ADULT INTAKE FORM

Dr. Michael Tassone, ND

Thank you for taking the time to complete the following new patient form to the best of your ability. It is an important step towards defining your health care needs and achieving your health goals.

Please bring this completed form to your first appointment, drop it off at the office in advance for review, or submit it online to info@drmichaeltassone.com. Please also bring in any recent, relevant blood work or health reports. This is a confidential record and will NOT be released unless you have authorized us to do so.

FULL NAME___________________________________ AGE_____ DATE OF BIRTH (DD/MM/YY) ____________________

ADDRESS____ POSTAL CODE____________________

PHONE: Home__________________________ Cell__________________________ Work___________________________

E-MAIL________________________________ PREFERRED METHOD OF CONTACT (PLEASE CIRCLE) HOME/ WORK/ CELL/ EMAIL

CARE CARD #__________________________ OCCUPATION____

EMERGENCY CONTACT (Name, Relationship)______________________________ PHONE________________________

NAME OF PRIMARY PHYSICIAN____ PHONE________________________

KNOWN ALLERGIES (Food, Drugs, Vaccines, Environmental)____

____

How did you hear about the clinic? (☑ check all that apply) ☐ Friend/Family Member ☐ Newspaper ☐ Website
☐ Already seeing one of the other practitioners in the clinic ☐ Other (Please Specify)______________________________

PRESENT HEALTH CONCERNS: (Please list in the order of priority to you)

1.)____

2.)____

3.)____

4.)____

5.)____

PAST MEDICAL HISTORY:

HOSPITALIZATION (When? For What? How Long?)____

____

ACCIDENTS AND INJURIES____

____

PSYCHIATRIC ILLNESSES____

LAST COMPLETE PHYSICAL EXAM DATE__________ Describe any abnormal findings: ________________________

♀ ONLY		♂ ONLY
Last Pap Smear Date:	Results: Normal Abnormal	Last Prostate Exam Date:
Last Mammogram Date:	Results: Normal Abnormal	________________
Do you do monthly self breast exams?	Yes No	Results: Normal Abnormal

PERSONAL LIFESTYLE: (Please check & fill in all that apply)

TOBACCO? ☐ YES ☐ NO If yes, how many years?___________ How many cigarettes per day?_________________
CAFFEINE? ☐ YES ☐ NO If yes, please circle type: coffee/ tea/ pop/ energy drinks How much daily?____________
ALCOHOL? ☐ YES ☐ NO If yes, how much?________________ How often?_____________________________
RECREATIONAL DRUGS? ☐ YES ☐ NO If yes, what kind?_______________ How often?___________________
REGULAR EXERCISE? ☐ YES ☐ NO If yes, what kind?___________________ How often?___________________

SOCIAL HISTORY:
MARITAL STATUS: ☐ Single ☐ Married ☐ Significant other/Common Law ☐ Divorced ☐ Widowed
SEXUALLY ACTIVE: ☐ Yes ☐ No TYPE OF BIRTH CONTROL: ____
HOW MANY CHILDREN? ________ AGES: ____

DIET:
Please describe a typical days diet:
BREAKFAST: ____
LUNCH: ____
DINNER: ____
SNACKS: ______________________________ BEVERAGES: ___________________________

FAMILY MEDICAL HISTORY:

	WHO?	COMMENTS		WHO?	COMMENTS
Allergies			Heart Disease		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Auto Immune			Kidney Disease		
Asthma			Mental Illness		
Cancer			Stroke		
Diabetes			Tuberculosis		
Epilepsy			Other		

MEDICATION AND SUPPLEMENT SUMMARY:
(Please include any prescriptions, over the counter medications, and supplements taken in the last month)

Start Date	Name of Medication or Supplement	Dose/Strength (ex. 250mg)	Frequency (ex. Twice per day)	With Food? (Y/N)	Reason for Medication or Supplement	Prescribed by	Comments

INFORMED CONSENT FOR TREATMENT:

Welcome to Naturopathic Medicine! As a doctor of Naturopathic medicine it is my honor to take your care and health seriously. The following document is an agreement between you and I that states that you are entitled to understand any detail you wish about your health condition, treatment and diagnosis. It states that you are aware of the costs of naturopathic medicine (including late cancellation policies), the benefits and potential risks and side effects. Your health is ultimately up to you, therefore you also have the right to refuse any suggested treatment. We are in this together, so be sure to ask any questions you have, no matter what they are, at anytime and I will do my best to fulfill the meaning of doctor (docere) "To Teach".

STATEMENT OF ACKNOWLEDGEMENT:

I, ______________________as a patient of Dr. Michael Tassone, ND understand that I am being treated under the practice philosophy and scope of naturopathic principles and practices. I will disclose all health concerns, conditions, medications and medical interventions, including supplements and over the counter drugs to my naturopathic doctor because I understand that safe care requires that I truthfully and completely disclose this information. I also will inform my naturopathic doctor if I am pregnant or breastfeeding so that he can take proper precautions for treatment.

I am aware and understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side effects. I am entitled to know the consequences of not accepting treatment and of alternative treatments that may be applicable. I am encouraged to take an active role in my care and ask any questions needed. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that he has answered all of my questions to the best of his ability.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some treatments. This may include, but not limited to: aggravation of pre-existing symptoms, allergic reactions to supplements, herbs or pharmaceuticals and bruising or injury from acupuncture or intravenous therapies.

I understand that my naturopathic doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at anytime. I accept full responsibility for any fees incurred during care and treatment, including a 50% late cancellation fee if providing less than 24 hours notice for cancellation of any appointments. I am aware that I am always at liberty to seek or continue care from another healthcare provider.

Signature (of patient, or legal guardian): ___________________________________ Date: ___________________________

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