Dr. Greg Sikorski ND
Synergy Collaborative Health
Suite 2201, 120 5th Ave, Cochrane, AB T4C 0A4
403 981 1999 | www.GregND.com

ADULT

ADULT INTAKE FORM

Our health is influenced by many different factors. Your health history provides valuable information to help me understand your current health. Please fill out this form to the best of your ability and bring it with you to your first visit.

GENERAL CONTACT INFORMATION

Name _____ Today's Date: _____
(*Last name)* *(First name)* *(M/D/Y)*

Birthdate (M/D/Y): _____ Age: _____ Gender: _____

Address:_____
Street *City* *Province* *Postal Code*

Phone (H): _____ (W): _____ (C): _____

E-mail: _____ Alberta Health Card Number:_____

May we add you to a monthly email newsletter?: Y or N May we leave a message about your appointment?: Y or N

Emergency Contact: _____
Name *Phone Number* *Relationship*

Occupation: _____Number of years:_____Job Satisfaction (out of 10, 10 =highest)_____

How did you hear about the clinic? Who were you referred by:_____

Medical Doctor: _____ Last Physical Exam: _____
Name *Clinic* *Telephone* *Fax* *(M/Y)*

PERSONAL MEDICAL HISTORY

What are your health concerns, in order of importance to you? When did they start? Possible causes?

1. _____
2. _____
3. _____
4. _____

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

1. _____
2. _____
3. _____

Do you have any allergies or hypersensitivities to any of the following?
Foods: _____
Medicines: _____
Environment: _____
Other: _____

Please list all prescription and over the counter medications, vitamins or other supplements you are currently taking (including brands):****Please bring medications & supplements to your first appointment****

_____

_____

_____

_____

Please list any other Healthcare Providers you are currently seeing (ie. Chiropractor/Osteopath/Acupuncturist/Specialist):

Name	*Phone Number*	*Reason*
Name	*Phone Number*	*Reason*
Name	*Phone Number*	*Reason*

Please state why you have chosen Naturopathic Medicine:

_____

_____

FAMILY MEDICAL HISTORY

Please indicate if there is a family history of any of the following health problems and indicate which relative:
F: Father M: Mother B: Brother S: Sister C: Children Sp: Spouse
MGM: maternal grandmother PGM: paternal grandmother MGF: maternal grandfather PGF: paternal grandfather

Condition	**Family Member (Age)**	**Condition**	**Family Member (Age)**
Allergies/ Hay Fever		Heart Disease	
Alcoholism/Drug Addictions		High Blood Pressure	
Alzheimer's / Parkinson's		High Cholesterol	
Anemia		Kidney Disease	
Arthritis		Liver Disease	
Asthma		Lupus	
Autoimmune Disease		Mental Illness	
Cancer		Multiple Sclerosis	
Celiac Disease		Myasthenia gravis	
Depression/Anxiety		Osteoporosis	
Dementia		Obesity	
Diabetes		Skin Conditions	
Digestive issues		Stroke	
Epilepsy		Syphilis	
Fibromyalgia		Thyroid Conditions	
Glaucoma		Tuberculosis	
Headaches		Other	

LIFESTYLE HABITS

Do you have any food allergies or intolerances? Please list

_____

_____

Do you have any dietary restrictions? (Religious, Vegetarian, Vegan, etc.)

_____

Typical Daily Food regime

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (Quantity and Amount): _____

Cravings: _____ Aversions: _____

Drinks	How many/day or week?	How long?	Have you quit? When?
Liquor			
Beer			
Wine			
Caffeine			
Soft Drinks			

Smoking/ Drugs:	How often?	How long?	Have you quit? When?
Cigarettes			
Cigars			
Pipe			
Marijuana			
Recreational drugs			
Other			

Are you exposed to significant tobacco smoke? (Work, Home, Etc.) Yes No

Are you frequently exposed to animals? (Pets, Work, etc.) Yes No

Do you have a job or hobby that increases your exposure to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc), or have you had a past exposure (living on farm, etc)

Yes No

Do you exercise regularly? What do you do for exercise? How often? How long?

_____

_____

_____

What are your hobbies? What do you do in your spare time?

_____

_____

How stressful is your work? Life? How do you handle your stresses?

_____

_____

_____

How many hours do you spend each day: Sleeping:_____Working:_____Recreation:_____

Please list the 3 most significant, stressful events in your life (physical, emotional) from the most recent to the most distant.

Are any of these situations continuing to impact your life? (Yes/No)

1. _____(Yes/No)Date: _____

2. _____(Yes/No)Date: _____

3. _____(Yes/No)Date: _____

REVIEW OF SYSTEMS

GENERAL

Height: _____ Weight: _____ Max weight: _____ Weight one year ago: _____

For the following please check the appropriate box. Yes indicating this is a condition you are currently experiencing and Past if you have experienced it in the past. If you've never had the condition, leave it blank.

SKIN/ HAIR/ NAILS

	YES	PAST		YES	PAST		YES	PAST
Frequent rashes	☐	☐	Dry Skin	☐	☐	Hair loss	☐	☐
Hives	☐	☐	Eczema	☐	☐	Changes in hair growth	☐	☐
Itching	☐	☐	Mole changes	☐	☐	Change in skin texture	☐	☐
Boils	☐	☐	Lumps	☐	☐	Nail changes	☐	☐
Psoriasis	☐	☐	Night sweats	☐	☐	Other: _____		
Acne	☐	☐	Skin cancer	☐	☐			

HEAD/ EYES/ EARS/ NOSE/ MOUTH/ THROAT/ NECK

	YES	PAST		YES	PAST		YES	PAST
Impaired vision	☐	☐	Blind spot	☐	☐	Sinus problems	☐	☐
Glasses/contacts	☐	☐	Headaches	☐	☐	Frequent sore throat	☐	☐
Eye pain	☐	☐	Migraines	☐	☐	Sore tongue/mouth	☐	☐
Tearing	☐	☐	Head injury	☐	☐	Bleeding gums	☐	☐
Dryness	☐	☐	Dizziness	☐	☐	Hoarseness	☐	☐
Double vision	☐	☐	Impaired hearing	☐	☐	Dental cavities	☐	☐
Glaucoma	☐	☐	Earache	☐	☐	Mouth ulcers	☐	☐
Cataracts	☐	☐	Ear discharge	☐	☐	Loss of taste	☐	☐
Blurring	☐	☐	Ear infections	☐	☐	Neck Lumps	☐	☐
Light Sensitive	☐	☐	Frequent colds	☐	☐	Swollen glands	☐	☐
Itchy eyes	☐	☐	Nose bleeds	☐	☐	Goiter	☐	☐
Redness	☐	☐	Nose stuffiness	☐	☐	Neck Pain or stiffness	☐	☐
Eye discharge	☐	☐	Hay fever	☐	☐			

RESPIRATORY

	YES	PAST		YES	PAST		YES	PAST
Emphysema	☐	☐	Sputum	☐	☐	Pain on breathing	☐	☐
Tuberculosis	☐	☐	SARS	☐	☐	Difficulty breathing	☐	☐
Tuberculin Test	☐	☐	Asthma	☐	☐	Shortness of breath (SOB)	☐	☐
Chronic cough	☐	☐	Bronchitis	☐	☐	SOB at night	☐	☐
Spitting up blood	☐	☐	Pneumonia	☐	☐	SOB lying down	☐	☐
Wheezing	☐	☐	Pleurisy	☐	☐	Last Chest-ray: _____		

GASTROINTESTINAL

	YES	PAST		YES	PAST		YES	PAST
Trouble swallowing	☐	☐	Flatulence	☐	☐	Hemorrhoids	☐	☐
Heartburn	☐	☐	Jaundice (yellow skin)	☐	☐	Black, tarry stool	☐	☐
Change in thirst	☐	☐	Liver disease	☐	☐	Abdominal pain	☐	☐
Change in appetite	☐	☐	Gall bladder disease	☐	☐	Food allergy	☐	☐
Nausea	☐	☐	Ulcer	☐	☐	Hernias	☐	☐
Vomiting	☐	☐	Indigestion	☐	☐	Other:_____		
Vomiting blood	☐	☐	Constipation	☐	☐	Bowel movements - how often?		
Blood in stool	☐	☐	Diarrhea	☐	☐	_____		
Belching	☐	☐	Rectal bleeding	☐	☐	Is this a change?	Y	N

CARDIOVASCULAR

	YES	PAST		YES	PAST		YES	PAST
Thrombophlebitis	☐	☐	Varicose veins	☐	☐	Swelling in ankles	☐	☐
Leg cramps	☐	☐	Heart disease	☐	☐	Palpitations	☐	☐
Extremity numbness	☐	☐	Angina	☐	☐	Fainting	☐	☐
Extremity coldness	☐	☐	High blood pressure	☐	☐	Cyanosis	☐	☐
Extremity swelling	☐	☐	Low blood pressure	☐	☐	Past ECG	☐	☐
Extremity ulcers	☐	☐	Murmurs	☐	☐	Other heart tests	☐	☐
Deep leg pain	☐	☐	Rheumatic fever	☐	☐	Other:_____		
Cold hands/feet	☐	☐	Chest pain	☐	☐			

ENDOCRINE/ IMMUNE

	YES	PAST		YES	PAST		YES	PAST
Heat or cold intolerance	☐	☐	Excessive sweating	☐	☐	Past transfusions	☐	☐
Thyroid Problems	☐	☐	Diabetes	☐	☐	Lymph node swelling	☐	☐
Goiter	☐	☐	Hypoglycemia	☐	☐	Drug sensitivity	☐	☐
Excessive thirst	☐	☐	Hormone therapy	☐	☐	Reaction to vaccine	☐	☐
Excessive hunger	☐	☐	Anemia	☐	☐	Other: _____		
Excessive urination	☐	☐	Easy bleeding or bruising	☐	☐	_____		

MUSCULOSKELETAL

	YES	PAST		YES	PAST		YES	PAST
Joint pain	☐	☐	Muscle spasms/ cramps	☐	☐	Muscle pain	☐	☐
Joint stiffness	☐	☐	Weakness	☐	☐	Reduced movement	☐	☐
Arthritis	☐	☐	Joint swelling	☐	☐	Decreased flexibility	☐	☐
Broken bones	☐	☐	Backache	☐	☐	Other: _____		

URINARY

	YES	PAST		YES	PAST		YES	PAST
Pain on urination	☐	☐	Inability to hold urine	☐	☐	Blood in urine	☐	☐
Increased frequency	☐	☐	Frequent infections	☐	☐	Urgency	☐	☐
Frequency at night	☐	☐	Kidney stones	☐	☐	Hesitancy	☐	☐

PSYCHOLOGICAL/ NEUROLOGICAL

	YES	PAST		YES	PAST		YES	PAST
Fainting	☐	☐	Depression	☐	☐	Sexual difficulties	☐	☐
Seizures	☐	☐	Mood swings	☐	☐	Suicidal thoughts	☐	☐
Convulsions	☐	☐	Anxiety or nervousness	☐	☐	Recurrent thoughts	☐	☐
Paralysis	☐	☐	Tension	☐	☐	Binge eating	☐	☐
Tremor	☐	☐	Phobias	☐	☐	Eating Disorder	☐	☐
Muscle weakness	☐	☐	Hallucinations	☐	☐	Low Self Esteem	☐	☐
Numbness or tingling	☐	☐	Alcohol/drug abuse	☐	☐	PTSD	☐	☐
Loss of memory	☐	☐	Insomnia	☐	☐	Self Injury	☐	☐
Loss of balance	☐	☐	Sadness	☐	☐	Poor Concentration	☐	☐
Loss of coordination	☐	☐	Grief	☐	☐	Memory difficulties	☐	☐
Speech problems	☐	☐	Anger	☐	☐	Hyperactivity	☐	☐

MALE REPRODUCTIVE

	YES	PAST		YES	PAST		YES	PAST
Hernias	☐	☐	Sexual difficulties	☐	☐	Penile sores	☐	☐
Testicular masses	☐	☐	Venereal disease	☐	☐	STIs	☐	☐
Testicular pain	☐	☐	Penile discharge	☐	☐	Sexually active	☐	☐

FEMALE REPRODUCTIVE

	YES	PAST		YES	PAST		YES	PAST
Bleeding between periods	☐	☐	Difficulty conceiving	☐	☐	Vaginal itching	☐	☐
Regular cycles	☐	☐	Sexually active	☐	☐	Breast lumps	☐	☐
Pain during intercourse	☐	☐	Sexual difficulties	☐	☐	Breast pain or tenderness	☐	☐
Painful menses	☐	☐	Venereal disease	☐	☐	Nipple discharge	☐	☐
Excessive flow	☐	☐	STIs	☐	☐	Breast Cancer	☐	☐
PMS	☐	☐	Vaginal discharge	☐	☐	Ovarian Cancer	☐	☐

Age menses began: _____ Last menstrual period: _____ Number of live births: _____

Average number of days: _____ Last PAP - (date): _____ Number of miscarriages: _____

Length of cycle: _____ Number of pregnancies: _____ Number of abortions: _____

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

_____

_____

_____

Thank you for taking the time to complete this form. The information provided will be discussed in further detail during your initial visit. Please bring this completed form with you to your visit

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CANCEL

CANCELATION POLICY FORM

If I am unable to make a scheduled appointment **I must provide 24 hours advance notice to avoid being charged a missed appointment fee of 100%**. I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as any other applicable fees.

Credit Card information: Visa or Mastercard

Patient's Name On Card (please print)_____
First Middle Last

Credit Card Number:_____ Expiration Date:_____CVC:_____
Month Year 3 digit on back

Patient's Full signature:_____ Today's Date: _____
Month Day Year

Credit card information will only be used in the event that less than 24 hours' notice was not given to The Natural Element, office of Dr. Greg Sikorski ND, by the patient above. If in the event the credit card does not work, the full amount will have to be paid prior to the next scheduled appointment. Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". They will be charged for their "missed" appointment and future service will be denied until payment is made.

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EMAIL/PP

EMAIL CONSENT FORM

Name: _____ E-mail: _____

I hereby acknowledge that I consent to email communications about my care. It is my responsibility to inform Dr. Sikorski if my email address changes. I understand that I am exposing myself to certain risks, which include but are not limited to:

- The privacy and security of email communication cannot be guaranteed.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Backup copies of Email may exist even after sender or recipients have deleted their copy.
- Email senders can easily misaddress an Email or be received by unintended recipients
- Email is easier to falsify than handwritten or signed documents.

Dr. Sikorski will use reasonable means to protect the security and confidentiality of emails. Due to the risks above, Dr. Sikorski cannot guarantee the security and confidentiality of emails and will not be liable for improper disclosure of confidential information that is not caused by Dr. Sikorski's intentional misconduct.

Dr. Sikorski will try to read and respond promptly to emails but cannot guarantee that all Emails will be read and responded to. No one shall use Email for medical emergencies or other time-sensitive matters. It is the patient's responsibility to follow up with Dr. Sikorski if a response has not been received within a reasonable time period.

Please be advised all Emails to or from Dr. Sikorski will be made part of your medical record. It is your responsibility to inform Dr. Sikorski of any types of information you do not want sent by Email. Dr. Sikorski will not forward Emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

I acknowledge that I have read and fully understood this consent. I understand the risks associated with email communications between Dr. Sikorski and myself, and consent to the conditions outlined. In addition, I agree to the instructions for communicating by Email, as well as any other instructions that Dr. Sikorski may impose to using Email.

Signature of Patient or Guardian: _____ Date: _____

PATIENT PRIVACY POLICY CONSENT FORM

Privacy of your personal information is an important part of providing you with quality naturopathic care. Dr. Greg Sikorski understands the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly.

We strive to ensure that:

- Only necessary information is collected about you;
- We only share your information with your written consent;
- Storage, retention, and destruction of your personal information complies with existing privacy legislation and privacy protection protocols of our regulatory body, The College of Naturopathic Doctors of Alberta.

Information is collected, used and disclosed about you for the following purposes:

- To assess your health concerns and advise you of treatment options;
- To establish and maintain contact with you and remind you of upcoming appointments;
- To communicate with other treating health-care providers;
- To allow us to efficiently follow-up for treatment, care and billing;
- To comply with legal and regulatory requirements;

I have read and understand how Dr. Greg Sikorski will use my personal information and the steps taken to protect my information. I am giving my informed consent to the collection, use and/or disclosure of my personal information as detailed above.

Signature of Patient or Guardian: _____ Date: _____

SYNERGY Collaborative Health

CONSENT

INFORMED CONSENT FORM

Please note that this form must be signed prior to your first appointment.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors 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 the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history and perform a physical examination. Each patient seeking care in this clinic should understand that the practitioner is a Naturopathic Doctor, not a medical doctor.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. Treatments used in this clinic include nutrition, botanical medicine, lifestyle counseling, homeopathy, Traditional Chinese medicine (including acupuncture), hydrotherapy, physical medicine, laboratory testing and supplement recommendations.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parental therapy.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa
- Muscle strains and sprains or disc injuries from spinal manipulation.
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened by your Naturopathic Doctor prior to manipulating the neck.

The Naturopathic Doctor is trained to handle emergencies should the need arise.

I have been informed and I understand that:

- The clinic does not guarantee treatment results.
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- I am free to withdraw my consent and to discontinue treatment at any time.
- I agree to pay my account in full at the time of each visit. I am aware that Alberta Health Care does not cover these fees.

Patient Name (please print): _____

Signature of Patient or Guardian: _____ Date: _____

Naturopathic Doctor: _____