family History	
Indicate if a	a close relative (parent, child, s any serious medical conditio	
	Other	
Occupation	Hobbies	
Do you exercise regularly? Y/r	What do you do for exercise	e, how much, how often?
How long do you sleep for?		
Do you wake well rested?		
Energy (1-10 where 10 is high	energy):	
Mood (1-10 where 10 is great r	nood):	
Bowel movementshow often	?	
Straining or loose stools? Y/N		

Y = A condition you have now   N = Never had   P = Significant problem in the past.     Mental / Emotional   Y N P   Considered or Attempted suicide   Y N P     Mood Swings   Y N P   Poor concentration   Y N P     Anxiety or nervousness   Y N P   Memory problems   Y N P     Endocrine   Y N P   Percessive hunger   Y N P     Hypo / hyperthyroid   Y N P   Excessive thirst   Y N P     Hypo / hyperthyroid   Y N P   Excessive hunger   Y N P     Hypo / hyperthyroid   Y N P   Excessive hunger   Y N P     Diabetes   Y N P   Fradueu   Y N P     Innune   Y N P   Fradueu   Y N P     Chronic infections   Y N P   P requent colds   Y N P     Nuccle weakness   Y N P   Easily stressed   Y N P     Nuccle weakness   Y N P   Loss of memory   Y N P     Nuccle weakness   Y N P   Loss of balance   Y N P     Nuccle weakness   Y N P   Loss of balance   Y N P     Rashes   Y N P   New problems/TMJ   Y N P     Acne   Y N P <th></th> <th>Review of Systems</th> <th></th>		Review of Systems	
DepressionY N PConsidered or Attempted suicideY N PMood SwingsY N PPoor concentrationY N PAnxiety or nervousnessY N PNemory problemsY N PSeasonal depressionY N PExcessive thirstY N PEndocrineY N PExcessive thirstY N PHeat or cold intoleranceY N PExcessive thungerY N PHypo / hyperthyroidY N PFaigueY N PHypoglycaemiaY N PSlow wound healingY N PDiabetesY N PSlow wound healingY N PInmuneTTY N PChronic infectionsY N PLoss of memoryY N PChronic infectionsY N PLoss of memoryY N PNumbness or tinglingY N PLoss of balanceY N PNumbness or tinglingY N PColour changeY N PSkinY N PLumpsY N PHivesY N PJaw problems/TMJY N PHadachesY N PJaw problems/TMJY N PHeadY N PSlaucomaY N PCataractsY N PEarachesY N PPouble visionY N PBalacomaY N PPouble visionY N PEarachesY N PPouble visionY N PBalacomaY N PHadachesY N PEarachesY N PHivesY N PBalacomaY N PHirdsY N PBalacomaY N PChronic sin figureY N PS		N = Never had P = Significant problem in	n the past.
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Neck       Lumps     Y N P Goiter     Y N P			
Lumps Y N P Goiter Y N P		Y N P Root canals	ΥΝΡ
Swollen glands Y N P Pain or stiffness Y N P	•		
	Swollen glands	Y N P Pain or stiffness	ΥΝΡ

Chest			
Cough	ΥNΡ	Tuberculosis	ΥΝΡ
Phlegm	ΥΝΡ	Shortness of breath	ΥΝΡ
Spitting up blood	ΥΝΡ	Shortness of breath at night	ΥΝΡ
Wheezing	ΥΝΡ	Pain on breathing	ΥΝΡ
Asthma	ΥΝΡ	Difficulty breathing	ΥΝΡ
Bronchitis	ΥΝΡ	Emphysema	ΥΝΡ
Pneumonia	YNP		
Cardiovascular			
Heart disease	Y N P	Phlebitis	YNP
Angina	YNP	Palpitations / Fluttering	YNP
High / Low Blood Pressure Murmurs	Y N P Y N P	Rheumatic Fever Chest Pain	Y N P Y N P
	YNP		YNP
Fainting Gastrointestinal	TNP	Swelling in ankles	TNP
Heartburn	YNP	Ulcer	YNP
Abdominal pain or cramps	YNP	Diarrhoea	YNP
Change in appetite	YNP	Jaundice (yellow skin)	YNP
Belching or passing gas	YNP	Liver or gall bladder disease	YNP
Nausea / vomiting	YNP	Black stools	YNP
Constipation	YNP	Hemorrhoids	YNP
Blood / Mucus in stools	YNP	Bowel Movements: How often?	YNP
Urinary			
Pain on urination	YNP	Kidney stones	YNP
Increased frequency	YNP	Frequent infec <mark>tion</mark> s	YNP
Inability to hold urine	YNP	Urgency	YNP
Musculoskeletal			
Joint pain or stiffness	YNP	Weakness	YNP
Arthritis	YNP	Easy fatigue	YNP
Broken bones	Y N P	Muscle spasms or cramps	YNP
Sciatica Peripheral Vascular	YNP		
Easy bleeding or bruising	YNP	Cold hands / feet	ΥNΡ
Anemia	YNP	Varicose veins	YNP
Deep leg pain	YNP	Thrombophlebitis	YNP
Male			
Sexually transmitted disease	YNP	Are you sexually active?	ΥN
Hernias	ΥΝΡ	Impotence?	ΥΝΡ
Testicular masses	ΥΝΡ	Premature ejaculation?	ΥΝΡ
Prostate issues	ΥΝΡ	Sexual orientation	
Female			
Age at first menses		Clotting	YNP
Length of cycle		Heavy or excessive flow	YNP
Are cycles regular?	ΥN	PMS	ΥΝΡ
Duration of bleeding		What symptoms?	
Bleeding between cycles	Y	Number of pregnancies Endometriosis	ΥΝΡ
Pain during intercourse	T IN P	Ovarian cysts	Y N P Y N P
		Ovaliali Cysis	

#### Thank you for completing this form.

#### If you haven't already done so, please call 780 757 8378 to book your first visit.

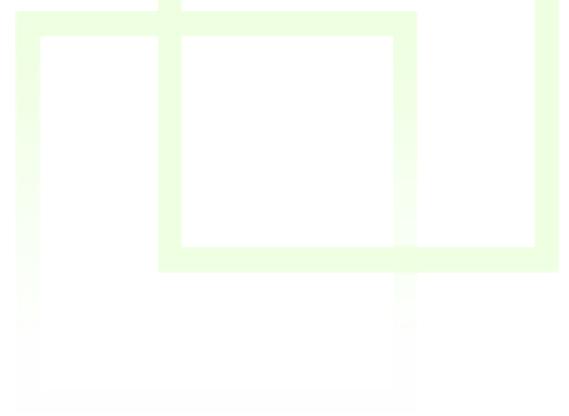
Cancellation policy: Your appointment time is reserved for you.

Appointments cancelled with less than 24 hours notice may be charged \$150.

Appointments cancelled the same day or missed appointments may be charged the full appointment fee.

We regret that Alberta Health does not cover Naturopathic services; therefore fees for Naturopathic services and all supplements are the responsibility of the patient, payable in full, at the time of the appointment.

Fortunately, Naturopathic Medicine is covered by many extended health care plans.



#### Consent

Naturopathic medicine is a system of healthcare that takes a holistic approach to assessment, diagnosis, and treatment with a focus on prevention, restoration and health maintenance.

Naturopathic medicine is a continually evolving body of knowledge that combines ancient healing traditions with current scientific advances in health care to treat the root cause of disease. The Naturopathic approach attempts to remove the cause of disease and stimulate the body's inherent healing capacity using gentle therapies.

Initial consultation will be approximately 60 minutes; this will allow you to express all of your health concerns, and a treatment plan will begin to be formulated. Laboratory testing and physical exam may be used to aid in diagnosis and treatment.

A number of different approaches may be used throughout the course of healing.

Primary treatment modalities include, but are not limited to, diet, lifestyle counselling, clinical nutrition (primarily via supplementation), botanical medicine, homeopathy, Traditional Chinese Medicine and acupuncture, intravenous therapy, mesotherapy and physical medicine.

Even the gentlest therapies may cause complications and unexpected reactions in certain physiological conditions; this depends greatly on individual factors such as age, genetic variation, pre-existing conditions, medications, environmental sensitivities amongst other factors.

It is very important that you inform Dr.Muradov or Dr. Deol of any disease process that you are suffering from, any allergies you have and any medications/over the counter drugs/supplements that you are currently taking.

Please advise immediately if you are pregnant, planning to be pregnant, suspect you are pregnant, or if you are breast-feeding.

By signing below, I certify that I agree and understand the above.

By agreeing below, I understand that Health risks associated with Naturopathic Medicine include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs or injections
- Pain, bruising or injury from injections/blood draws, acupuncture, manual therapy, or cupping
- Fainting or puncturing of an organ with acupuncture needles
- Muscle strains and sprains or disc injuries from spinal manipulation
- And in rare instances, death.

However, Dr.Muradov and Dr Deol have been extensively trained in Naturopathic healing and strives to practice medicine with the greatest regard for patient safety in order to reduce the likelihood adverse reactions.

By agreeing below:

You understand that some of the diagnostic/therapeutic techniques we use, at this time, are considered non-standard.

That you are accepting or rejecting this care of your own free will and choice.

That you accept full responsibility for any fees incurred during care and treatment at the time of the visit unless prior arrangements have been made

I understand that, as in all health care, there are some risks to treatments. Although Dr. Muradov and Dr. Deol take great care in reducing possible side effects and adverse reactions and interactions, I do not expect Dr. Muradov or Dr. Deol to anticipate or explain all the risks and potential complications.

As a patient of TruMed Clinic, I am at liberty to seek or continue medical care from a medical doctor; TruMed strongly encourages this. TruMed does not suggest or recommended that I refrain from seeking or following the advice of another licensed health care provider.

I understand that TruMed practitioners play a secondary role in my healthcare, and offer complaint oriented healthcare, and that I will regularly seek the opinion of a medical doctor as a primary care provider, for standard health oriented screening tests because I understand that these tests are not totally available for a Naturopathic doctor in Alberta to run, therefore we strongly encourage regular health screening from a medical doctor.

I understand, the treatment and therapies rendered or recommended at TruMed Clinic may be different that those usually offered by a medical doctor or other licensed health care providers.

As a patient of TruMed Clinic, I understand that results are not guaranteed.

I understand and am informed that, as in the practice of other medicine, there are some risks to naturopathic therapies, some of which, but not all, are outlined in this document. Furthermore, as in the practice of other medicine, there is always the potential for misdiagnosis, missed diagnosis or ineffective treatment and I acknowledge that I do not hold Dr. Muradov, Dr. Deol or TruMed responsible for any of these potential mentioned possibilities. The information I have provided is complete and inclusive of all health concerns, including the possibility of pregnancy, allergy and all medications I am taking, including over-the-counter drugs and supplements.

I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic.

I acknowledge that Dr. Muradov or Dr. Deol will be playing an adjunctive role in my health care and standard screening tests and primary care should still be provided by a licensed medical doctor.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private or public agency attempting to gather information without so stating.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Date: \_\_\_\_\_

#### **Collection of information and privacy:**

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To advise you of treatment options
- To provide health care
- To distribute health care information to you
- To book and confirm appointments
- To email you about your care or to inform you about promotions or lectures at the clinic

- For teaching and publishing purposes on an anonymous basis

- To communicate with other treating healthcare providers .

- To allow us to efficiently follow-up for treatment, care and billing which may include leaving information on a voicemail service. - To establish and maintain contact with you

- To communicate to a legal guardian or a significant other or family member if a situation calls for these individuals to know more about your health.

- To invoice for goods and services

- To complete claims for insurance purposes

- To process credit card payments
- To collect unpaid accounts
- To comply generally with the law

- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

I agree to the above:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_