true potential
health services inc.

Dr. Kahlen Pihowich ND
PH (306) 373-5209 | FAX (306) 373-5207
#3, 1810 – 8th Street East | Saskatoon, SK S7H 0T6
contact@truepotentialhealth.com | truepotentialhealth.com

NATUROPATHIC ADULT PATIENT INTAKE FORM

PERSONAL CONTACT INFORMATION

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 office events and will not be distributed for any other use.

Name: _____ Date: _____

Address:_____

City: _____ Province: _____ Postal Code:_____

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

Email address: _____ (fax): _____

Age: _____ Date of Birth: _____ Gender: _____ Education:_____

Occupation: _____ Employer:_____ Hours per week: _____

Marital Status:_____ Number of Children and their ages: _____

_____

PHN: _____

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

Who can we thank for referring you? _____

Emergency contact: _____ Relationship: _____

Phone: _____ Address: _____

_____

PHYSICIAN INFORMATION

Do you see a medical doctor? Y / N

Doctor's Name: _____Telephone: _____ Fax: _____

Have you previously been treated by a naturopathic doctor? Yes _____ No _____

Name _____ When? _____

Other health care practitioners you are seeing (including conventional and complementary practitioners):

1._____
2._____
3._____

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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.

What do you know about our approach at this clinic?

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%) 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 that are undermining your health and adhering to the therapeutic protocols that I 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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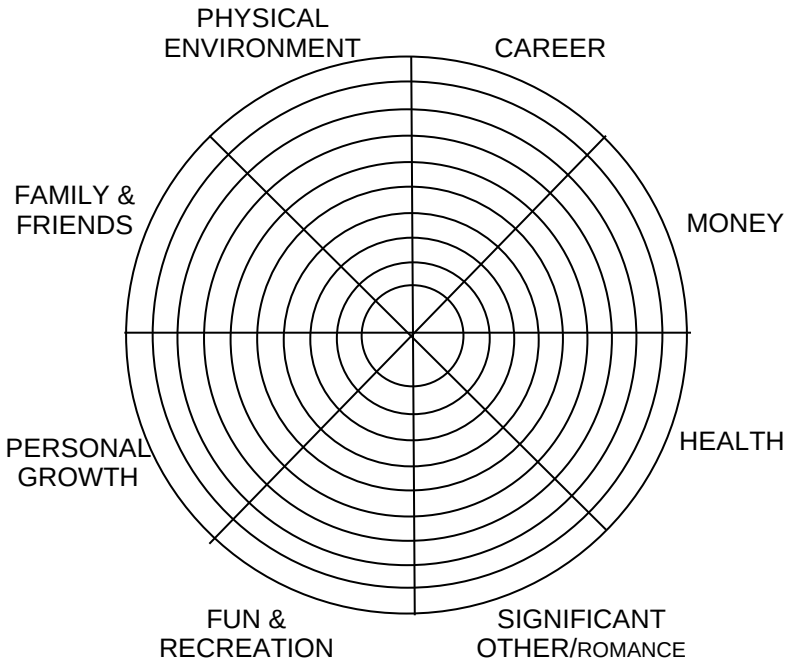
WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



PRIMARY HEALTH CONCERNS

Please list, in order of importance, your primary health concerns/reasons for your visit	**Please indicate any current or previous treatments for the listed concerns and whether or not you found them effective**

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

FAMILY HISTORY

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Do you or anyone in your family have a history of any of the following? (please circle and say who):

Alcoholism	Cancer	Gallbladder	Hyper/Hypothyroid
Allergies	Celiac Dz	GERD/Hiatal Hernia	Irritable Bowel
Anemia	Crohn's/Colitis	Glaucoma/Cataracts	Kidney Disease
Arthritis	Depression	Gout	Liver Disease
Asthma	Diabetes	Heart Disease	Mental Illness
Auto-Immune Dz	Eczema	Heart Murmurs	Tuberculosis
Aneurysm/Stroke	Epilepsy	High Blood Pressure	Ulcers

Any other relevant family history? _____

What is your family heritage? _____

CHILDHOOD ILLNESSES

Birth place: _____ Birth time: _____ Birth weight:_____

Please circle whether you had any of the following as a child:

Rheumatic fever	Diphtheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	

VACCINATIONS (please circle)

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

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, dental procedures, x-rays, CAT scans, EEG, EKGs have you had?

_____year _____ _____year _____

_____year _____ _____year _____

_____year _____ _____year _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmentals or chemicals? _____

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CURRENT MEDICATIONS
Do you take or use any of the following (please circle):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Blood Pressure Meds	Sleeping Pills	Thyroid Medication
Birth Control Pills	Hormone Replacement	Anti-Depressants	Blood Thinners

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking: **Please bring all the medications and supplements you are taking to your first visit.**

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

GENERAL
Height: _____ Weight: _____ Ideal Weight: _____ Blood Type: _____

When during the day is your energy the best? _____ Worst? _____

Main interests and hobbies: _____

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

Watch TV: Y / N If so, how many hours? _____ Read: Y / N If so, how many hours? _____

Other Screen Time (Games / Internet / etc.) Type & Hours/Day: _____

Do you have a religious or spiritual practice? Y / N If so, what kind? _____

TYPICAL FOOD INTAKE
Non-Vegetarian: _____ Vegetarian: _____ Vegan: _____ How Long? _____
Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

Beverages (type and total quantity): _____

Please indicate the intake frequency of the following:

Per week:	None	Once a month	Once a week	Every day	Multiple times a day
Alcohol	____	____	____	____	____
Caffeine	____	____	____	____	____
Tobacco	____	____	____	____	____
Drugs	____	____	____	____	____
Soft Drinks	____	____	____	____	____

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FOR THE FOLLOWING, PLEASE CIRCLE:

0 = never **1 = occassionally** **2 = frequently** **3 = all the time**

GENERAL

Do you sleep well?	0	1	2	3
Average 6-8 hours?	0	1	2	3
Awake rested?	0	1	2	3
Have supportive relationship?	0	1	2	3
Have a history of abuse?	0	1	2	3
Experienced a major trauma?	0	1	2	3
Use recreational drugs?	0	1	2	3
Treated for drug dependence?	0	1	2	3
Use alcoholic beverages?	0	1	2	3
Use tobacco?	0	1	2	3
If in the past, how many years? _____				
How many packs per day? _____				
Do you enjoy your work?	0	1	2	3
Take vacations?	0	1	2	3
Spend time outside?	0	1	2	3
Eat three meals a day?	0	1	2	3
Do you go on diets often?	0	1	2	3
Do you eat out often?	0	1	2	3
Do you drink coffee?	0	1	2	3
Drink black/green tea?	0	1	2	3
Drink soda?	0	1	2	3
Do you eat refined sugar?	0	1	2	3
Do you add salt to your food?	0	1	2	3

NEUROLOGIC

Seizures?	0	1	2	3
Muscle weakness?	0	1	2	3
Loss of memory?	0	1	2	3
Vertigo or dizziness?	0	1	2	3
Paralysis?	0	1	2	3
Numbness or tingling?	0	1	2	3
Easily stressed?	0	1	2	3
Loss of balance?	0	1	2	3

ENDOCRINE

Hypothyroid?	0	1	2	3
Hypoglycemia?	0	1	2	3
Excessive thirst?	0	1	2	3
Fatigue?	0	1	2	3
Heat or cold intolerance?	0	1	2	3
Hyperthyroid?	0	1	2	3
Diabetes?	0	1	2	3
Excessive hunger?	0	1	2	3
Seasonal depression?	0	1	2	3
Difficulty exercising?	0	1	2	3

IMMUNE

Reactions to immunizations?	0	1	2	3
Chronically swollen glands?	0	1	2	3
Slow wound healing?	0	1	2	3
Chronic fatigue syndrome?	0	1	2	3
Chronic infections?	0	1	2	3
Night sweats?	0	1	2	3

EARS

Impaired hearing?	0	1	2	3
Ringing in ears?	0	1	2	3
Dizziness?	0	1	2	3
Earaches?	0	1	2	3

EYES

Impaired vision?	0	1	2	3
Cataracts?	0	1	2	3
Glaucoma?	0	1	2	3
Spots in vision?	0	1	2	3
Color blindness?	0	1	2	3
Tearing or dryness?	0	1	2	3
Eye pain or strain?	0	1	2	3

HEAD

Headaches?	0	1	2	3
Migraines?	0	1	2	3
Head injury?	0	1	2	3
Jaw or TMJ problems?	0	1	2	3

NOSE AND SINUS

Frequent colds?	0	1	2	3
Stuffiness?	0	1	2	3
Sinus problems?	0	1	2	3
Nose bleeds?	0	1	2	3
Hay fever?	0	1	2	3
Loss of smell?	0	1	2	3

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NECK

Lumps in neck?	0	1	2	3
Goiter?	0	1	2	3
Difficulty swallowing?	0	1	2	3
Pain or stiffness in neck?	0	1	2	3

MOUTH AND THROAT

Frequent sore throat?	0	1	2	3
Copious saliva?	0	1	2	3
Sore tongue or lips?	0	1	2	3
Hoarseness?	0	1	2	3
Jaw clicks?	0	1	2	3
Teeth grinding?	0	1	2	3
Gum problems?	0	1	2	3
Dental cavities?	0	1	2	3

SKIN

Rashes?	0	1	2	3
Acne/boils?	0	1	2	3
Change in skin color?	0	1	2	3
Lumps or bumps on skin?	0	1	2	3
Eczema or hives?	0	1	2	3
Itching?	0	1	2	3
Perpetual hair loss?	0	1	2	3

RESPIRATORY

Cough?	0	1	2	3
Sputum?	0	1	2	3
Asthma?	0	1	2	3
Wheezing?	0	1	2	3
Bronchitis?	0	1	2	3
Coughing up blood?	0	1	2	3
Shortness of breath?	0	1	2	3
Shortness of breath when lying down?	0	1	2	3
Pain in breathing?	0	1	2	3
Emphysema?	0	1	2	3
Tuberculosis?	0	1	2	3

GASTROINTESTINAL

Trouble swallowing?	0	1	2	3
Change in thirst?	0	1	2	3
Change in appetite?	0	1	2	3
Nausea/vomiting?	0	1	2	3
Ulcer?	0	1	2	3
Jaundice?	0	1	2	3
Gall bladder disease?	0	1	2	3
Liver disease?	0	1	2	3
Hemorrhoids?	0	1	2	3
Pancreatitis?	0	1	2	3
Heartburn?	0	1	2	3
Abdominal pain or cramps?	0	1	2	3
Belching or passing gas?	0	1	2	3
Constipation?	0	1	2	3

Bowel movements: how often?_____
Is this a change?_____

Black stools?	0	1	2	3
Blood in stools?	0	1	2	3

MENTAL/EMOTIONAL

Treated for emotional problem?	0	1	2	3
Depression?	0	1	2	3
Anxiety or nervousness?	0	1	2	3
Poor concentration?	0	1	2	3
Do you have mood swings?	0	1	2	3
Considered suicide?	0	1	2	3
Attempted suicide?	0	1	2	3
Tension?	0	1	2	3
Memory problems?	0	1	2	3

URINARY

Increase urination frequency?	0	1	2	3
Inability to hold urine?	0	1	2	3
Pain in urination?	0	1	2	3
Frequency at night?	0	1	2	3
Frequent UTI's?	0	1	2	3
Kidney stones?	0	1	2	3

MUSCULOSKELETAL

Joint pain or stiffness?	0	1	2	3
Arthritis?	0	1	2	3
Broken bones?	0	1	2	3
Weakness?	0	1	2	3
Muscle spasms or cramps?	0	1	2	3
Sciatica?	0	1	2	3

BLOOD

Anemia?	0	1	2	3
Easy bleeding or bruising?	0	1	2	3
Cold hands/feet?	0	1	2	3
Deep leg pain?	0	1	2	3
Thrombophlebitis?	0	1	2	3
Varicose veins?	0	1	2	3

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FEMALE REPRODUCTIVE

Age of first menses:_____
Age of last menses (if menopausal):_____
Length of cycle:_____days
Duration of menses:_____ days

Are your cycles regular?	0	1	2	3
Painful menses?	0	1	2	3
Heavy or excessive flow?	0	1	2	3
PMS?	0	1	2	3

Symptoms:_____
_____

Bleeding between cycles?	0	1	2	3
Clotting?	0	1	2	3
Endometriosis?	0	1	2	3
Ovarian cysts?	0	1	2	3
Vaginal odor?	0	1	2	3
Vaginal discharge?	0	1	2	3

Date of last pap smear:_____

Abnormal PAP?	0	1	2	3
Cervical dysplasia?	0	1	2	3
Are you sexually active?	0	1	2	3

Sexual orientation:_____
Birth control? Type:_____

Pain during intercourse?	0	1	2	3
Gonorrhea?	0	1	2	3
Herpes?	0	1	2	3
Chlamydia?	0	1	2	3
Genital warts?	0	1	2	3
Syphilis?	0	1	2	3

Difficulty conceiving?	0	1	2	3

Number of pregnancies:_____
Number of live births:_____
Number of miscarriages:_____
Number of abortions:_____

Do you do self breast exams?	0	1	2	3
Breast pain/tenderness?	0	1	2	3
Breast lumps?	0	1	2	3
Nipple discharge?	0	1	2	3
Menopausal symptoms?	0	1	2	3

MALE REPRODUCTIVE

Are you sexually active?	0	1	2	3

Sexual orientation:_____
Birth control? Type:_____

Discharge or sores?	0	1	2	3
Chlamydia?	0	1	2	3
Gonorrhea?	0	1	2	3
Genital warts?	0	1	2	3
Herpes?	0	1	2	3
Syphilis?	0	1	2	3
Hernias?	0	1	2	3
Testicular masses?	0	1	2	3
Testicular pain?	0	1	2	3
Prostate disease?	0	1	2	3
Impotence?	0	1	2	3
Premature ejaculation?	0	1	2	3
Urinary Incontinence?	0	1	2	3

Is there anything you feel is important that is not covered here?

_____
_____
_____
_____
_____

Thank you & welcome to our clinic. It's time for your healing journey to begin…

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Informed Consent and Request for Naturopathic Medical Care and Acupuncture

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Kahlen Pihowich, ND, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with naturopathic medicine and acupuncture by Dr. Kahlen Pihowich, 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. Kahlen Pihowich, and/ or with the allied health care provider, providing backup:

1.) My suspected diagnosis(es) or condition(s)
2.) The nature, purpose, goals and potential benefits of the proposed care
3.) The inherent risks, complications, potential hazards or side effects of treatment or procedure
4.) The probability or likelihood of success
5.) Reasonable available alternatives to the proposed treatment procedure
6.) 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 venipuncture, 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 use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials). Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Bowen therapy (gentle, non-forceful physical therapy)

The scope of practice of acupuncture is outlined below. I understand that traditional oriental medicine and acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Moxa (indirect or direct burning of herbal material in the form of a loosely compacted herb or stick
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Dietary advice (based on traditional oriental medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals, and animal materials)

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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; 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, Dr. Kahlen Pihowich, ND, of these conditions.

Please Initial:

☐ I understand that Dr. Kahlen Pihowich, ND, is currently not licensed to prescribe drugs or any controlled substances.

☐ I understand that Dr. Kahlen Pihowich, ND, is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

☐ 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 (eg. Tylenol) and supplements.

I do not expect Dr. Kahlen Pihowich 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. Pihowich 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

_____ _____
Printed Name of Guardian Signature of Guardian

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Fee Schedule

Please see complete Fee Schedule located on our website, www.truepotentialhealth.com

Phone consultations are billed at the same rate as return visits.

Lab work and supplements prescribed by Dr. Pihowich are an additional cost and not included in the visit fee.

Please note: Patient is responsible for payment at the time of service, unless previously arranged by Dr. Pihowich. A portion of your visit may be claimed through your extended health coverage, please check with your provider. We are happy to provide physical exams at no extra charge. All other testing is done at additional charge, please ask Dr. Pihowich for prices during your visit. You will be billed for phone consultations except those regarding problems or questions with prescribed treatments. ***Because fees are subject to change, please confirm at time of booking.***

Cancellation policy: Any appointments cancelled with less than 24 hours notice will be subject to a charge for the full cost of the missed visit.

I clearly understand that Dr. Pihowich is not a medical doctor, but a naturopathic doctor who practices with natural therapeutics.

I have reviewed the above fees and understand that I am responsible for payment at the time of service, unless previously arranged by Dr. Pihowich. I also understand that I will be billed for phone consultations, except those regarding questions about prescribed treatments.

I also understand that I will be charged the full visit fee for appointments cancelled without 24 hours notice, except in cases of emergency.

Signed: _____ Date: _____