true potential
health services inc.

Dr. Jacqui Fleury ND

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NATUROPATHIC ADULT PATIENT INTAKE FORM

Our professional association requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission. E-mail will only be used by our office to inform you of our office events and will not be distributed for any other use.

First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Telephone (H) _____ (W) _____ Health Card # _____

E-mail _____ (Cell) _____

Date of Birth _____ Age_____ Sex M____ F____ Marital Status _____

Occupation _____ Employer _____

Emergency Contact _____ _____ _____
(Full name) (Relation) (Telephone)

Number of children & their ages _____

Has any other family member already been a patient at this clinic? _____

Whom can we thank for referring you? _____ Blood Type _____ Height _____ Weight _____ Ideal Weight _____

Religion or personal philosophy _____

Name of Medical Doctor _____ Clinic _____ Telephone(___) _____

Date of last physical _____ Date of last lab tests _____

Have you previously been treated by a Naturopathic Doctor? Yes _____ No_____

Name _____ When?_____

Other health practitioners you are seeing (including conventional & complementary practitioners).

1. _____
2. _____
3. _____

Please list (in order of importance) your primary health concerns/reasons) for your visit.	Please indicate any treatments that you have tried previously to address your health issues and how effective you found these treatments.

Please list all prescription medications, herbals, vitamins and supplements (& dosages, if known)

Now	In the Past

Approximately how many times have you been treated with antibiotics and when would be your most recent round? _____

Please list any allergies you have and what kind of reaction occurs.

Allergy	Reaction

Please list all hospitalizations, fractures or major illnesses that you have had (including tonsils, adenoids, appendix, etc.)

Type of illness, operation/procedure	Date	Any ongoing concerns?

How would you rate your energy level? _____ (from 1-10, **10 being highest)**

Do you wake up feeling refreshed? Y____ If N, give details _____

What kinds of water do you drink and how many glasses of each kind per day?

Tap_____ Filtered_____ Spring _____ Reverse Osmosis _____ Distilled _____ How many cups/day do you drink of each of the following?

Coffee _____ Black Tea _____ Herbal Tea _____ Do you add milk/cream?_____ Sugar? _____

Do you smoke? N ___Y____# per day_____ How many years? _____In the past? Y ____ Quit when_____

Do you drink alcohol? N ___ Y ___ Type of _____# of drinks per week_____ In the past but quit? Y _____

Do you use recreational drugs? N ___Y __In the past? Y ___ What kind/how often? _____

Do you exercise? N___ Y___ Hours per week _____ Type of exercise _____

Do you watch TV? N ___ Y ___ Hours per week _____

Have you been vaccinated? N ___ Y ___ Did you have any adverse reactions? _____

What vaccines have you had recently? _____

Please check all of the following conditions that are applicable to **you** & **your family** and note who.

	Alcoholism			Glaucoma/Cataracts	
	Allergies			Gout	
	Arthritis			Heart Disease	
	Asthma			Heart Murmurs	
	Auto Immune			High Blood Pressure	
	Cancer			Hypo/Hyper Thyroid	
	Crohn's or Colitis			Irritable Bowel	
	Depression			Kidney Disease	
	Diabetes			Liver Disease	
	Eczema			Mental Illness	
	Gallbladder			Stroke or Aneurysm	
	GERD/Hiatal Hernia			Ulcers	
	Other				

Diet: Non ☐ Vegetarian Vegetarian ☐ Vegan ☐ For how long? _____

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

_____

Describe a typical day's diet:

Breakfast _____

Snacks _____

Lunch _____

Snacks _____

Dinner _____

Snacks _____

Beverages (type & total quantity) _____

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

_____

_____

Thank you! It's time for your healing journey to begin.....

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CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

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

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

What expectations do you have of me personally as your health care provider?

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:

0% 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

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

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

What do you love to do?

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Informed Consent

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's healing capacity.

Naturopathic Doctors are required to obtain informed consent and to make sure you are aware of possible side effects/risks due to treatment. Dr. Jacqui Fleury ND uses the following in her practice: diet and nutritional counseling, traditional Chinese medicine, botanical medicine, hydrotherapy, physical medicine, homeopathy, and lifestyle counseling. It is important to know that any treatment or advice provided is not mutually exclusive from any treatment or advice that you may now be receiving or may in the future receive from another licensed health care provider. You are at liberty to continue medical care from a medical doctor or any other health care provider licensed to practice in Saskatchewan.

Dietary therapy and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, improved gastrointestinal function, enhanced immunity, and general well-being.

Botanical medicine is plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine based on the Law of Similars; that is, the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses, of plant, animal, or mineral origin, are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Physical medicine refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation for the purpose of treating musculoskeletal and neurological problems.

Lifestyle counseling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.
During your initial visits, Dr. Jacqui Fleury will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take urine samples for further testing, or blood samples for lab investigation.
Even the gentlest of therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases including but not limited to diabetes and heart/liver/kidney disease. It is very important therefore that you inform Dr. Jacqui Fleury, ND immediately of any disease process that you are suffering from as well as any medications

(prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise Dr. Jacqui Fleury immediately.

There are some risks to treatment by Naturopathic Medicine. These include but are not limited to aggravation of pre-existing symptoms, allergic reactions to supplements or herbs.

Initials:

_____ I understand that my case may be discussed for educational purposes and information from my medical record may be analyzed for research purposes in which my identity will be kept confidential.

_____I acknowledge that I have discussed, or have had the opportunity to discuss, with Dr. Jacqui Fleury, ND the nature and purpose of naturopathic treatment in general and my treatment in particular as well as the contents of this consent.

_____I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____I understand that Dr. Jacqui Fleury, ND will answer any questions that I have to the best of her ability. Because each individual responds differently to treatment, I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

_____

_____ I understand that fees and supplements are to be paid for at the time of the consultation.

_____ I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours notice.

As the patient, you are responsible for the total charges incurred for each visit. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company. Dr. Jacqui Fleury, ND may prescribe supplements that can be purchased from our inhouse dispensary, or elsewhere. Most insurance companies do not cover the supplements that we prescribe and dispense.

I have read and understand the above-stated policies and information. I hereby authorize and consent to naturopathic treatment and examination by Dr. Jacqui Fleury, ND. I intend this consent to apply to all my present and future naturopathic care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print): _____

Signature of Patient or Guardian: _____

Date: _____