

Nature's Touch Naturopathic Clinic

Dr. Maria Papasodaro, ND
A Healing Place: 247 Main St. North
Brampton, ON
L6X 1N3

Thank you for calling to inquire about an appointment with Dr. Maria Papasodaro at Nature's Touch Naturopathic Clinic.

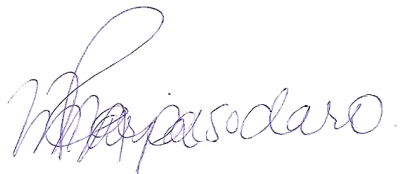
Enclosed is a detailed intake questionnaire. Please fill out the questionnaire and bring it with you to your appointment. The first visit is about one hour in length. The cost of the initial visit is \$150. Follow up visits are about 30 minutes in length and the cost is \$65 + tax.

The first visit includes a review of the detailed intake questionnaire and physical exam. Please bring copies of any blood work or laboratory reports that have been taken within the last six months.

Nature's Touch Naturopathic Clinic is located at *A Healing Place*: 247 Main St. North, Brampton which is between Queen St and Vodden St. The office accepts all standard methods of payment. Most extended health care providers cover Naturopathic treatments; please check with your provider to determine the amount this is covered under your policy. There is free parking at the building, David St or Rosedale Ave. Note that our offices are scent free to respect those clients with allergies or sensitivities.

I look forward to meeting with you. Kindly give us a call at (905) 459-4385 or email from www.naturestouchnd.ca if you have any questions.

Wishing you good health,

A handwritten signature in blue ink that reads "M. Papasodaro". The signature is fluid and cursive, with a large loop at the beginning.

Maria Papasodaro
Doctor of Naturopathic Medicine

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Adult/Senior Intake Form

(please print clearly)

Name: _____

Date _____

Date of birth : _____ (M/D/Y) Sex: M F

Address: _____

E-mailAddress: _____

Would you like to receive free emailed articles written by Maria Papasodaro, ND: _____

Telephone number: Home: _____ Work: _____

May we leave messages relating to your visits? Y / N

Emergency contact: Name: _____

Phone number: _____ Relation: _____

****Naturopathic medicine works the best when the doctor has a complete picture of the physical, emotional and mental symptoms. Therefore, please take the time to thoroughly complete this health questionnaire.****

How did you hear about our Clinic? Please check one of the following:

- Newspaper Article/Ad
- Corporate Health/Wellness Event/ Presentation
- Nature's Touch Open House
- A Healing Place staff
- Centennial college faculty
- Friend
- Family
- Nature's Touch patient
- Other _____

Referred by: _____

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Other health care providers you are seeing:

1. _____

(_____)_____
2. _____

(_____)_____
3. _____

(_____)_____

Context of Care

1a. Why did you choose to come to this clinic?

b. What do you know about my approach?

2a. What three expectations do you have from this visit to my clinic?

b. What long term expectations do you have from working with my clinic?

c. What expectations do you have of me personally as your physician?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

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b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

7. What do you LOVE to do?

Health Concerns:

What are your health concerns, in order of importance to you:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

If you are female are you currently pregnant? Yes No (Please circle one)

Medical history:

How would you describe your general state of health? Excellent Good Fair Poor

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

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Do you have any allergies (medicines, environmental, etc.)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

Please list past prescription medications.

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/implants/injections

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often _____

Please indicate what immunizations you have had

DPT (diphtheria, pertussis, tetanus)

Haemophilus influenza B

Hepatitis A

Tetanus booster; when? _____

"Flu"

Hepatitis B

MMR (measles, mumps, rubella)

Polio

Smallpox

Other _____

Please indicate if any caused adverse reactions:

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y / N

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Diet

Do you have any food allergies or intolerances? Please list.

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Family history

Indicate if a close relative (parent, child, sibling) has had any of the following:

Please indicate which family member

Allergies: _____

Asthma: _____

Heart Disease: _____

High Blood Pressure: _____

Cancer: _____

Diabetes: _____

Depression: _____

Other Mental Illness: _____

Drug Abuse/Alcoholism: _____

Kidney Disease: _____

Other: _____

I don't know my family medical history

Environment

Occupation: _____

Hobbies: _____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

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How is your home heated?

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

How would you describe the emotional climate of your home?

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

Is there anything that you feel is important that has not been covered?

Review of Systems

Y = A condition you have **now**

P = A condition you have had in the **past**

N = A condition you have **never had**

GENERAL

Weight

Weight 1 year ago

Maximum weight & date

Height

Fatigue/Weakness	Y	P	N
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Fever/Chills	Y	P	N
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SKIN

Rashes	Y	P	N
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Eczema, hives	Y	P	N
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Acne, boils	Y	P	N
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Itching	Y	P	N
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Colour change	Y	P	N
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Lumps	Y	P	N
Night sweats	Y	P	N
Dryness/moistness	Y	P	N
Temperature fluctuations	Y	P	N
Nail changes	Y	P	N
Changes in mole	Y	P	N
Skin cancer	Y	P	N

HEAD

Headache	Y	P	N
Head injury	Y	P	N
Dizziness	Y	P	N

EYES

Impaired vision	Y	P	N
Glasses/contacts	Y	P	N
Eye pain	Y	P	N
Tearing/dryness	Y	P	N
Double vision	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N
Blurring	Y	P	N
Bothered by sun	Y	P	N
Itching	Y	P	N
Redness	Y	P	N
Discharge	Y	P	N
Blind spot	Y	P	N

EARS

Impaired hearing	Y	P	N
Earache	Y	P	N
Dizziness	Y	P	N
Discharge	Y	P	N
Infections	Y	P	N

NOSE/SINUSES

Frequent colds	Y	P	N
Nose bleeds	Y	P	N
Stuffiness	Y	P	N
Hay fever	Y	P	N
Sinus problems	Y	P	N
Post-nasal drip	Y	P	N

MOUTH/THROAT

Frequent sore throat	Y	P	N
Sore tongue/mouth	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental cavities	Y	P	N

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Loss of taste	Y	P	N
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NECK

Lumps	Y	P	N
Swollen glands	Y	P	N
Goitre	Y	P	N
Pain/stiffness	Y	P	N

RESPIRATORY

Cough	Y	P	N
Sputum	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Pleurisy	Y	P	N
Emphysema	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N
Shortness of breath	Y	P	N
Shortness of breath at night	Y	P	N
Shortness of breath lying down	Y	P	N
Tuberculosis	Y	P	N
Tuberculin Test	Y	P	N
Last Chest X-Ray: _____			

BREASTS

Do you do self exams	Y	P	N
Lumps	Y	P	N
Pain/tenderness	Y	P	N
Nipple discharge	Y	P	N

GASTROINTESTINAL

Trouble swallowing	Y	P	N
Heartburn	Y	P	N
Change in thirst	Y	P	N
Change in appetite	Y	P	N
Nausea	Y	P	N
Vomiting	Y	P	N
Vomiting blood	Y	P	N
Bowel movements (how often)	Y	P	N
Is this a change	Y	P	N
Blood in stool	Y	P	N
Belching/passing gas	Y	P	N
Jaundice (yellow skin)	Y	P	N
Liver disease	Y	P	N
Gall bladder disease	Y	P	N
Ulcer	Y	P	N

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Indigestion	Y	P	N
Diarrhea	Y	P	N
Rectal bleeding	Y	P	N
Haemorrhoids	Y	P	N
Black, tarry stool	Y	P	N
Abdominal pain	Y	P	N
Food allergy	Y	P	N
Hernias	Y	P	N

URINARY

Pain on urination	Y	P	N
Increased frequency	Y	P	N
Frequency at night	Y	P	N
Inability to hold urine	Y	P	N
Frequent infections	Y	P	N
Kidney stones	Y	P	N
Blood in urine	Y	P	N
Urgency	Y	P	N
Hesitancy	Y	P	N

MALE REPRODUCTIVE

Hernias	Y	P	N
Testicular masses	Y	P	N
Testicular pain	Y	P	N
Are you sexually active?	Y	P	N
Sexual difficulties	Y	P	N
Venereal disease	Y	P	N
Discharge/sores	Y	P	N

Sexual preference: Heterosexual: _____
 Bisexual: _____
 Homosexual: _____

FEMALE REPRODUCTIVE

Age menses began: _____			
Average number of days: _____			
Length of cycle: _____			
Last menstrual period: _____			
Last PAP test (date): _____			
Number of pregnancies: _____			
Number of live births: _____			
Number of miscarriages: _____			
Number of abortions _____			
Bleeding between periods	Y	P	N
Are cycles regular	Y	P	N
Pain during intercourse	Y	P	N
Painful menses	Y	P	N
Excessive flow	Y	P	N
PMS	Y	P	N
Birth control (and type)	Y	P	N

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Difficulty conceiving	Y	P	N
Are you sexually active?	Y	P	N
Sexual difficulties	Y	P	N
Venereal disease	Y	P	N
Vaginal discharge	Y	P	N
Vaginal itching	Y	P	N
Sexual preference: Heterosexual:	_____		
Bisexual:	_____		
Homosexual:	_____		

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N
Arthritis	Y	P	N
Broken bones	Y	P	N
Muscle spasms/cramps	Y	P	N
Weakness	Y	P	N
Joint swelling	Y	P	N
Backache	Y	P	N

PERIPHERAL VASCULAR

Deep leg pain	Y	P	N
Cold hands/feet	Y	P	N
Varicose veins	Y	P	N
Thrombophlebitis	Y	P	N
Leg cramps	Y	P	N
Extremity numbness	Y	P	N
Extremity coldness	Y	P	N
Extremity swelling	Y	P	N
Extremity ulcers	Y	P	N

NEUROLOGIC

Fainting	Y	P	N
Seizures/convulsions	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness/tingling	Y	P	N
Loss of memory	Y	P	N
Involuntary movement	Y	P	N
Loss of balance	Y	P	N
Speech problems	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N
Thyroid trouble	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Excessive urination	Y	P	N
Excessive sweating	Y	P	N
Diabetes	Y	P	N

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Hypoglycemia	Y	P	N
Hormone therapy	Y	P	N

BLOOD/LYMPHATIC

Anemia	Y	P	N
Easy bleeding/bruising	Y	P	N
Past transfusions	Y	P	N
Lymph node swelling	Y	P	N

ALLERGIC HISTORY

Drug sensitivity	Y	P	N
Reaction to vaccine	Y	P	N
List allergies			

EMOTIONAL

Depression	Y	P	N
Mood swings	Y	P	N
Anxiety/nervousness	Y	P	N
Tension	Y	P	N
Phobias	Y	P	N
Alcohol use	Y	P	N
Drug use	Y	P	N
Insomnia	Y	P	N

HOBBIES/HABITS

Do you eat 3 meals per day?	Y	N
Do you wake well rested?	Y	N
Do you sleep well?	Y	N
Do you average 6-8 hours sleep?	Y	N
Do you enjoy your work?	Y	N
Do you watch television? (how many hrs.)	Y	N
Do you read?	Y	N
Do you exercise?	Y	N
How many hours/day?	Y	N
Do you take vacations?	Y	N
Have you been treated for drug dependence?	Y	N
Have you been treated for alcoholism?	Y	N
What are your main interests/hobbies?		

****Thank you for taking the time to fill out this intake form. Any information received will remain confidential.****

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