Kinga Babicki-Farrugia B.Sc. (Hons), N.D
Doctor of Naturopathic Medicine

Holly Meadows Chiropractic Clinic

420 Essa Rd. Unit 3C
Barrie, ON
L4N 9J7

Tel/Fax: (705) 728 9999

Rates of Service - Naturopathic (rates include HST)

Adult		Student*/Senior	
Initial Visit (90-120mins)	$ 177.98	Initial Visit (90-120 mins)	$ 142.38
Follow ups:		**Follow ups:**	
60 mins	$ 118.65	60 mins	$ 94.92
45 mins	$ 94.92	45 mins	$ 71.19
30 mins	$ 71.19	30 mins	$ 59.33
15 mins	$ 41.53	15 mins	$ 35.60

***In school full time – with valid student ID**

CONFIDENTIAL ADULT INTAKE FORM

(please print clearly)

Today's Date: ____________________

Name: (First)_________________________ (Last) _______________________________________

Address: ____

City: __________________ Province: _______________ Postal Code: ____________________

Home phone: ______________________________Work/Cell phone: _________________________

E-mail address: ____

Please indicate how you would prefer to be contacted: ____________________________________

Age: ____ Date of birth: ______________ (M/D/Y) Gender: M / F

Emergency contact: Name: ____

Phone number:___________________ Relation:____

Do you have extended medical insurance? ____

How did you hear about this clinic?____

Referred by: ____

Other health care providers (name/title and phone number);

1. ____ Phone __________________________
2. ____ Phone __________________________
3. ____ Phone __________________________

Circle one: • Married • Single • Widowed • Divorced • Separated • Common-law

Live with: • Spouse • Partner • Parents • Children • Friends • Alone

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.

CONTEXT OF CARE:

1a. What expectations do you have from this visit?

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

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2. 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 behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

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

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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?

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

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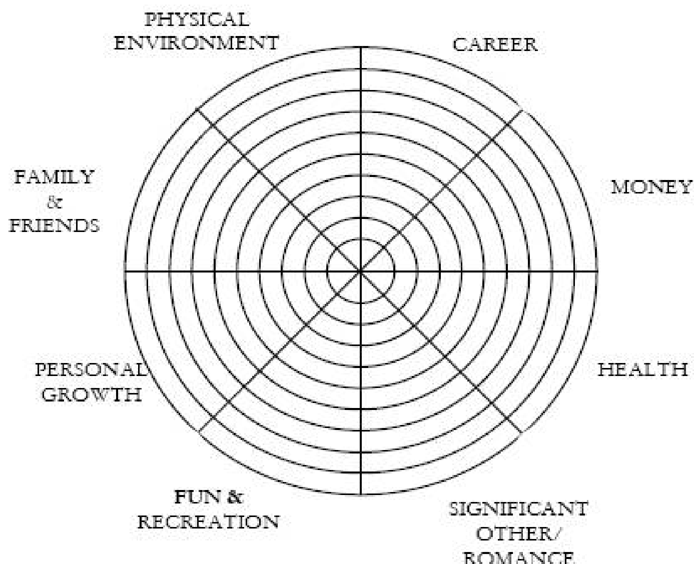
7. What do you LOVE to do?

WHEEL OF BALANCE

Balance in life consists 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 out.



MEDICAL HISTORY
What are your health concerns that brought you here today? Please list in order of importance to you:

1. ____
2. ____
3. ____
4. ____
5. ____

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

Do you get regular screening tests done? Yes / No If so, which ones? ____________________
____

Date of Last Physical exam: ____________________

If you are female are you currently pregnant? Yes / No /Not sure

Type of birth control used: ____________ If birth control pill use, how many years?________

Has there been a trauma or sickness that you have never fully recovered from and/or have not been well since?
____

Please indicate any serious conditions, illnesses, injuries or hospitalizations; with approximate dates:

____

____

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

If yes, what?____

Please (√) which immunizations/vaccinations you have had:

 DPT (diphtheria, pertussis, tetanus)
 MMR (measles, mumps, rubella)
 Polio
 Smallpox
 Haemophilus influenza B
 Hepatitis A
 Hepatitis B
 Tetanus booster; Date of last booster? ____________
 “Flu”
Other ____

Have you ever experienced an adverse reaction to a vaccination? Yes/No

If yes please elaborate: ____

CHILDHOOD ILLNESSES

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

Rheumatic fever	Diptheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, ECGs have you had?

________________________ year _______ ________________________ year ________
________________________ year _______ ________________________ year ________
________________________ year _______ ________________________ year ________

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs?____

Any foods?____

Any environmentals or chemicals?____

CURRENT MEDICATIONS

Do you take or use any of the following: (please circle those which apply)

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping pills	Thyroid medications
Birth Control Pills	Hormone Replacement		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

1)_______________________________________ 6)___________________________________
2)_______________________________________ 7)___________________________________
3)_______________________________________ 8)___________________________________
4)_______________________________________ 9)___________________________________
5)_______________________________________ 10)__________________________________

How many times have you been treated with antibiotics in your life? _____________________

GENERAL

Height:___________________ Current Weight:____________________

Maximum Weight:____________ When?____________ Lowest Weight: __________ When?_____________

What time of the day is your energy the best? ______________________ Worst?________________________

Main interests and hobbies:____

Exercise: Yes / No If so, what kind and how often/week: ____

Watch TV: Yes / No If so, how many hours/day? ____________________

Read: Yes / No If so, how many hours/day? _____________________

Do you have a religious or spiritual practice? Yes / No If so, what kind? ______________________________

Are you frequently in a state of: (√)

__ Fear __Worry __Anger __Sadness/depression __Anxiety

Do you use: (√) __Cigarettes? (packs/day? ____________)

__Alcohol (how much/often?_____________) __Recreational Drugs

Are you an ex-smoker? Yes / No If yes how long ago did you quit? ___________

Are you exposed to animals (work, pets, etc.)? Yes / No

Occupation ____

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

____

Is your living environment: (√) __ Dry __Damp

DIET

Describe a typical day's diet:

Breakfast____

Lunch____

Dinner____

Snacks____

Beverages (and total quantity)____

Water Intake: ________ cups / day Purified water: • Yes • No Tap water: • Yes • No

Do you have a preference for: (√) __ Cold drinks __Warm drinks

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

____

Do you have any preference for the following flavours: (√) __ Spicy __Sour __Sweet __Salty __Greasy

FAMILY HISTORY

Has a close relative (parent, child, sibling, grandparent) had any of the following: (**Indicate who with their age**)

Allergies: ____
Alzheimer's: ____
Asthma:____
Arthritis:____
Cancer:____
Diabetes:____
Depression:____
Drug Abuse/Alcoholism/Addiction:______________________________
Mental Illness:____
Glaucoma: ____
High Cholesterol:____
Heart Disease/High Blood Pressure:______________________________
Kidney Disease:____
Multiple Sclerosis: _______________________________________
Stroke: ____
Thyroid problems: ____
Tuberculosis: ____
Other:____
☐ **(√)** I don't know my family medical history

STRESS

How stressful is your work? 0 = No stress   10 = Highest level of stress: ___________________

Are other areas in your life stressful? Yes / No   If yes please describe _____________________

____

How do you handle these stresses?

____

How would you describe the emotional climate of your home?

____

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

____

____

Thank you for taking the time to fill out this form.
I look forward to working with you on your journey toward better health and wellbeing.

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INFORMED CONSENT

Please Read. To be signed once you have had an opportunity to discuss any questions or concerns with the Naturopath.

NATUROPATHIC MEDICINE

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate/support the body's inherent healing ability. A number of different approaches may be used throughout the course of treatment.

WHAT TO EXPECT

Dr. Babicki will take a thorough case history and perform a screening/complaint oriented physical exam. When indicated she may refer out for blood work and request a urine sample be taken. Dr. Babicki uses the following therapeutic procedures in her practice which may be used throughout the course of your treatment: Nutritional counseling and supplementation, Botanical/Herbal medicine, Homeopathy, Traditional Chinese Medicine/Acupuncture, Hydrotherapy and Lifestyle counseling. All treatment options will be discussed and decided upon together.

TREATMENT RISKS

Even the gentlest therapies may cause complications in certain physiological conditions (e.g. pregnancy, lactation, very young children, or those taking multiple medications). Some therapies must be used with caution in certain diseases such as but not limited to: diabetes, heart, liver, or kidney disease. It is very important, therefore, that you are as honest and forthcoming as possible with Dr. Babicki. Informing her about all illnesses/diseases that you are suffering from, all allergies you may have, as well as all medications (prescription and/or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or are breast-feeding, please advise Dr. Babicki immediately.

There may be some slight health risks to treatment through Naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms.
- Allergic reactions to supplements or herbs.
- Herbs/supplements taken in doses that exceed the prescribed dose may become toxic
- Minor bleeding/bruising, minor pain/soreness and fainting from acupuncture.

More serious, though very rare, risks that have been associated with acupuncture treatment include:

- Infection, organ perforation, bent or stuck needles and seizures.

CONSENT
Please initial in spaces below

________ 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 but will be subject to a photocopying fee. ($0.10/page up to a maximum of $50.00)

________ I understand that Dr. Babicki will answer any questions that I have to the best of her abilities. I understand that results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications.

________ As the patient, I understand that I am responsible for the total charges incurred for each visit, including consultation and any dispensary/supplement items at the time of the visit.

If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company – Dr. Babicki will provide you with all of the information necessary to send your claim for reimbursement.

Supplements may be recommended and can be purchased through Dr. Babicki, at various Health Food stores or elsewhere.

Most insurance companies do not cover the cost of supplements prescribed and/or dispensed.

I, the undersigned, do herby acknowledge that I have been informed and understand the above-stated policies, information and recommended therapeutic procedure(s)/plan. I have discussed to my satisfaction any related information with the above named Naturopathic doctor. I consent to the Naturopathic treatments offered or recommended to me by my Naturopath. 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 and must inform the above mentioned N.D. in writing if I choose to do so.

Patient Name: (please print) ____

Signature of Patient or Guardian: ____

Date: ___________________

Naturopathic Doctor: ____
Kinga Babicki-Farrugia BSc. (Hons), ND