

Dr. Karina Wickland, B Sc, ND
Catalyst Integrative Health
10 - 2495 Commercial Drive
Vancouver, BC
V5N 4B8
604 568 7655

www.drwickland.com

www.catalysthealth.ca

Adult Intake Form

General Information

Name: _____ Date of First Visit: _____ MSP # _____
Address: _____ City, Province: _____ Postal code: _____
Telephone # (home): _____ Telephone # (work): _____

Email address: _____ Birthday: _____ Age: _____
Occupation: _____

Are you: Single Partnership Married Separated Divorced Widowed
Live with: Alone Partner Parents Friends Children Relatives

Emergency Contact

Name: _____ Relationship: _____ Phone #: _____

How did you hear about Dr. Wickland? _____
Do you currently have an active ICBC or WCB claim? _____
Are you on Premium Assistance (MSP)? _____

List your **current health care providers** including **designation** (e.g. medical doctors, chiropractors, counselors, massage, physiotherapist, acupuncturist) and **contact information**

Do you have any known contagious diseases at this time?

No Yes: _____

Do you have any known life-threatening allergies?

No Yes: _____

Email Correspondence (your email will never be sold, shared or traded)

Would you like to receive a copy of my newsletter via email? No Yes

Health Overview - *Comprehensive health care requires a complete picture of your health. Please take the time to complete this questionnaire carefully. If you are unsure about a question, mark it and we can discuss it during the visit.*

What are your most important health problems? List as many as you can, in order of importance to you.

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Family History

___ - I don't know my family history (skip to next section)

Please indicate if you have a family history of any of the following conditions, specifying whom [mother (M), father (F), sibling (S), child (C), maternal grandparent (MG), paternal grandparent (PG)].

- | | |
|--|---|
| <input type="checkbox"/> Diabetes (include type) | <input type="checkbox"/> Arthritis (include type) |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer (include type) | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> MS |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Celiac disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other |

Childhood illnesses (Check all that apply)

Chicken pox	Mumps	Measles	Rubella	Whooping cough
Diphtheria	Scarlet fever	Asthma	Others: _____	

Immunization history (Check all that apply)

- no immunizations
- all childhood immunizations
- immunizations for travel or work (please list):

- selective immunizations (please list):

- any adverse reactions to immunizations (please describe):

List known allergies or sensitivities:

Foods: _____
Medications: _____
Environmental factors: _____
Chemicals: _____

Do you currently take or use:

Laxatives	Pain relievers	Antacids	Cortisone	Sleeping pills
Antibiotics	Anti-depressants	Hormones	Birth control pills/patch/shot	

List all current medications with dosages:

Prescription medications: _____
Over the counter medications: _____
Supplements: _____
Natural remedies (herbal, homeopathic): _____

What accidents/traumas have you had?

What hospitalizations or surgeries have you had?

What medical tests (x-rays, CT scans, MRI, ECG) have you had?

General Information

Current height: _____ Current weight: _____
What time of day is your energy best? _____ Worst? _____

Review of Systems: List any continuing or recurrent problems in the following areas:

General

- Weight loss
- Weight gain
- Fatigue
- Sleep disturbance

Immune

- Chronic Fatigue Syndrome
- Chronic infections
- Chronically swollen glands
- Slow wound healing

Endocrine

- Thyroid problem
- Heat or cold intolerance
- Hypoglycemia
- Diabetes
- Excessive thirst
- Excessive hunger

Neurologic

- Seizures/epilepsy
- Paralysis
- Muscle weakness
- Numbness or tingling
- Loss of memory
- Easily stressed
- Vertigo or dizziness
- Loss of balance

Mental / Emotional

- Depression
- Mood Swings
- Anxiety or nervousness
- Considered/Attempted suicide
- Tension
- Poor concentration
- Memory problems

Head

- Headaches
- Head Injury
- Migraines
- Jaw/TMJ problems
- Fainting

Skin

- Rashes
- Eczema, Hives
- Acne
- Boils
- Itching
- Color Change
- Hair Loss
- Lumps
- Dry or scaling
- Night Sweats
- Excessive or no sweat

Ears

- Hearing loss
- Ringing
- Earaches
- Dizziness
- Sensitivity to noise
- Discharge from ears

Nose and Sinuses

- Frequent colds
- Nose Bleeds
- Stuffiness
- Hayfever
- Sinus problems
- Loss of smell

Eyes

- Color blind
- Double Vision
- Spots in eyes
- Recent change in vision
- Blurred vision
- Eye pain/strain
- Sensitive to light
- Eyes water excessively
- Bloodshot or puffy eyes
- Dryness

Mouth and Throat

- Frequent sore throat
- Copious saliva
- Teeth grinding
- Mouth ulcers
- Sore tongue/lips
- Gum problems
- Hoarseness

- Loss of voice
- Dental cavities
 - Type of fillings: _____
- Jaw clicks
- Cold sores

Neck

- Lumps
- Swollen glands
- Goiter
- Pain or stiffness

Cardiovascular

- Heart disease
- High/Low Blood Pressure
- Murmurs
- Blood clots
- Fainting
- Phlebitis
- Palpitations/Fluttering
- Chest pain
- Swelling in ankles

Respiratory

- Cough
- Sputum (mucus)
- Spitting up blood
- Wheezing
- Painful breathing
- Emphysema
- Difficulty breathing
- Pain on breathing
- Shortness of breath

Gastrointestinal

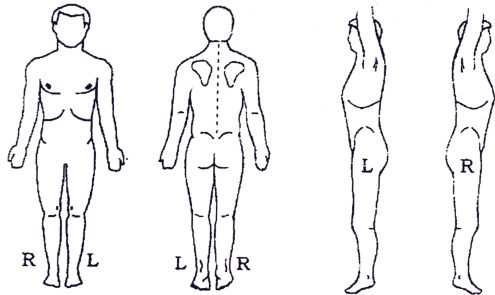
- Bowel Movements: How often? _____
- Is this a change? _____
- Constipation
- Diarrhea
- Trouble swallowing
- Heartburn
- Change in thirst or appetite
- Abdominal pain or cramps
- Belching or passing gas
- Nausea/vomiting
- Hemorrhoids
- Black stools
- Blood or mucus stool
- Undigested food in stool
- Ulcer

Urinary

- Pain on urination
- Increased frequency
- Frequency at night
- Inability to hold urine
- Blood in urine
- Difficulty starting to urinate
- Frequent infections
- Kidney stones

Musculoskeletal

- Joint pain or stiffness
- Broken bones
- Muscle weakness
- Muscle spasms or cramps
- Sciatica
- Mark areas you currently feel pain:



Blood / Peripheral Vascular

- Easy bleeding or bruising
- Anemia
- Deep leg pain
- Cold hands/feet
- Varicose veins
- Thrombophlebitis
- Fluid retention

Male Reproduction

- Hernias
- Testicular masses
- Testicular pain
- Do you do testicular self-exam?
- Prostate problems
- Venereal disease
- Discharge or sores

Males continued

- Are you sexually active? No Yes
- Birth control? No Yes, type: _____
- Erectile dysfunction
- Low libido
- Premature ejaculation
- Sexually transmitted infection

Female Reproduction / Breasts

- Do you do breast self-exams?
- Recent changes in breasts
- Breast lumps
- Breast pain/tenderness
- Nipple discharge
- Date of last annual exam/PAP _____
- Any abnormal PAPs? No Yes, when: _____
- Age of first menses? _____
- Are you sexually active? No Yes
- Low libido
- Pain during intercourse
- Sexually transmitted infection

Fill in this section if pre-menopausal:

- Irregular or no cycle:
- Duration of menses: _____ days
- Length of cycle: _____ days
- Bleeding between cycles
- Abnormal bleeding
- Painful menses
- Clotting
- Heavy or excessive flow
- Discharge
- PMS
- Birth control? No Yes, type: _____
- Difficulty conceiving
- Perimenopausal

Fill this section if menopausal:

- Age of last menses
- Any menopausal symptoms? No Yes, type: _____
- Vaginal bleeding since menopause

Lifestyle

How often do you eat out? _____
How often do you consume:
Coffee _____ Alcohol _____
Pop _____ Recreational drugs _____
Sugar _____ Tobacco _____
Added salt _____ Artificial sweeteners _____
What are your main interests and hobbies? _____
What exercise do you do and how often? _____
How many hours sleep do you get? _____
Do you awake feeling rested? _____
Do you have supportive relationships? _____
Do you have any occupational hazards? _____
Have you ever been treated for an addiction? _____
Smoked previously? How many years? How many packs per day? _____

Is there anything else you would like to add or comment on?

Context of Care

Why did you choose to come to this clinic?

What long-term expectations do you have?

What expectations do you have of me as your naturopathic physician?

What is your current level of commitment to addressing your health issues?

- I am willing to make any changes and do whatever in necessary
- I am willing to make some changes in my lifestyle to feel better
- I may consider change if absolutely necessary to feel better
- I am specifically looking for a medication/surgical alternative
- I am here to learn more about my healthcare options and what you offer

Thank you for taking the time to fill in this information.

Declaration and Consent for Naturopathic Care

I would like to take this opportunity to welcome you to our clinic. As a naturopathic doctor (ND) I will conduct a thorough case history, a physical exam and may utilize specific blood, urinary or other laboratory reports as part of the treatment work-up. I integrate supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, physical medicine and lifestyle counseling to assist the body's ability to heal and to improve the quality of life and health.

Statement of Acknowledgement

Printed name of patient: _____

As a patient of Dr. Karina Wickland, I have read the information and understand that the form of medical care is based on **naturopathic** and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. **Slight** health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from venipuncture or injections

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient of Dr. Wickland is **not mutually exclusive** from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. I understand results are not guaranteed.
- I understand that a record will be kept of my visits. This record will be kept confidential and **will not be released** without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am responsible for **payment at the time services are rendered**. Dispensary items must be paid for in full before leaving the office.
- I am aware that **24 hours notice** must be given for all cancelled appointments or a **cancellation fee** will be applied.
- I understand that Dr. Wickland reserves the right to determine which cases fall outside of her scope of practice, in which case the **appropriate referral will be recommended**.

I consent to receive naturopathic treatment from Dr. Karina Wickland. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: _____

Date: _____