DR. LANI NYKILCHUK, ND
NATUROPATHIC DOCTOR
Timber Massage & Wellness
B, 6935 Harvie Avenue
604-344-0605
info@drlani.ca

ADULT INTAKE FORM

PATIENT INFORMATION

Please note that all the information that you provide will be held absolutely confidential.

Today's Date: _____

Full Name: _____ Preferred Name:_____

Care Card Number (PHN):_____

Age: _____ Date of Birth (M/D/Y): _____ Gender: _____

Address:_____

City: _____ Province: _____ Postal Code:_____

Phone # (home): _____ (cell): _____ (work): _____

Email address: _____

Do you wish to receive our seasonal e-newsletter? Y ❒ N ❒

Can Dr. Lani contact you via email regarding your care? Y ❒ N ❒

How did you hear about this clinic? _____

If you were referred, please indicate whom we may thank: _____

Occupation: _____Hours per week: _____

Emergency contact:

Name:_____Relationship:_____Phone:_____

Do you see a medical doctor? Y ❒ N ❒

Doctor's Name: _____ Telephone: _____ Fax: _____

Other types of health care: (ie. Chiropractor, massage therapy, physiotherapist)_____

_____

Do you have extended coverage Y ❒ N ❒ Do you receive MSP premium assistance Y ❒ N ❒

What are your main health concerns? List as many as you can in order of importance.

1) _____When did this start?_____

2) _____When did this start?_____

3) _____When did this start?_____

4) _____When did this start?_____

CONTEXT OF CARE QUESTIONNAIRE

Why did you choose to come to this clinic?

What do you know about our approach?

*What expectations do you have for **this visit** to our clinic?*

*What **long-term** expectations do you have from working with our clinic?*

*What is **your present level of commitment** to address any underlying causes of your health concerns?*

0% 10 20 30 40 50 60 70 80 90 100%

*What potential **obstacles** do you foresee in adhering to the therapeutic protocols that I will be sharing with you?*

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HEALTH HISTORY INFORMATION

FAMILY HISTORY

Does anyone **in your family** have a history of any of the following? Note maternal (M) or paternal (P) side of the family

M❒	P❒	Cancer	M❒	P❒	Arthritis	M❒	P❒	Asthma
M❒	P❒	Diabetes	M❒	P❒	Kidney disease	M❒	P❒	Epilepsy
M❒	P❒	Heart disease	M❒	P❒	Liver disease	M❒	P❒	Anxiety/Depression
M❒	P❒	High blood pressure	M❒	P❒	Anemia	M❒	P❒	Eating Disorder
M❒	P❒	Stroke	M❒	P❒	Autoimmune	M❒	P❒	Addiction
M❒	P❒	Glaucoma	M❒	P❒	Thyroid disease	M❒	P❒	Neurological disorder
M❒	P❒	Osteoporosis	M❒	P❒	Allergies/ Hives	M❒	P❒	Skin disorder

Other relevant family history? _____

Family Heritage: _____

PAST MEDICAL HISTORY

Please check if you had any of the following as a child:

❒ Rheumatic fever	❒ Diphtheria	❒ Scarlet fever	❒ German Measles
❒ Measles	❒ Mumps	❒ Chicken pox	Other:_____

VACCINATIONS

Have you received all scheduled vaccinations? Y ❒ N ❒

If no, please specify which you have had:

❒ Polio	❒ MMR (Measles/Mumps/Rubella)	❒ Pertussis	❒ Diphtheria
❒ Tetanus Shot	❒ Hepatitis A	❒ Hepatitis B	Other: _____

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, significant trauma, diagnostic testing (X-ray, CAT scan, MRI, EEG, EKG, etc…) have you had?

_____year _____ _____year _____

_____year _____ _____year _____

_____year _____ _____year _____

Major accidents/trauma (fall, motor vehicle accident, loss of loved one, etc.)

_____

CURRENT MEDICAL INFORMATION

Do you have any known contagious diseases at this time? Y ❒ N ❒ If yes, what? _____

ALLERGIES/SENSITIVITIES

Any medication/drugs? _____

Any foods? _____

Any environmental, chemical or other?_____

CURRENT MEDICATIONS OR SUPPLEMENTS Please list any prescription medications, over the counter medications, or supplements (vitamins, minerals, herbal formulas, homeopathics, …) you are taking.

1) _____dose:_____ start date:_____
2) _____dose:_____ start date:_____
3) _____dose:_____ start date:_____
4) _____dose:_____ start date:_____
5) _____dose:_____ start date:_____

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GENERAL HEALTH HISTORY

Height: _____ Weight: _____Weight one year ago: _____

Energy level 1-10:_____When during the day is your energy the best? _____ Worst? _____

Level of stress: 1-10_____ Main cause?_____

Main interests and hobbies: _____

Exercise: Y ❒ N ❒ If so, what kind and how often: _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Are you or have you ever been on a restricted diet? If so, what kind? _____

Alcohol consumption: ❒ None ❒ Once a month ❒ Once a week ❒ Every day ❒ Multiple times a day

Caffeine consumption: ❒ None ❒ Once a month ❒ Once a week ❒ Every day ❒ Multiple times a day

PLEASE CHECK IF THE FOLLOWING IS A CURRENT OR RECURRING SYMPTOM:

GENERAL

Hours of sleep?_____ Awake rested?	Y ❒ N ❒	Do you enjoy your work?	Y ❒ N ❒
Have supportive relationship?	Y ❒ N ❒	Spend time outside?	Y ❒ N ❒
Treated for addiction/dependence?	Y ❒ N ❒	Cravings?	Y ❒ N ❒
Use tobacco **currently** or in **past?**	Y ❒ N ❒	Toxic exposure (at home or work)?	Y ❒ N ❒

IMMUNE

❒ Reactions to immunizations	❒ Chronic fatigue syndrome	❒ Chills
❒ Chronically swollen glands	❒ Night sweats	❒ Fever
❒ Slow wound healing	❒ Chronic infections	❒ Frequent cold/flu

SKIN/HAIR

❒ Rashes	❒ Eczema	❒ Perpetual hair loss
❒ Acne/boils	❒ Hives/ Itching	❒ Dandruff
❒ Change in skin color/texture	❒ Recent moles	❒ Sweat easily

HEAD, EYES, EARS, NOSE, THROAT

❒ Recent change in vision	❒ Headaches/migraines	❒ Pain or stiffness in neck
❒ Cataracts	❒ Head injury	❒ Frequent sore throat
❒ Glaucoma	❒ Jaw or TMJ problems	❒ Sores on tongue or lips
❒ Spots in vision	❒ Sinus problems/congestion	❒ Hoarseness
❒ Redness or itching of eyes	❒ Nose bleeds	❒ Teeth grinding
❒ Eye pain, tearing or dryness	❒ Hay fever	❒ Gum problems
❒ Loss of hearing	❒ Loss of smell	❒ Dental cavities
❒ Ringing in ears	❒ Lumps in neck	❒ Facial pain
❒ Ear infection/pain	❒ Difficulty swallowing	❒ Loss of sense of taste

RESPIRATORY

❒ Cough ❒Phlegm (Colour?)	❒ Shortness of breath	❒ Emphysema
❒ Asthma	❒ Pain in breathing	❒ Bronchitis
❒ Wheezing	❒ Coughing up blood	❒ Tuberculosis

HEART AND CIRCULATION

❒ Irregular heart beat	❒ High or low blood pressure	❒ Dizziness/Fainting

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❒ Chest pain
❒ Anemia
❒ Easy bleeding or bruising
❒ Deep leg pain
❒ Varicose veins
❒ Blood clots/thrombosis/DVT
❒ Swelling of extremities

ENDOCRINE

❒ Hypothyroid
❒ Hypoglycemia
❒ Excessive hunger or thirst
❒ Fatigue
❒ Heat or cold intolerance
❒ Hyperthyroid
❒ Diabetes
❒ Difficulty exercising
❒ Goiter

DIGESTION AND ELIMINATION

❒ Change in appetite/thirst
❒ Bad breath
❒ Nausea/vomiting
❒ Ulcer
❒ Gall bladder or Liver disease
❒ Pancreatitis
❒ Heartburn
❒ Abdominal pain or cramps
❒ Belching or passing gas
❒ Constipation
❒ Diarrhea
❒ Chronic laxative use
Bowel movement frequency:_____
Is this a change? Y ❒ N ❒
❒ Black stools
❒ Blood in stools
❒ Hemorrhoids
❒ Rectal pain

GENITO-URINARY

❒ Frequent or urgent urination
❒ Inability to hold urine
❒ Painful urination
❒ Blood in urine
❒ Frequent UTI's
❒ Kidney stones
❒ Sores on genitals
❒ Sexually transmitted disease:
Which: _____

FEMALE REPRODUCTIVE

Age of first menses:_____
Length of cycle: _____days
Duration of menses:_____ days
Date of last menses: _____
Are your cycles regular? ❒ Y ❒N
❒ Painful menses
❒ Heavy or excessive flow
❒ Clots
❒ PMS
Symptoms:_____
_____
_____
❒ Bleeding between cycles
❒ Endometriosis
❒ Ovarian cysts
❒ Vaginal discharge/odor
Date of last pap smear:_____
❒ Abnormal PAP
❒ Cervical dysplasia
Are you sexually active? ❒Y ❒N
Birth control? ❒Y ❒N
Type:_____
How long:_____
❒ Pain during intercourse
❒ Difficulty conceiving
Number of pregnancies:_____
Number of live births:_____
Number of miscarriages: _____
Number of abortions:_____
Do you perform monthly self-breast exams? ❒Y ❒N
❒ Breast pain/tenderness
❒ Breast lumps/nipple discharge
❒ Menopausal symptoms?_____
_____
_____

MALE REPRODUCTIVE

Are you sexually active? ❒Y ❒N
❒ Discharge or sores
❒ Hernias
❒ Testicular masses or pain
❒ Prostate disease
❒ Impotence

MENTAL/EMOTIONAL

❒ Treated for emotional problem
❒ Depression
❒ Anxiety or nervousness
❒ Poor concentration
❒ Easily stressed
❒ Quick temper/irritable
❒ Do you have mood swings
❒ Considered suicide
❒ Attempted suicide
❒ Tension
❒ Memory problems
❒ Seasonal depression

NEUROLOGICAL

❒ Seizures
❒ Muscle weakness
❒ Loss of memory
❒ Vertigo or dizziness
❒ Paralysis
❒ Numbness or tingling
❒ Loss of balance/coordination
❒ Nerve pain/Sciatica

MUSCULOSKELETAL

❒ Joint pain or stiffness
Indicate which areas:_____
_____
❒ Arthritis
❒ Bone pain
❒ Muscle weakness
❒ Muscle spasms or cramps
Indicate which areas:_____
_____

Thank you & Welcome! Looking forward to working with you on your path to better health!

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INFORMED CONSENT AND REQUEST FOR NATUROPATHIC MEDICAL CARE & ACUPUNCTURE

I, _____, hereby request and consent to examination and treatment by Lani Nykilchuk, ND, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Nykilchuk, and/or with the allied health care provider, providing backup:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including pap smears, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including naturopathic/osseous manipulation of the spine and extremities)
- Dietary advice and therapeutic nutrition (including food, nutritional supplements, or intravenous injection of nutrients)
- Traditional Oriental medicine- including acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface), moxa and cupping.
- Botanical/ herbal medicines
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Lifestyle counseling (including but not limited to visualization for improved lifestyle strategies)
- Bowen therapy (gentle physical therapy)
- Prescribed medication (which are within the naturopathic scope of practice in BC)

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat, hydrotherapies; allergic reaction to prescribed herbs, supplements and medications; soft tissue or bony injury from physical manipulation; aggravation of pre-existing symptoms.
Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief or pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.
Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some therapies prescribed could present a risk to the pregnancy.
Notice to individuals with bleeding disorders, pace makers, and/or cancer: For your safety it is vital to alert your provider, Lani Nykilchuk, ND, of these conditions.

☐ I recognize that even the gentlest therapies may potentially have complications in certain conditions, in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy, and all medications, including over the counter drugs and supplements.

I do not expect Lani Nykilchuk, ND and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Nykilchuk explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date