Dr. Reka Laszlo, ND
19140 Centre Street – Unit B
Mount Albert, ON. L0G 1M0
905-473-2176

Mount Albert CHIROPRACTIC & WELLNESS CENTRE

Adult Intake Form

Please take the time to fill out the following information on your computer. It provides a basis for further questions during your visit and helps provide insight into your health. All information is for office use only and is ***strictly confidential****.*

Once complete please email your forms to DrReka@EnterToBeWell.com

Date of First Visit: _____

Patient Information

Full Name: _____ Date of Birth: _____ Age:_____ Gender: M___ F___

Address: _____ City: _____ Postal Code:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ May we leave messages regarding your visits ? On what number? _____

Occupation: _____ Full or Part-time? _____ Shift work? yes____ no____

Marital Status: single____ married____ common-law____ separated____ divorced____ other: _____

Children: yes ____ no____ If yes, please list ages: _____

How did you find out about the naturopathic services at this clinic? If referred please indicate from whom.

_____

Emergency Contact

Full Name: _____

Relationship to Patient: _____

Home Phone / Cell: _____

Please List Other Health Care Providers

1._____ Speciality: _____ Phone_____

2. _____ Speciality: _____ Phone_____

3. _____ Speciality: _____ Phone_____

Current Health Concerns

What are your health concerns in order of importance to you?

1. _____ 2. _____

3. _____ 4. _____

How do you rate your general state of health? poor ____ fair____ good____ very good____ excellent____

Comments: _____

_____

Medical History

Current or past diagnosed conditions (incl. year diagnosed):

_____

_____

_____

Allergies or sensitivities (foods, drugs, environmental, pets etc.): _____

_____

_____

_____

Current or past illnesses, accidents or hospitalizations (incl. year):

_____

_____

_____

How many times have you been treated with antibiotics? _____

Do you get regular screening tests (PAP, blood, etc.)? Yes___ No___

Date of last screening physical exam: _____

Are you currently pregnant? Yes____ No____ Due Date:_____

Are you currently breast feeding? Yes____ No_____

Medications and Supplements

List all CURRENT prescribed medications:

Drug name: _____ Dosage: _____ Length taken: _____

Drug name: _____ Dosage: _____ Length taken: _____

Drug name: _____ Dosage: _____ Length taken: _____

Drug name: _____ Dosage: _____ Length taken: _____

List all CURRENT vitamins, minerals, herbs and supplements:

_____

_____

List all PAST prescribed medications that you've taken for longer than 3 months:

_____

_____

List any prescribed medication you've had an adverse reaction to in the past. Indicate drug name, when you took it and the reaction you had:

_____

_____

Lifestyle History

Please list a typical day's diet:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

Do you exercise? Yes____ No____

If yes, how often? _____ times per week

... how long? _____ minutes per workout

....what type? _____

How much water do you drink? _____ glasses per day

Do you avoid any foods and why? _____

Describe your appetite: _____

How would you rate your energy level? *(rate from 1-10, 10 = Best)* _____

How many hours of sleep do you get a night? _____ Do you wake rested? Yes____ No____

Do you have difficulty falling asleep? Yes____ No____ Do you have difficulty staying asleep? Yes____ No____

What are your sleep patterns? (Include usual time of sleep and wake, daytime naps, etc.):

_____

_____

What is your height? _____ Current weight? _____ Max. weight? _____ Min. weight? _____

Have you lost any weight lately? Yes___ No___ If yes, how many pounds? _____

Mount Albert CHIROPRACTIC & WELLNESS CENTRE

Indicate whether you use or are exposed to the following (and if so, how much/how often)

Tobacco smoke: _____

Coffee: _____

Tea: _____

Pop: _____

Alcohol: _____

Recreational drugs: _____

Excess stress: _____

Chemicals: _____

Family History- *Please indicate any health conditions that have affected members of your family:*

Relative	Age if Alive	Age at Death	Health Conditions
Mother			
Father			
Siblings			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Clarification of Goals

What are 3 goals you want to achieve by seeing an ND?

1. _____ 2. _____ 3. _____

What long terms expectations do you have from working with me as your Naturopathic Doctor? _____

_____

What behaviours/activities do you currently engage in to support your health?_____

_____

What behaviours/activities do you currently engage in that hinder your health? _____

_____

What is your present level of commitment to learn and implement healthy changes which will improve your health and well-being?

(*Rate from 1-10*) _____

If below 8, what will it take to increase your level of commitment? _____

_____

What potential obstacles do you foresee in addressing factors undermining your health and adhering to the therapeutic protocol?_____

Who do you know that will support you with your health journey? _____

What do you love to do? _____

Review of Systems
Please check (√) **Y** if you have the symptom now, and **P** if you've had the symptom in the past.

SKIN	Y	P
Rashes		
Hives		
Acne		
Boils		
Eczema		
Psoriasis		
Dry skin		
Itching		
Lumps		
Night sweats		
Other		

HEAD	Y	P
Tension Headaches		
Migraine headaches		
Head injury		
Dizziness		
Other		

EYES	Y	P
Impaired vision		
Use of contact lenses		
Eye pain		
Tearing		
Dryness		
Double vision		
Cataracts		
Glaucoma		
Blurring		
Light sensitive		
Itching		
Redness		
Discharge		
Blind spot		
Other		

EARS	Y	P
Impaired hearing		
Earache		
Dizziness		
Discharge		
Infections		
Excessive wax		
Other		

NOSE & SINUSES	Y	P
Frequnt colds		
Nose bleeds		
Stuffiness		
Hay fever		
Infections		
Other		

MOUTH & THROAT	Y	P
Hoarseness		
Gum problems		
Difficulty swallowing		
Dental problems		
Sores		
Dryness		
Sore throat		
Loss of taste		
Other		

NECK	Y	P
Lumps		
Swollen glands		
Goiter		
Pain or stiffness		
Other		

RESPIRATORY	Y	P
Cough		
Sputum		
Spitting with blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Emphysema		
Difficulty breathing		
Pain on breathing		
Shortness of breath		
Shortness of breath at night		
Shortness of breath when lying		
Positive tuberculosis test		
Last TB test		
Last chest X-ray		
Other		

CARDIOVASCULAR	Y	P
Angina		
Murmurs		
Chest pain		
Swelling in ankles		
Palpitations, fluttering		
Last ECG		
Other		

BREASTS	Y	P
Do you do self breast exams?		
Lumps		
Pain (tenderness)		
Fibrocystic breasts		
Nipple discharge		
Last mammogram		
Other		

GASTROINTESTINAL	Y	P
Heartburn		
Change in appetite		
Nausea		
Vomiting		
Vomiting blood		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		

Constipation		
Blood in stool		
Hemorrhoids		
Black, tarry stool		
Jaundice		
Liver disease		
Gallbladder disease		
Food allergy		
Hiatus hernia		
Last colonoscopy		
Other		

BLOOD/ LYMPHATIC	**Y**	**P**
Anemia		
Easy bleeding/ bruising		
Past transfusions		
Lymph node swelling		
Other		

ENDOCRINE	**Y**	**P**
Heat or cold intolerance		
Thyroid condition		
Excessive thirst		
Excessive hunger		
Excessive urination		
Excessive sweating		
Diabetes		
Hypoglycemia		
Hormone therapy		
Other		

URINARY	**Y**	**P**
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced urine flow		
Other		

MALE REPRODUCTIVE	**Y**	**P**
Hernia		
Testicular masses		
Testicular pain		
Impotence		
Premature ejaculation		
Venereal disease (STD)		
Discharge		
Sexually active		
Last prostate exam:		
Last PSA level:		
Other		

FEMALE REPRODUCTIVE	**Y**	**P**
Age of first menses:		
Last menstrual period:		
Length of cycle:		
Number of days of menses:		
Bleeding between periods		
Irregular cycles		
Pain during intercourse		
Painful menses		

Excessive flow		
PMS symptoms		
Number of pregnancies		
Number of live births		
Number of miscarriages		
Number of abortions		
Difficulty conceiving		
Sexual difficulties		
Vaginal discharge		
Vaginal itching		
Sexually active		
Menopause		
Age of onset:		
Hormone therapy		
Last gynecological exam:		
Last PAP smear:		
Other		

MUSCULOSKELETAL	**Y**	**P**
Broken bones		
Muscle spasms/ cramps		
Weakness		
Joint swelling		
Backache		
Other		

PERIPHERAL VASCULAR	**Y**	**P**
Deep leg pain		
Cold hands/ feet		
Varicose veins		
Deep vein thrombosis		
Leg cramps		
Extremity numbness		
Extremity coldness		
Extremity swelling		
Extremity ulcers		
Other		

NEUROLOGIC	**Y**	**P**
Fainting		
Seizure/ Convulsions		
Paralysis		
Muscle weakness		
Numbness or tingling		
Loss of memory		
Involuntary movements		
Loss of balance		
Speech problems		
Other		

EMOTIONAL	**Y**	**P**
Depression		
Anger		
Mood swings		
Anxiety		
Nervousness		
Tension		
Phobias		
Insomnia		
Sexual difficulties		
Drug abuse		
Psychiatric care		
Psychological counseling		
Other		

Informed Consent

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's healing capacity.

Naturopathic Doctors are required to obtain informed consent and to make sure you are aware of possible side effects/risks due to treatment. Dr. Reka Laszlo, ND uses the following in her practice: diet and nutritional counselling, traditional Chinese medicine and acupuncture, botanical medicine, hydrotherapy, homeopathy, and lifestyle counselling. It is important to know that any treatment or advice provided is not mutually exclusive from any treatment or advice that you may now be receiving or may in the future receive from another licensed health care provider and you are at liberty to continue medical care from a medical doctor or any other health care provider licensed to practice in Ontario.

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, improved gastrointestinal function, enhanced immunity, and general well-being.

Botanical medicine is plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine based on the Law of Similars; that is, the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses, of plant, animal, or mineral origin, are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, Dr. Reka Laszlo, ND will take a thorough case history and perform a basic/complaint-oriented physical examination in order to obtain a complete assessment of your case.

Even the gentlest of therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those taking multiple medications. Some therapies must be used with caution in certain diseases including, but not limited to, diabetes, heart/liver/kidney disease. It is very important therefore that you inform Dr. Reka Laszlo, ND immediately if any of the above applies to you.

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/injury from acupuncture, fainting or puncturing of an organ with acupuncture needles.

_____ Initials

I understand that my case may be discussed for educational purposes and information from my medical record may be analyzed for research purposes in which my identity will be kept confidential. I acknowledge that I have discussed, or have had the opportunity to discuss, with Dr. Reka Laszlo, ND the nature and purpose of naturopathic treatment in general and my treatment in particular as well as the contents of this consent.

_____ Initials

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 without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____ Initials

I understand that Dr. Reka Laszlo, ND will answer any questions that I have to the best of her ability. Because each individual responds differently to treatment, I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions): _____

_____ Initials

I understand that fees and supplements are to be paid for at the time of the consultation and visit.

_____ Initials

I understand that a fee will be charged (Cost of the Visit) for any missed appointments or cancellations with less than 24 hours' notice.

As the patient, you are responsible for the total charges incurred for each visit. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company. Dr. Reka Laszlo, ND may prescribe supplements that can be purchased from our in-house dispensary, or elsewhere. Most insurance companies do not cover the supplements that we prescribe and dispense.

I have read and understand the above-stated policies and information. I hereby authorize and consent to naturopathic treatment and examination by Dr. Reka Laszlo, ND. I intend this consent to apply to all my present and future naturopathic care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print): _____

Signature of Patient or Guardian: _____

Date: _____

Dr. Reka Laszlo, ND

Mount Albert CHIROPRACTIC & WELLNESS CENTRE

List of Services

Fee Schedule

Initial Consultation	60 min	$180
Second Visit	45-60 min	$100
Follow-up visits	30 min	$80
Acute visit	15 min	$45
Telephone or email consultation	15 min	$45
Acupuncture (requires initial consultation)	30 min	$70

Other Services

B12 Injections		$15
Medical Letter		$25

- Please note all fees are subject to HST.
- Fees are payable at the end of each visit.
- Prices do not include supplements, botanical tinctures, homeopathic remedies or laboratory testing.
- Payment methods include cash, cheque, Interac, Visa and Mastercard.
- Please note that fees are not covered by OHIP, however, they may be covered by your extended health care plan. Please check with your insurer to determine your coverage.
- Cancellation Policy:

  Cancellations made without 24 hours notice or missed appointments will be charged a full visit fee.

I have read, fully understand, and agree to honour the fee schedule listed above.

Patient's/ Guardian's Signature: _____ Date:_____