

## ADULT INTAKE FORM

This intake form is a *confidential* health assessment tool designed to gain insight into your personal health status. When embarking on an individualized health plan it is important to begin with a thorough understanding of where you are currently, your personal and family history, as well as your habits, concerns, and thoughts with respect to your health. Please take the time to answer the questions on this form as genuinely and as accurately as possible.

Patient Contact Information				
First Name _____	Last Name _____	Gender <b>Male / Female</b>		
Birthday: ____/____/____ <small>Day / Month / Year</small>	Current Age ____	Height _____	Weight _____	Frame <b>S / M / L</b>
Address: _____				
Street	City	Postal Code	Country	
Home Phone # _____	Mobile # _____	Work # _____		
Email _____	Preferred Contact _____			
Marital Status Single / Married/ Partnered	# of Children _____	Occupation _____		
Referred by _____ (Please let us know how you found out about imbuir, so that we can say thank you)				

Emergency Contact	
Name _____	Relationship _____
Phone Number _____	

Current Health Concerns (Please list in the order of importance to you)	
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Medical History	LIST OF MEDICATIONS AND SUPPLEMENTS
Current /past illnesses and hospitalizations (please include dates) _____ _____	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____
Allergies/Sensitivities (medications, foods, environmental) _____ _____	
(♀) Are you currently pregnant: <b>YES / NO</b>	
Have you received all vaccinations? <b>YES / NO</b>	
Date of last - Physical exam / Blood test _____	
Date of last - Antibiotic use _____	
If yes, were there any complications? _____	

Family Physician _____	Specialty _____	Phone number _____
Address _____		Fax number _____

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### Family Medical History

Please indicate current/past medical conditions (cancer, diabetes, heart disease, chronic disease, mental illness, etc)

Father		Mother	
P. Grandfather		M. Grandmother	
P. Grandmother		M. Grandfather	

### Diet + Lifestyle

Do you eat or use any of the following? ✓ Please check all that apply.

<input type="checkbox"/> Aluminum pans	<input type="checkbox"/> Microwave	<input type="checkbox"/> Margarine
<input type="checkbox"/> Refined sugars	<input type="checkbox"/> Fried foods	<input type="checkbox"/> Processed foods
<input type="checkbox"/> Luncheon meats	<input type="checkbox"/> Plastic Tupperware/Water bottles	<input type="checkbox"/> Artificial sweetener
<input type="checkbox"/> Fast foods	<input type="checkbox"/> Air Fresheners	<input type="checkbox"/> Scented body products

How would you describe your eating habits, any dietary restrictions: ✓ Please check one

- |   |  |
|---|--|
| <input type="checkbox"/> A meat eater<br><input type="checkbox"/> Vegan – Eat no animal foods of any type<br><input type="checkbox"/> Other - gluten free<br><input type="checkbox"/> Other - dairy free<br><input type="checkbox"/> Other - kosher | <input type="checkbox"/> Lacto-ovo-vegetarian – Eat dairy, eggs, but exclude animal meat<br><input type="checkbox"/> Ovo-vegetarian – Eat eggs, but no dairy or animal meat<br><input type="checkbox"/> Lacto-vegetarian – Eat dairy, but no eggs or animal meat<br><input type="checkbox"/> Pesca-tarian – Eat dairy, eggs, and fish, but avoid red meat, poultry and fish<br><input type="checkbox"/> Flexi-tarian – Eat dairy, eggs, fish and poultry, with some vegetarian meals |
|---|--|

How do you eat?

- |   |  |
|---|--|
| <input type="checkbox"/> Around the table with family<br><input type="checkbox"/> In front of the TV<br><input type="checkbox"/> On the run<br><input type="checkbox"/> Alone | <input type="checkbox"/> Restaurant How often? _____<br><input type="checkbox"/> Fast food How often? _____<br><input type="checkbox"/> At the computer<br><input type="checkbox"/> In the car |
|---|--|

Please describe what you typically eat in a day

Breakfast _____	Time _____	Water (cups/day) _____
Lunch _____	Time _____	Caffeine (cups/day) _____
Dinner _____	Time _____	Juice/pop (x/day) _____
Snacks _____	Time _____	Alcohol (x/day) _____
		Other _____

### Digestion

Do you have a bowel movement every day? **YES / NO** Do you Strain? **YES / NO**

Acid reflux/bloating/gas? \_\_\_\_\_

Food Cravings/Aversions \_\_\_\_\_

### Lifestyle

Do you smoke? Yes / No Cigarettes/day \_\_\_\_\_ How long have you been smoking? \_\_\_\_\_

Do you use recreation drugs Yes / No What type? \_\_\_\_\_

Do you exercise? Yes / No What type? \_\_\_\_\_ How often? \_\_\_\_\_

Describe your stress levels: Low / Moderate / High

How many hours do you sleep daily? (Include naps) \_\_\_\_\_

Do you wake feeling rested? (Please circle one) Yes / No / Sometimes

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### Female Health

Do you have regular menstrual cycles? Yes / No Cycle Length \_\_\_\_\_

When was the date of your last menstrual cycle? \_\_\_\_\_

Describe your PMS symptoms \_\_\_\_\_

How many days do you menstruate for? \_\_\_\_\_

Are you concerned about heavy menstrual flow or clotting? Yes / No

Do you have a history of estrogen positive cancer in your family? Yes / No

Do you have uterine fibroids/polyps/ovarian cysts? \_\_\_\_\_

Are you concerned about low libido? Yes / No

Do you have a Sexually Transmitted Infection (STI)? Yes / No

### Male Health

Are you concerned about low libido? Yes / No

Do you have concerns with erectile dysfunction? Yes / No

Do you have difficulty with increasing muscle mass, despite exercise? Yes / No

Do you experience concerns with urination or rectal pain? Yes / No

Do you have a Sexually Transmitted Infection (STI)? Yes / No

### Additional Health Information

If there is any additional information that you feel is important for our practitioners to know, please indicate this in the space provided below

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## ADULT INTAKE FORM

### imbuir™ PRIVACY POLICY

At imbuir - integrative medicine + iv therapy we understand the importance of protecting your/the minor's personal information. Below is an outline of how our office is using and disclosing your/the minor's information.

The office will collect, use and disclose only necessary information about you/the minor for the following purposes:  
(Please ✓ if interested)

- To collect information for assessments conducted by our practitioners
- To collect fees for services and dispensary purchases

- Subscription to monthly newsletters via email or mail (Optional)
- Emailing of continuing education, wellness, and health related topics (Optional)
- Seminars, workshops and surveys to promote patient education (Optional)

Your/the minor's information will be disclosed to the following individuals

- To all health professionals employed by imbuir - integrative medicine + iv therapy
- To any emergency service personnel dispatched if one's life is endangered

We will only share your/the minor's information with your consent. Storage, retention and destruction of your/the minor's personal information complies with existing legislation, and privacy protocols set out by the Board of Drugless Therapies Naturopathy (BDDT-N) and Ontario's Personal Health Information Protection Act (PHIPA).

At imbuir, we value the time we get to spend with you and strive to offer the best customer service possible, even if that is to schedule you a last minute appointment. Thus, in order to serve you better we enforce a strict 24 hour cancellation policy. If something comes up and you cannot make your appointment, please call us right away. If we do not receive a phone call or voice message, a cancellation fee of \$75 will apply. We hope you will appreciate this service as your time here at imbuir is valuable.

I have reviewed the above information that explains how imbuir - integrative medicine + iv therapy will use my/the minor's personal information, and the steps that will be taken to protect my/the minor's personal information. I agree that imbuir- integrative medicine + iv therapy can collect, use, and disclose my/the minor's personal information as set out above in the privacy policy and consent to treatment.

\_\_\_\_\_  
Signature of Patient or Guardian                      Print Name                      Date

### CONSENT TO NATUROPATHIC TREATMENT/IV THERAPY

I understand and acknowledge that my attending Naturopathic Doctor or IV certified practitioner has explained verbally the nature of the naturopathic treatment or parenteral therapy I/the minor is to receive including benefits, risks, and any medical alternatives to the prescribed treatment. I hereby consent to the treatment as set out above. I may withdraw my consent to this treatment at any time.

\_\_\_\_\_  
Signature of Patient or Guardian                      Print Name                      Date

### For Office Purposes Only

- Verbal consent acquired and witnessed. Patient/Guardian understands and acknowledges risks and benefits to treatment explained.

**CREDIT CARD PRE-AUTHORIZATION FORM  
 FOR MISSED APPOINTMENTS, AND PAST DUE STATEMENTS**

We require your credit card information for several reasons:

- 1) If you miss an appointment without calling 24 hours in advance, then we charge your card a missed appointment fee of \$75.00. This fee cannot be submitted to insurance.
- 2) If you miss an iV/injection appointment without calling prior to 9 am on the day of the appointment, then we charge your card a missed appointment fee of \$75.00 for infusions and \$25 for injections. This fee cannot be submitted to insurance.
- 3) In the event that you have an outstanding balance past 30 days, then we will notify you in writing that your card will be charged for the outstanding balance within 15 days if you do not call our office to make partial or full arrangements for payment.

Please complete the following:

I authorize imbuir – naturopathic medicine + iV therapy to keep my signature on file and to charge my Visa, Mastercard, or American Express account for an initial or recurring charge of \$75.00 for any missed appointment in which I have not called 24 hours in advance to cancel and for any outstanding balances past 30 days. I realize I will only be charged for outstanding balances past 30 days if I have not made any payment arrangements with the billing department.

I authorize imbuir – naturopathic medicine + iV therapy to keep my signature on file and to charge my Visa, Mastercard, or American Express for an initial or reoccurring charge of \$75 for any missed iV appointments and \$25 for any missed injection appointments that are NOT cancelled prior to 9 am on the date of the appointment.

I understand this form is valid for one year unless I cancel the authorization in writing. I promise not to dispute charges (“charge back”) for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize imbuir – naturopathic medicine + iV therapy to disclose information about my attendance/cancellation to my credit card issuer if I dispute the charge.

\_\_\_\_\_  
 Client Name

\_\_\_\_\_  
 Cardholder Name

Cardholder Billing Address	City	Province	Postal Code
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Account Number	Expiration Date
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Cardholder Signature	Date
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