



Complete Wellness Clinic
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Milton, ON. L9T 4A4 (905) 875-2288

KIM VIVIAN BSc, ND



total health, naturally...

Welcome! The information package provided below will help you to prepare for your first visit. Please read and fill out the information requested.

If your initial visit is for **Naturopathic treatment**, please bring any of the following available to you for your first visit:

- *all current medications, supplements, vitamins, homeopathics, etc, or comprehensive list of said items.*
- completed forms which include checking the appropriate boxes on the **Review Of Systems (ROS)** and completing the **Intake Form** and the **Informed Consent Form**.

Your first visit will typically be between 1 – 1 ¼ hours. During this time a comprehensive health assessment is usually done including a physical examination and thorough review of all of your chief complaints. Treatment may begin at this time depending on the complexity of your situation.

Ideally, after the first visit I will review your ROS, chief complaints and health history. An individualized treatment plan will then be formulated, which will be discussed with you and implementation will begin on your second visit. This visit can take approx. ½ an hour.

If your initial visit is for **Acupuncture** or **Bowen Therapy***, please complete the **Intake Form** and the **Informed Consent Form**.

* for the **Bowen Therapy** only, please bring a t-shirt & shorts to the initial visit

Your first visit will be approx. 1 hr. During this time you will receive a treatment and a comprehensive health assessment.

I look forward to your first visit and to begin working together to address your health concerns. If you have any questions regarding the procedures described above or otherwise, please feel free to call me.

Sincerely,

Kim Vivian BSc, ND

INTAKE FORM

Date of Appointment: ___/___/___ Name: _____

Date of Birth: ___/___/___ Age: _____ Sex: ___M ___F
dd/mm/yy

Address:

(Street#/P.O. Box) (Apt.#) (City)

(postal code) (email address)

Are you interested in receiving a monthly newsletter (via email) which includes the latest in nutritional research?

Yes _____ No _____

Home Telephone _____ Work Telephone _____

Occupation: _____ ___Full Time ___Part Time

Employer _____

Are you: ___Single ___Married ___Separated ___Divorced ___Widowed
___Living with a partner

Emergency Contact:

Do you have children? Yes/No If yes, how many: _____

Referred By/How did you hear about our office?: _____

Is this your first visit with an alternative medicine doctor? _____

Date of last physical? _____
(month) (year)

General Practitioner (MD):

Name: _____

Phone number: _____

Fax Number: _____

When did you last visit an optometrist? _____

Who is your regular optometrist? _____

Are you under the care of any specialists? Yes/No

_____ (explain)

Are you receiving other health care? Yes/No:

_____ (explain)

Please list your major health concerns in order of importance

COMPLAINT	SINCE	POSSIBLE CAUSE(S)

Do you have access to a car? Yes/No

What medications/supplements are you currently taking (prescription/over-the-counter/supplements/vitamins, etc)?

Medications/Supplements	Since	Daily Dose	Side effects you have experienced?

List all surgeries you have had:

Procedure	Year	Complications?

List all major injuries you have sustained:

Injury	Year	Long Term Effects

Which of the following conditions have you had? (Check all that apply)

- | | | | | |
|--------------------------------------|---|--|--|--|
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> PID | <input type="checkbox"/> Somisotos |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Peritonitis | <input type="checkbox"/> Sunstroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Amnesia | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Malaria | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hey Fever | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rubella | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Venereal Warts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes Genitalia | <input type="checkbox"/> Parasites | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Whooping Cough |
| | | | <input type="checkbox"/> Yellow Fever | <input type="checkbox"/> Worms |

How long do you take to eat an average meal? _____

What are you doing when eating? (ie. TV, etc.) _____

List any foods you exclude from your diet:

Why are these foods excluded?

List any of the foods that you crave (eg. chocolate, salty, sour, breads, rich/fatty or spicy):

Have you had a bad reaction to any foods? _____

Are you satisfied with your diet as it is now? Yes/No

Are you satisfied with your lifestyle as it is now? Yes/No

Do you tend to be thirsty compared to others around you?: Yes/No

How many glasses of WATER do you drink each day?: _____

Do you prefer beverages: ___Hot ___Cold ___Room Temperature

CIRCLE THE MOST APPROPRIATE DESCRIPTION OF YOUR DIGESTION IN GENERAL:

Frequency of Bowel Movements in 24 hour period:

once twice three times less than once

Color of Bowel Movements: black dark brown brown yellow green

Generally my stool: floats but flushes floats and is difficult to flush sinks

I notice grease or fat in my stools: YES NO

I experience pain with my bowel movements: YES NO

I experience blood in my stools: YES NO

I must strain to make a bowel movement: YES NO

The odor of my bowel movements is: odorless mild odor strong odor

The form of my bowel movement is: hard pellets thin ribbons watery Large single soft

Have you had any adverse effects from a vaccination? Yes/No

If Yes, which one(s)?

Have you had any flu shots? Yes/No
If yes, any adverse effects?

Please list the most significant, stressful, events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (yes/no)

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

If you have access to any of the following please circle the appropriate equipment:

Juicer Crock Pot Blender Coffee Grinder

How much time could you see yourself learning to cook/prepare new foods?

None _____ A little _____ As much as necessary _____

Would you be interested in attending extra workshops to learn valuable life skills about your health? Yes _____ No _____

Is there anything else I need to know about you personally, about your health condition, or about circumstances relating to you condition?
