Dr. Tas

Intake Form for Men

Name _____ Date _____
Age _____ Birthdate _____ Blood type _____
Address _____ Phone (home) _____
City/Province/Postal Code: _____ Phone (cell) _____
Email address: _____ Fax: _____
If we need to contact you, messages can be left at *(check all that apply)*: ☐ work ☐ home ☐ e-mail

Would you like to receive our clinic newsletter via e-mail? (*yes/no*)

Occupation (full/part time?) _____ Employer _____
Nearest Relative _____ Phone _____
Who else can we reach in case of emergency? _____ Phone _____
How did you hear about my office? _____
If referred, please give us name of referee (so we can thank them) _____
Last physician or health practitioner seen? _____ When? _____
When was your last blood test? _____ What kind? _____

Your Current Health Concerns
What is your **main** reason for coming in today? If you have a specific health condition, please describe in detail. When was the very first time you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation.

_____

_____

_____

What are you willing to do to change this situation? _____

How long are you willing to work at it? _____

List in order of importance other health concerns that are troubling you:

1. _____ & length of time _____
2. _____ & length of time _____
3. _____ & length of time _____
4. _____ & length of time _____
5. _____ & length of time _____

Other problems: _____

How long has your main concern been troubling you? _____

Is your current "main problem" getting (better, worse, same) and for how long? _____

What kind of treatment have you received and from whom? _____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health

Dr. Tas

practitioner for your current main health concern? (yes/no) or for any problem? (yes/no)

What was the therapy and what were the results? _____

_____

Your Health History

The general state of your health is (circle one):

Excellent Good Average Fair Poor

and on average, your energy level is best described on a scale of 1 to 10 (10 is highest, 1 is lowest) as _____

When during the day is your energy best? _____ worst?_____

What is your current approximate weight? _____ One year ago?_____

Ideal weight? _____ Height?_____

As an adult, what has been your maximum _____ and minimum weight _____

Please list the 5 most significant stressful events in your life, from the most recent to the most distant

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

Are any of these situations continuing to impact your life? *(yes/no) If yes, please circle which*

Are you currently working with a professional counsellor, psychologist, social worker, pastor or other therapist? __

Have you in the past: _____ If so, when? (please give dates):_____

Are you currently working with a Doctor of conventional medicine (M.D.)? *(yes/no)* If so, whom? _____

Which of the following illnesses have you had? *Please indicate "n" for now or "p" for past*

	N	P		N	P		N	P		N	P
Allergies			Weight problems			Stroke			Venereal disease		
Asthma			Gallstones			Cancer			Syphilis		
Eczema			Gout			Epilepsy			Gonorrhea		
Psoriasis			Arthritis			Migraine			HIV		
Ear infections			Thyroid problems			Pneumonia			Varicose veins		
Strep throat			Anemia			Diabetes			Broken bones		
Hay fever			High blood press.			Malaria			Numbness/tingling		
Measles			Rheumatic fever			Tuberculosis			Cold hands/feet		
Mumps			Fainting			Small pox			Visual problems		
Chicken pox			Poor memory			Polio			Headaches		
Whooping cough			Balance problems			Gas/bloating			Mono		

Dr. Tas

Diphtheria			Speech problems			Hemorrhoids			Depression		
Scarlet fever			Ringing in ears			Parasites			Child abuse		
Sinusitis			Jaundice			Rectal bleeding			Physical abuse		
Canker sores			Hepatitis			Herpes			Sexual abuse		
Acne			Heart disease			Warts			Emotional abuse		
Tonsillitis			Alcoholism			Rape					

Other:_____
Are there any of these from which you feel you have never been well since? _____
Previous surgeries and hospitalizations (please give dates) _____
_____
Have you had any major injuries? If so, what happened and when? _____
_____
Do you have any allergies to any drugs, herbs, foods, animals or other? *(yes/no)* If so, what? _____
_____

Which of the following do you currently use?

Amount (how often, how much & how long)

Alcohol: _____
Hormones: _____
Cortisone: _____
Sedatives: _____

Amount (how often, how much & how long)

Tobacco: _____
Coffee: _____
Laxatives: _____
Antacids: _____

Other medications (please give full name and dosage and how long you have been taking the medication)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Vitamins/herbs:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Dr. Tas

Family History

Please indicate which of the following is found in your family with date of diagnosis if possible.

	Mother	Father	Sister/Brother	Grandparents
Cancer				
Tuberculosis				
Heart Disease				
Arthritis				
Diabetes				
High blood				
Asthma				
Kidney disease				
Depression				
Anemia				
Stroke				
Heart attack				
Ulcers				
Other				

When did you last use antibiotics? _____

Were you vaccinated? (yes/no) Did you have any adverse reactions (e.g. fever)? (yes/no)

Your currently live with? spouse ___ partner ___ parents ___ friends ___ children ___ alone ___

Are you? married ___ separated ___ divorced ___ widowed ___ single ___ in a supportive relationship ___

What is your current level of education? _____ Are you satisfied with this? (yes/no)

Do you have any children? (yes/no) If so, how many? _____

Do they have any health problems? _____

What is your weakest organ system and why? _____

_____

Kidneys and Bladder

How much water do you drink daily? _____

Have you had recurrent bladder infections? *(yes/no)* How were they treated? _____

How many bladder infections have you had in the last 3 years? _____

Do you have any burning sensation during or after urination? *(yes/no)* If yes, is it past or present?

Is your urine *(dark yellow, bright yellow, cloudy, pale or clear*)?

Does your urine have a strong odor to it? *(yes/no)*

Do you have difficulty starting or stopping when urinating? *(yes/no)*

Do you have difficulty perspiring? *(yes/no)* Do you perspire when you exercise? *(lightly, moderately, heavily)*

Do you perspire at times other than when exercising? *(yes/no)* If yes, when? _____

Does your perspiration have a strong smell? *(yes/no)*

Dr. Tas

Digestion and Elimination

Do you have any problems with gas, bloating or fullness after eating? (*yes/no*)

If so, how often? (*often, sometimes, never*) How severe? _____

Do you have gas in (*the upper part of the abdomen, the lower part, or both*)?

How long have you had this problem? _____

How often do you have bowel movements? _____ Do your stools tend to be (*formed or loose*)?

Do you ever have any (*blood, mucus, undigested food, black*) stools? Any rectal itching? (*yes/no*)

How often do you have diarrhea? _____

Do you ever have alternating constipation and diarrhea? (*yes/no*)

Do you ever have yellow or light colored stools? (*often, sometimes, never*)

How often do your stools have a strong disagreeable odor? (*often, sometimes, never*)

Have you ever fasted? (*yes/no, juice or water*) If yes, how long have you fasted? _____

How did you feel while you were fasting? _____

Have you traveled outside Canada in the last 5 years? (*yes/no*) If yes, where did you go? _____

Reproductive Health

Are you currently sexually active? (*yes/no*) How often? _____Is this (*more or less*) than 1 year ago?
Sexual preference: Heterosexual _____ Bisexual _____ Homosexual _____ Transexual _____
Do you use birth control? (*yes/no*) What type of birth control do you currently use? _____
How often do you get up at night to urinate? ____ Is this an increase in past few years? (*yes/no*)
Any problems with impotency (getting or maintaining an erection)? (*yes/no*)
Do you have any sores on penis? (*yes/no*) _____
Do you have any abnormal discharge from the penis? (*yes/no*)
Any prostate problems? (*yes/no*) Ever have your prostate examined? (*yes/no*) When? _____

Personal Habits

What do enjoy most in your life? _____

Please rate your satisfaction with the following areas of your life on a scale of 1 to 10: (10 is highest, 1 is lowest)

Fun & recreation _____ Personal growth _____ Significant other/romance _____ Friends & Family _____
Health _____ Money _____ Physical Environment _____ Career _____

What are your main interests or hobbies? _____

What do you worry most about in your life? _____

Do you have any dietary restrictions? (yes/no) If yes, what? _____

Do you exercise? (yes/no) If yes, what kind, how much & how often? _____

Dr. Tas

Do you have a religious or spiritual practice? (yes/no) If yes, what? _____

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) _____

Do you have problems (falling or staying) asleep? _____How many hours do you sleep at night? _____

Do you awaken at night? (yes/no) If yes, how many times per night and at what time(s) do you usually wake up?_____

Do you ever sweat at night while sleeping? (yes/no) How frequently and how much do you sweat? _____

Do you wake up feeling refreshed? (yes/no) Do you nap or rest horizontally throughout the day? (yes/no)

If yes, how long and at what time usually? _____

What do you normally feel like temperature wise, compared to others? (warmer, cooler, or average)

What are the temperatures of your hands and feet generally? (warmer, cooler, or average)

Do you enjoy your work? (yes/no) Do you take vacations? (yes/no)

Are you currently in a happy satisfying relationship with someone? (very, mostly, somewhat, not)

How often do you get colds, flus, sore throats during the year? _____

When you rise quickly from a sitting or lying position do you ever get dizzy? (yes/no)

If yes, how often? (daily, few times per week, once a week, twice a month, once a month, rarely)

How do you learn best? reading listening (lectures) Television storytelling visually

Occupational/Household

How long have your lived at your present address? _____ Where have you lived previously? (please describe location, if old or new place, if damp, moldy, etc.) _____

Do you have specialized air filtration at home? (yes/no) Do you live in a city? (yes/no)

Do you work in an office building? (yes/no) Do the windows open? (yes/no)

Do you have specialized air filtration at your work place? (yes/no)

Do you work in the presence of toxic fumes or chemicals? (yes/no)

Do any of your hobbies involve toxic materials? (yes/no)

Do you smoke? (yes/no) If yes, what and how much and how often? _____

Are you currently exposed to second hand smoke? (yes/no)

What do you use for your drinking water? (bottled, filtered, or tap water)

Is there anything else you feel I should know about you? _____

_____

_____

_____

Thank you for taking the time to fill in this lengthy questionnaire.

It will be a valuable resource in assessing your health.

Dr. Tas

CARE AGREEMENT

Naturopathic medicine uses non-invasive methods for the assessment of bodily dysfunction and natural therapeutics for correction. The methods used in this clinic for assessment and therapeutics include clinical nutrition, homeopathy, botanical medicine, hydrotherapy, detoxification, acupuncture and lifestyle counseling.

Each person must sign this document before any treatment is rendered.

PLEASE READ CAREFULLY , INITIAL AND SIGN BELOW

I understand that:

a) The treatments that I receive at this office are different from those usually offered by a medical doctor or other licensed health care practitioner.

b) I understand that I am at liberty to seek or continue to seek medical care from a physician or surgeon or other health care provider.

c) I confirm that Tasleem Kassam, N.D. nor anyone else has suggested that or recommended that I refrain from seeking or following the advice of another licensed health care provider.

d) I declare that I authorize and consent to treatment. I further understand and am informed that, as in all health care, in the practice of naturopathy, there are some very slight risks to treatment. I do not expect the doctor(s) to be able to anticipate and explain all the risks and complications; I wish to rely on the doctor's judgment during the course of treatment, based upon the facts then known, is in my best interest.

e) I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Therefore, all services rendered to me are charged to me directly and that I am personally responsible for payment. I am aware that these fees are not covered by provincial health care plans. I also understand that if I suspend or terminate my naturopathic care, any outstanding charges for consultation, labwork, supplements or other incidental fees arising from my treatment will be immediately due and payable.

Payment is due once services are rendered. (_____ Initial)
I will be charged 50% of my treatment cost should I fail to give 24 hours' notice for missed appointments or should I fail to show up without warning. (_____Initial)
If I a late for my appointment, time will be reduced accordingly and the appointment will end as scheduled. (_____Initial)

I, (please print name)_____, have read and understand the above and give permission to the discussion of any of the information provided amongst the Health Care Professionals necessary for my care.

Patient's Name _____

Signature: _____ Date:_____