Dr. Melissa Klatt ND
Naturopathic Doctor

Rise Wellness Centre
101-2504 Skaha Lake Rd
Penticton 778-476-2550

New Patient Intake Form - Adult

Welcome! Please complete this questionnaire as thoroughly and clearly as possible. Mark anything you don't understand with a question mark. All information contained in these pages is completely confidential.

Name____ Today's Date_________________

Age_______ Date of birth_________________ Gender M / F PHN____________________

Home Phone___________________ Work or Mobile _______________________

Address____

City________________________ Province__BC________ Postal Code_______________

Email address____

Check: Married____ Separated/Divorced _____ Widowed ______ Single ___ Partnership ____

Live with: Spouse/Partner____ Parents_____ Children (#)______ Friend _______ Alone___

Occupation_____________________________________ Hours per week________

Emergency Contact: Name ____

Relationship & Phone Number____

Referred by/How did you hear about our office? ______________________________________

Please list your health concerns **in order of importance:**

Complaint	Since	Possible Cause(s)

What expectation/goal(s) do you have for this visit?

What long-term expectations do you have for working with Dr. Klatt?

Allergies/Intolerances
Are you hypersensitive or allergic to...Any drugs? ______________________
Any foods? ______________________
Any environmental (pollens/pets) or chemical sensitivities? ______________________

Do you have any known contagious diseases at this time? Y / N
If yes, please list.______________________

Other practitioners you are currently seeing or have recently seen (MD, DC, RMT):

Name | Type of Practitioner | Treatment

1) ______________________
2) ______________________
3) ______________________

Please list all surgeries/major procedures you've had:

Procedure	Year	Reason

Females Only (P = significant past problem)

Age of first menses? ______________________
Age of last menses? (if menopausal) __________
Length of monthly cycle? _______ days
Duration of menses/bleeding? ______ days
Date of last PAP exam ______________
Abnormal PAP? Y N P
Are you sexually active? Y N P
Are you currently breastfeeding? Y N

Are cycles regular? Y N
Bleeding between cycles? Y N P
Number of pregnancies: __________
Number of live births: __________
Number of miscarriages: __________
Number of abortions: __________
Birth control? Y N P Type? _________

Males Only (P = significant past problem)

Prostate disease? Y N P
Testicular masses? Y N P
Are you sexually active? Y N P
Erection difficulty? Y N P

Testicular pain? Y N P
Discharge or sores? Y N P
Difficulty urinating? Y N P
Low sex drive? Y N P

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Review of Symptoms *please circle any present or significant past concerns (mark with P if past)*
Skin Rash, eczema, itching, pigmentation, changes in hair growth, nail changes, cold sores
Head Headaches. vertigo, lightheadedness, injury
Vision vision changes, tearing, blind spots, pain, dry eyes, degeneration
Nose Bleeding, recurrent colds, obstruction, discharge, sinus infections, inhalant allergies
Dental Extensive dental work, gingival bleeding, dentures, root canal
Neck Stiffness, pain, whiplash, masses in thyroid
Cardiovascular Pain/angina, palpitations, hypertension, heart murmurs, varicosities, stroke
Respiratory Pain, shortness of breath, cough, respiratory infections, asthma
Gastrointestinal
Low appetite, indigestion, abdominal pain, heartburn, burping, nausea, vomiting, constipation, diarrhea, abnormal stools, flatulence, hemorrhoids, hepatitis, parasites, gallstones, bloating
Genitourinary Urgency, frequency, unusual color of urine, KI stones, infections, discharge
Musculoskeletal Joint pain, swelling, decreased motion, weakness, cramps
Neurologic/Psychiatric
Convulsions, paralysis, tremor, incoordination, numbness, difficulties with memory, anxiety, depression, previous psychiatric care, OCD, bipolar
General Anemia, bleeding tendency, intolerance to heat or cold, night sweats, diabetes, cancer

Any other conditions not listed above?
____

Family History (Please check all that apply)
☐ Alcoholism ☐ Allergies ☐ Arthritis ☐ Asthma ☐ Cancer type: ____________________.
☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Eczema/skin diseases
☐ Gallstones ☐ Glaucoma ☐ Heart Disease ☐ Stroke ☐ Hypertension
☐ Kidney Disease ☐ Mental Illness ☐ Osteoporosis ☐ Thyroid disease
Any other relevant family history? ____

Current Medications
Please list everything you are currently taking (Prescription, over the counter, supplements, vitamins, minerals).

Medication/supplement	Since	Dose & Reason

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Physical Exam Questions

Height: ____________________Weight:__________________ Weight 1 year ago: ____________
Highest weight?__________________________When ____
When was the last time you had a complete physical exam? ________________

Typical Food Intake

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Liquids/Drinks ____

Do you eat three meals a day? Y / N   Drink coffee? Y / N How often do you eat out? _____
Do you know your blood type? A / B / O / AB

Lifestyle questions

Interests and hobbies____
Exercise type:____ How often________________

Please indicate using a Y, N, or amount as applicable:
Average 7-9 hours of sleep? _____   Sleep well? _____
Enjoy your work? _____   Take vacations? _____   Spend time outside? _____
Have a supportive relationship? ________   History of physical or emotional abuse? _____
Any major traumas (physical or emotional)? _____   At what age(s)?
How many hours of TV / week? ___   Use recreational drugs in past or present? _____
Drink alcoholic beverages? Y / N   How many per week?_____.
Use tobacco? Y / N   How many per day?____   Smoked previously? Y / N
Do you have a religious or spiritual practice, and what is it?__________________________

Is there anything else you would like to add that might be relevant to your health care?

Thank you for your time and effort.
We look forward to providing you with the best possible care.
Informed Consent for Naturopathic Treatment

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Naturopathic treatment may include the following modalities:

- Botanical medicine
- Hydrotherapy
- Clinical nutrition
- Homeopathy & Bach Flower Essences
- Lifestyle and Psychological counselling
- Traditional Chinese Medicine (TCM) including acupuncture and eastern herbs
- Physical treatments such as Chiropractic style adjustments, Bowen therapy, muscle energy technique, massage, Craniosacral therapy or joint play.
- Prescription Medicine

The following diagnostic procedures may be used:

- Physical exam including ears, eyes, respiratory, cardiac, abdominal, lymph, nervous systems.
- Orthopedic assessment of spine and other joints.
- TCM pulse and tongue diagnosis
- In office testing such as urinalysis or blood glucose via fingerstick
- Specimen collection using saliva, urine, stool, or blood to be sent to external labs.
- Breast, gynecological, genital, rectal, or prostate exams as necessary

Even the gentlest therapies may cause complications in certain physiological conditions, such as pregnancy, lactation, very young children, or those taking multiple medications. Some therapies must be used with caution in certain diseases including but not limited to diabetes, heart, liver and kidney disease. Fully inform the doctor of your current condition.

There are some slight health risks associated with Naturopathic Medicine, including but not limited to:

1. Aggravation of pre-existing symptoms
2. Allergic reactions to supplements or herbs
3. Pain, possible bruising or injury from venipuncture, fingerstick or acupuncture
4. Muscle or joint pain from alignment techniques.

All payments are due when services are rendered.

Please ensure that you give 24 hours notice to change or cancel appointments to avoid a missed appointment fee.

I ______________________ hereby authorize Dr. Melissa Klatt to perform specific procedures as deemed necessary to facilitate my diagnosis and treatment. I understand that I am free to withdraw my consent and discontinue my treatment at anytime. I understand that Dr. Klatt will answer any questions that I have to the best of her ability. 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.

Signature__________________________(parent/guardian if under 18)   Date: _____________