DR. NATALIE RAHR
NATUROPATHIC DOCTOR

info@drnatalierahr.com
www.drnatalierahr.com

Adult Intake Form

Please complete and email back to info@drnatalierahr.com
Please be as complete as possible with your answers. Feel free to include reports or test results. This allows for the best possible care for your individual needs.
All information is kept completely confidential.

First Name: _____ Last Name:_____

Gender:_____ Age:_____ Birthdate (dd/mm/yy):_____

Care Card Number: _____

Address:_____ City:_____

Province:_____ Postal Code:_____

Phone:_____ Work:_____

Email Address:_____

Are we allowed to contact you by email? Y N

Are you currently receiving healthcare? Y N

If so from whom and where?

Names of other healthcare providers/therapists (including naturopathic doctors, medical doctors, chiropractors, etc)

Please list your main health concerns in order of importance:

Medications
List all prescriptions, over-the-counter drugs, vitamins, herbs, supplements and any non-medical drugs.

Do you have practices in your life to maintain your mind/body/soul health? If so, what are they?

Please list any known allergies including to medications, environmental and food:

Are there any foods/food groups that you avoid? (Please list):

Please list any hospitalizations, serious injuries, and/or surgeries (date and type):

How often do you consume the following per week?

Tobacco _____

Alcohol _____

Drugs _____

Coffee/Caffeine _____

Dairy Products _____

Sweets _____

Meditation _____

Exercise _____

Your Past Medical History:
Please check off and date

Asthma_____ High Blood Pressure_____
Allergies_____ Gastrointestinal Disease_____
Arthritis_____ Birth Defects_____
Seizures_____ High Cholesterol_____
Deafness_____ Heart Disease_____
Cancer_____ TB/Cystic Fibrosis_____
Mental Illness_____ Autoimmune Disease_____
Depression_____ Anxiety_____
Diabetes_____ Developmental Delay_____
Kidney Disease_____ Alzheimers/Dementia_____

Other Major Illness:

Significant Trauma (auto accidents, falls, other):

Family Medical History:
Please check off if there is a family history of any and indicate Maternal (M) or Paternal (P) for which side of the family

Asthma_____ High Blood Pressure_____
Allergies_____ Gastrointestinal Disease_____
Arthritis_____ Birth Defects_____
Seizures_____ High Cholesterol_____
Deafness_____ Heart Disease_____
Cancer_____ TB/Cystic Fibrosis_____
Mental Illness_____ Autoimmune Disease_____
Depression_____ Anxiety_____
Diabetes_____ Developmental Delay_____
Kidney Disease_____ Alzheimers/Dementia_____

Others:

Please check if the following symptoms are a current or recurring:

General
Poor appetite
Night sweats
Weight gain
Poor sleep
Sweat easily
Weight loss
Fatigue
Chills
Cravings
Bleed or bruise easily
Fevers
Strong thirst
Sudden energy drop

Skin and Hair
Rashes
Change in hair or skin texture
Recent moles
Itching
Loss of hair
Ulcerations
Eczema
Dandruff
Pimples

Head, Eyes, Ears Nose, Throat
Headaches
Night blindness
Sinus problems
Neck pain
Colour blindness
Nose bleeds
Concussions
Cataracts
Jaw clicks or pain
Eye pain
Earaches
Tooth pain
Eye strain
Poor hearing
Mercury tooth fillings
Blurry vision
Ringing in the ears
Recurrent sore throats
Using glasses
Facial pain
Sores on lips or tongue

Respiratory
Difficulty breathing
Asthma
Coughing blood
Cough
Pain with a deep breath
Pneumonia
Bronchitis
Phlegm production (colour?)

Gastrointestinal
Indigestion
Abdominal pain or cramps
Rectal pain
Gas
Nausea
Hemorrhoids
Bad breath
Vomiting
Leaning abdomen over furniture
Blood in stool
Constipation
Chronic laxative use
Diarrhea

Urinary
Frequent urination
Unable to hold urine
Wetting the bed
Pain with urination
Blood in urine

Neuro-Psychological
Loss of balance
Depression
Quick temper/irritable
Susceptible to stress
Sensory issues
Seizures
Poor memory
Dizziness
Areas of numbness
Anxiety
Lack of coordination

Musculoskeletal
Muscle pain
Joint pain
Muscle weakness

Female Hormones
Age of first menses _____
Duration of menses (days) _____
Days in cycle _____
Date of last PAP exam _____
Breast Tenderness
Clots
Irregular Periods
Heavy Periods
Painful Periods
Spotting
Changes in body or mood prior to menses?

Do you practice birth control? What type and how long?

Painful Intercourse
Number of pregnancies
Number of births
Miscarriages
Abortions

What are your goals of treatment?

Please describe anything else you would like to discuss.

DR. NATALIE RAHR
NATUROPATHIC DOCTOR

Informed Consent to Treatment

Please complete and email back to info@drnatalierahr.com

1. I understand that Dr. Natalie Rahr, ND is a BC licensed Naturopathic Doctor and that she will provide therapies that are within her scope of practice.
2. I understand that any advice given to me as a patient of Dr. Natalie Rahr is not mutually exclusive from any treatment or advice I may now, or in the future, be given from another health care provider.
3. I understand that I am accepting or rejecting the advice given during my consultation by my own free will.
4. I understand that I am at liberty to seek or to continue medical care from other health care providers.
5. I understand that Dr. Natalie Rahr, ND is not suggesting or recommending that I refrain from seeking advice or continuing care from other health care providers.
6. I understand that Naturopathic Physicians reserve the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.
7. I understand that the services are not covered by MSP or other provincial health plans and that fees are payable at the time of appointment, including fees for services, laboratory tests and any prescriptions provided.
8. I understand that 48 hours notice is required to cancel otherwise I will be responsible for a cancellation fee of $75-200 depending on length of appointment.
9. I understand that all therapies, services and supplements/prescriptions provided are non-refundable and that prices may change without notice.
10. I understand that any therapies recommended will be explained to me in full by my physician and I will give consent to treatment based on informed consent.
11. I understand that COVID 19 precautions are being taken for in person visits, and that Dr. Natalie Rahr, ND is not liable if I should contract COVID 19 or other illnesses while visiting the office or surroundings.
12. During Telemedicine visits (phone or online) I understand that all information is kept as secure and confidential as possible and that these visits do not replace in person primary care.

I _____ have read, understood and agree to the above statements.

Signature: _____ Date: _____