Dr. Shannon Ferguson, ND
Country Hills Massage Therapy, 5149 Country Hills Blvd NW, Unit 336
p: 403-547-2243, e: drshannon@calgarynaturopathiccare.com

Adult Intake

Name: _____ Today's Date: _____
(First) (Last) dd / mm / yy

Date of Birth: ___/___/____ Gender: F M Age: _____
dd/ mm / yy Other:_____
Preferred pronoun:_____

Home Address: _____

Town/ City: _____ Postal Code: _____

Home Telephone: ( ) _____ Work: ( ) _____

May we leave messages on your home phone relating to your visits? Y N

Emergency contact: _____ Phone:( )_____

Email Address: _____

How did you find out about our services?

☐ Referral by: _____

☐ Newspaper/ magazine / flyer

☐ Yellow pages

☐ Other _____

Family Physician: _____ Phone:( )_____

Other Health Care Provider(s):
Name: _____ Phone: ( )_____ Name: _____ Phone: ( )_____

Chief Health Concerns

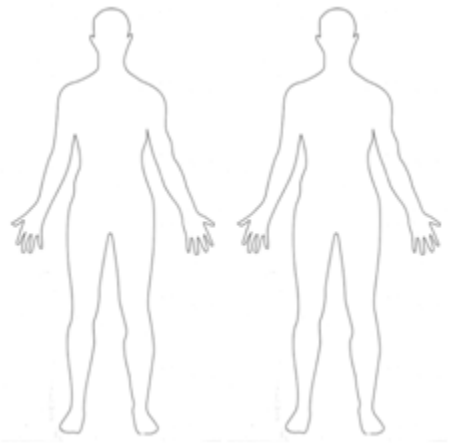
What are your health concerns, in order of importance to you:
1. _____
2. _____
3. _____
4. _____
5. _____

Dr. Shannon Ferguson, ND
Country Hills Massage Therapy, 5149 Country Hills Blvd NW, Unit 336
p: 403-547-2243, e: drshannon@calgarynaturopathiccare.com

List any other concerns you may want to discuss:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Front Back



Please indicate below any areas of pain:

Medical History

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

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? Please list with approximate dates:

_____
_____
_____
_____

Do you have any allergies (medicines, environmental, foods)?

_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics), with dosage:

_____
_____
(medications continued)_____
_____

Please list any past prescription medications:

_____
_____

Approximately how many times have you been treated with antibiotics in your life?
_____

Do you frequently use any of the following?

☐ Laxatives ☐ Antacids
☐ Diet pills ☐ Aspirin/Tylenol/Advil

☐ Caffeine - form and amount/day_____
☐ Alcohol - how much/day or week_____
☐ Recreational drugs - what and how often_____

Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B
☐ Hepatitis A ☐ Tetanus booster
☐ "Flu" ☐ Hepatitis B
☐ MMR (measles, mumps, rubella) ☐ Polio
☐ Smallpox

Please indicate any adverse reactions you may have had to past immunizations:
_____
_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) Y N

Diet

Do you have food allergies or intolerance's? Please list:
_____
_____
_____

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

Dr. Shannon Ferguson, ND
Country Hills Massage Therapy, 5149 Country Hills Blvd NW, Unit 336
p: 403-547-2243, e: drshannon@calgarynaturopathiccare.com

Describe a typical day's diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages (total amount) _____

Family Health History (√ - currently or 'P' - past):
Indicate if a close relative (parent, grandparent, sibling) has, or has had any of the following:

☐ Allergies	☐ Endometriosis	☐ Osteoporosis
☐ Artificial Heart Valve	☐ Gallstones	☐ PMS
☐ Arthritis	☐ Heart Disease	☐ Rubella
☐ Asthma	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Cancer (type_____)	☐ Kidney Disease	☐ Skin Disease
☐ Diabetes	☐ Mental Illness	☐ Stroke
☐ Eczema	☐ Multiple Sclerosis	☐ Tuberculosis

Any other medical conditions?
_____
_____
_____

Female:

Are you pregnant now? Yes No

Indicate number of occurrences if applicable:
Live births_____ Pregnancies_____ Miscarriages_____ Terminations_____

Age at first period _____ Age at menopause_____

Are your menstrual cycles regular? Yes No

Male:

Do you have any urinary symptoms? Yes No
Describe:_____
_____

Do you get up in the night to urinate? Yes No How often? _____

Dr. Shannon Ferguson, ND
Country Hills Massage Therapy, 5149 Country Hills Blvd NW, Unit 336
p: 403-547-2243, e: drshannon@calgarynaturopathiccare.com

Environment

Occupation(s)

_____
_____
_____

Hobbies

_____
_____
_____

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

_____
_____
_____

Do you exercise regularly? Y N

What type of exercise, how much, how often?

_____
_____
_____

How would you describe the emotional climate of your home?

_____
_____
_____

How stressful is your work, or other aspects of your life? How do you manage stress?

_____
_____
_____

Is there anything that you feel that is important that hasn't been covered?

_____
_____
_____
_____

Thank you for taking the time to fill out this form!

Dr. Shannon Ferguson, ND
Country Hills Massage Therapy, 5149 Country Hills Blvd NW, Unit 336
p: 403-547-2243, e: drshannon@calgarynaturopathiccare.com

Consent

Naturopathic Medicine is the treatment and prevention of diseases using natural therapies and treating the person as a whole, and as an individual. Naturopathic doctors use many modalities and therapies that are used to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history, and may do a screening physical examination, including a breast exam and may suggest labs or copies of lab work completed by your medical doctor.

It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication, supplements or over the counter drugs. Inform your Naturopathic doctor of any changes to these. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

As a patient it is your right to receive information about your diagnosis as well as treatment, including treatment alternatives, costs, benefits, risks, adverse effects, and consequences of not treating. As with any form of medical treatment, there are some risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, fainting or injury from injections or acupuncture

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 unless so directed by myself unless law requires it. If required, I understand that my Naturopathic Doctor may discuss my case with other healthcare providers. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee of $0.10 per page. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the Doctors to be able to anticipate and explain all possible risks and complications. With this knowledge, I voluntarily consent to Naturopathic care I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent at any time.

Patient Name: (Please Print) _____

Signature of Patient or Parent/Guardian: _____ Date: _____

Naturopathic Doctor: _____

Please ensure to give at least 2 hours cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on within two hours or missed appointments, 100% of the cost of the appointment will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of the Naturopathic doctor. Please be aware that phone calls and emails outside of appointments are for clarification purposes only, beyond this is subject to additional consultation fees.

I, _____ (Name), understand and accept the above policies and associated fees.

Signature: _____ Date:_____