TWIST PERFORMANCE + WELLNESS

Naturopathic Medicine | Dr. Jason Marr ND | Dr. Rigobert Kefferputz ND

new patient intake forms

please complete and bring this form with you to your initial consultation.

personal information

name: last name | first/given name

address: street

city, province | postal code

telephone: main | work

email: please print clearly

date of birth: day/month/year

sex: m | f

weight: lbs or kg

height: feet or cm

marital status

occupation

referral information

how did you hear about our naturopathic services?

Please be specific

medical contact information

family physician

doctor's full name

address

phone | fax

other healthcare practitioners

full name/speciality

phone | fax

full name/speciality

phone | fax

emergency contact

last name | first/given name | relationship

main phone | work

health priorities & primary concerns

please list your main health concerns (or reasons for seeking treatment), and state their relative importance:

priority/concern	severity (0-10)	importance (high/med/low)
1		
2		
3		
4		

medical history

diagnosed medical conditions, surgeries, hospitalizations

please indicate any past or present illnesses, injuries, conditions or hospitalization/surgeries

medical condition or reason for hospitalization	date	is this condition still ongoing? (Y/N)
1		
2		
3		
4		

allergies and/or food sensitivities

please indicate any allergies and/or food sensitivities of which you are aware

allergy/sensitivity	severity of reaction	details
1		
2		
3		
4		

medications/supplements/herbs

please indicate all current medications, supplements & herbal treatments you are taking (over the counter and prescription)

medication/supplement/herb	date started	prescribed by	condition for which prescribed
1			
2			
3			
4			
5			
6			

family history

please outline any significant health conditions your family has experienced

review of systems

lifestyle

do you partake in, or have you in the past (p), partaken in the following?

alcohol	y	n	p	#/frequency/duration
cigarettes	y	n	p	#/frequency/duration
recreational drugs	y	n	p	#/frequency/duration
aspirin	y	n	p	#/frequency/duration
laxatives	y	n	p	#/frequency/duration
diet pills	y	n	p	#/frequency/duration
antacids	y	n	p	#/frequency/duration
coffee	y	n	p	#/frequency/duration
black tea	y	n	p	#/frequency/duration
green tea	y	n	p	#/frequency/duration
birth control	y	n	p	#/frequency/duration
metal implants	y	n	p	#/frequency/duration

sources of stress

- financial
- career
- personal
- family
- health
- marriages/relationship
- spiritual
- emotional trauma/loss
- other *(please specify)*

current stress level

- unbearable
- high
- average
- low
- none

how does your stress manifest?
what are your coping mechanisms?

last vacation

sleep *(hrs/night)*

quality of sleep *(0-10)*

do you feel rested upon waking? y n

do you take naps? y n

when? for how long?

excerise & physical activity

cardio	freq.
weight-lifting	freq.
yoga/pilates	freq.
sports	freq.
walking	freq.
other	freq.

average energy level (0-10)

additional information

if you need to elaborate on any of the questions answered above, or on the system symptom map, please detail here.

dietary habits

please indicate if you consume any of the following, and indicate frequency

- fresh vegetables
- fresh fruits
- cold-water fish
- tuna
- canned goods
- soft drinks/pop
- milk/dairy products
- water
- juice
- processed foods
- microwavable foods
- deli meats
- "diet" products
- red meat
- fast foods
- sushi

meals (per day): 4+ / 3 / 2 / 1 -

snacks (per day): 4+ / 3 / 2 / 1 -

cravings

- sugar
- chocolate
- dairy
- salt
- other *(please* specify)

do you adhere to a specific diet?

e.g. vegetarian, gluten-free, etc.

are you satisfied with the quality of your diet? y n

on a scale from 1-10, how comfortable are you in the kitchen?

(1 = what's a kitchen? 10 = master chef)

specialty kitchen equipment available

- blender
- juicer
- other
- food processor
- dehydrator

please specify

1-day diet recall

on a typical day, what would you eat for?

breakfast

typical time

lunch

typical time

dinner

typical time

snacks

typical time

typical time

system symptom map

please indicate if you have experienced any of the following symptoms/conditions. indicate **y** if you are currently experiencing, **n** if you have never experienced, or **p** if you have experienced this condition in the past.

general

cancer	y	n	p
sensitivity to cold	y	n	p
sensitivity to heat	y	n	p
excessive hair loss	y	n	p
fatigue	y	n	p
fever/chills	y	n	p
rapid weight change	y	n	p
excess/night sweating	y	n	p

head/neck, eye/ear/nose/throat

headaches/migraines	y	n	p
tmj/jaw clicking	y	n	p
head trauma	y	n	p
tinnitus/ringing in ear	y	n	p
earache	y	n	p
hearing loss	y	n	p
dizziness/vertigo	y	n	p
changes in vision	y	n	p
eye pain	y	n	p
sensitivity to light	y	n	p
colour blindness	y	n	p
blurring/spots/stars	y	n	p
glasses/contact lenses	y	n	p
frequent nosebleeds	y	n	p
allergies/hayfever	y	n	p
stuffiness	y	n	p
sinus problems	y	n	p
loss of smell	y	n	p
nasal obstructions	y	n	p
dental/gum problems	y	n	p
dental cavities	y	n	p
mercury amalgams	y	n	p
mouth/lip/tongue sores	y	n	p
frequent sore throats	y	n	p
metallic taste in mouth	y	n	p
neck pain/stiffness	y	n	p
swollen glands/lumps	y	n	p
goiter	y	n	p

cardiovascular

heart disease	y	n	p
stroke	y	n	p
arrythmia	y	n	p
chest pain/angina	y	n	p
high blood pressure	y	n	p
murmurs	y	n	p
ankle swelling	y	n	p
rheumatic fever	y	n	p
phlebitis	y	n	p
cold hands/feet	y	n	p
easy bleeding/bruising	y	n	p
leg pain	y	n	p
varicose veins	y	n	p
anemia	y	n	p
swollen lymph nodes	y	n	p

skin

eczema	y	n	p
psoriasis	y	n	p
hives	y	n	p
rashes	y	n	p
acne	y	n	p
dry skin	y	n	p
lice/scabies/mites	y	n	p
new/changing moles	y	n	p

respiratory

chronic cough	y	n	p
frequent colds	y	n	p
excess phlegm/mucous	y	n	p
pain on breathing	y	n	p
asthma/wheezing	y	n	p
bronchitis/copd	y	n	p
coughing blood	y	n	p
chest pain	y	n	p
difficulty breathing/sob	y	n	p
pneumonia	y	n	p
tuberculosis	y	n	p
last tb test			
last chest x-ray			

urinary

pain on urination	y	n	p
increased frequency	y	n	p
decreased frequency	y	n	p
inability to urinate	y	n	p
abnormal thirst	y	n	p
kidney/bladder infection	y	n	p
kidney stones	y	n	p
coloured/bloody urine	y	n	p
frequent utis	y	n	p

psychosocial

anxiety/panic	y	n	p
depression	y	n	p
mood swings	y	n	p
attempted suicide	y	n	p
tension	y	n	p
easily angered	y	n	p
emotional outbursts	y	n	p
phobias	y	n	p
alcoholism/drug abuse	y	n	p
schizophrenia	y	n	p

breast

pain	y	n	p
lump(s)	y	n	p
pain/tenderness	y	n	p
fibrous tissue	y	n	p
do you self-examine?	y	n	p
last breast exam			

gastrointestinal

difficulty swallowing	y	n	p
food allergy/sensitivity	y	n	p
colitis	y	n	p
spitting up blood	y	n	p
jaundice	y	n	p
nausea/vomiting	y	n	p
indigestion/bloating	y	n	p
belching/burping/gas	y	n	p
regurgitation/heartburn	y	n	p
appendicitis	y	n	p
abdominal pain	y	n	p
change in appetite	y	n	p
change in thirst	y	n	p
hernias	y	n	p
hepatitis	y	n	p
gall bladder problems	y	n	p
diarrhea	y	n	p
constipation	y	n	p
black stools	y	n	p
mucous in stool	y	n	p
bloody stools	y	n	p
hemorrhoids	y	n	p
changes in bowel movements	y	n	p
# of bowel movements per day			

neurological/endocrine

fainting	y	n	p
numbness/tingling	y	n	p
paralysis	y	n	p
involuntary movements	y	n	p
muscle weakness	y	n	p
change in coordination	y	n	p
concussion/head injury	y	n	p
loss of (poor) memory	y	n	p
seizures/convulsions	y	n	p
loss of balance	y	n	p
speech difficulties	y	n	p
hallucinations	y	n	p
poor concentration	y	n	p
thyroid problems	y	n	p
excessive thirst	y	n	p
excessive hunger	y	n	p
diabetes	y	n	p
hormone therapy	y	n	p
excessive fatigue	y	n	p
seasonal depression	y	n	p
hair loss	y	n	p
brittle nails	y	n	p

muscoskeletal

joint pain/stiffness	y	n	p
arthritis/rheumatism	y	n	p
broken bones	y	n	p
sciatica	y	n	p
numbness/tingling	y	n	p
spasm/cramps	y	n	p
muscle weakness	y	n	p

sexual/reproductive

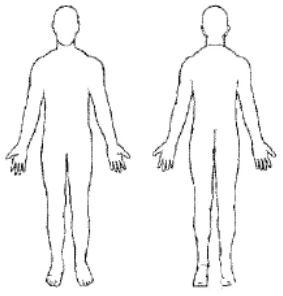
sexual difficulties	y	n	p
change in sex drive	y	n	p
warts on genitals	y	n	p
hiv+/aids	y	n	p
sexually active	y	n	p
pain with intercourse	y	n	p
infection/sti *(please specify)*	y	n	p

males only

prostate disease	y	n	p
testicular pain/mass	y	n	p
discharge/sores	y	n	p
hernias	y	n	p
impotence	y	n	p
erectile dysfunction	y	n	p
premature ejaculation	y	n	p

females only

age of menopause			
irregular periods	y	n	p
spotting	y	n	p
clots	y	n	p
duration of cycle			
duration of flow			
regular cycles?	y	n	p
age of first period			
# of pregnancies			
# of miscarriages			
# of abortions			
complications in pregnancy	y	n	p
date of last pap			
vaginal discharge	y	n	p
yeast/other infections	y	n	p
endometriosis	y	n	p
ovarian cysts	y	n	p
difficulty conceiving	y	n	p
cervical dysplasia	y	n	p
nipple discharge	y	n	p
self breast exams	y	n	p
premenstural syndrome	y	n	p



mark pain locations with “x”;
numbness/tingling with “o”;
use arrows to indicate radiating pain.

informed consent to treatment for naturopathic services

Twist Performance & Wellness

Our naturopathic physicians, work to ensure you are acquiring the best, most current information and the absolutely most cost-effective and individualized treatment plan. while you are establishing a relationship with one of our practitioners, your case information may be discussed between our team members in order to optimize your treatment plan.

About Naturopathic Medicine

Naturopathic medicine is a comprehensive and thorough system of healthcare. Various medical philosophies and natural approaches to treat and prevent disease and dysfunction are integrated into a holistic view, with the patient as the focus of treatment. this integrated, functional view takes into account the physical, biochemical, physiological, mental and emotional aspects of an individual, in order to deliver the most effective and appropriate treatment protocol based on individual need. Treatment approaches utilized by most naturopathic physicians are generally non-invasive modalities, with the intention of stimulating the body's own inherent ability to heal and repair itself. When necessary, other additional healthcare practitioners may be recommended, referred to, or consulted upon.

Treatment by a naturopathic physician requires a level of cooperation and involvement on behalf of the patient that you may not be accustomed to: Our practitioners encourage open dialogue and discussion regarding your process in order to ensure your needs and expectations are being met, while concurrently providing the most effective solution to your healthcare needs.

Treatment Modalities & Risks

When working with our naturopathic physicians, treatment modalities that may be utilized may include, but not necessarily be limited to: Cl inical nutrition & nutraceutical and orthomolecular supplementation; lifestyle & diet counselling; herbal & botanical medicine; acupuncture & traditional chinese medicine; exercise prescription; physical/rehabilitation medicine, low-intensity laser therapy; homeopathy; intravenous therapies; imagery training & meditation; craniosacral therapy; bowen therapy. Our practitioners generally utilize non-invasive, and low-risk treatment modalities. the patient always has the right to refuse any treatment and will be verbally informed of all treatments before they are administered. all therapies are associated with some potential risks. complications from treatments of naturopathic medicine (including acupuncture and intravenous therapies) may include, but are not limited to: Aggravation of bleeding, lightheadedness/fainting, nausea/vomiting, puncture of internal organs/structures); injury to soft tissues and/or joints, bone, spine arising from physical medical procedures; unforeseen interactions between recommended herbs/supplements, over-the-counter and/or prescription medications; bruising, infiltration, bleeding, lightheadedness or fainting from injection therapies.

Confidentiality

All treatment records, examinations, laboratory, blood work, test and treatment results are required by law to be held with the licensed healthcare practitioner of record. These records are kept strictly confidential and will not be released to others without written consent from you, unless required by law. information from your file may be used for research, teaching or training purposes; however, your identity is at all times protected. Conversations and dialogue between you and your healthcare practitioner are always confidential and stay within the confines of the examination room unless you provide written consent for this information to be released.

Statement of Consent

I understand that my Naturopathic Doctor is a sole practitioner and proprietor and practices under his/her own medical license and business license as a contractor to Twist Performance + Wellness. Twist Performance + Wellness will not be held liable or responsible for the medical or professional practices executed by the Naturopathic Doctor.

I understand the consequences and potential risks of the treatment modalities that may be recommended to me. I understand that there may be potential risk and complications that my healthcare practitioner(s) cannot anticipate. Further, I understand that my healthcare practitioner(s) may not at all times be able to explain all risk and complications that may arise. I agree to contact my practitioner(s) immediately should I have any questions or concerns regarding my treatment. I further agree to maintain an open dialogue with my practitioner(s) in order to best manage these risks and consequences. I understand that

I understand that like any healthcare practitioner, my practitioner(s) cannot guarantee results. I understand that the advice and/or treatments offered by my practitioner(s) are not intended to substitute or replace advice and/or treatments provided to me by my other healthcare practitioners. This consent form is intended to apply to the entire course of my care with any of the naturopathic physicians at Twist Performance + Wellness. I voluntarily consent to the diagnostic and therapeutic procedures outlined in this document, which may be recommended by my practitioner(s), and understand that I may withdraw consent for any further treatment, and discontinue treatment at any time with a written statement. Further, I consent to my treatment records, examinations, laboratory, blood work, test and treatment results to be released between the practitioners and staff of Twist Performance + Wellness for the purpose of advancing therapies and optimizing individualized treatment protocols.

Cancellation Policy

I agree to provide at least 24 hours notice for changes or cancellations to appointments. I agree to pay the cancellation fee of 100% for any missed or cancelled appointments.

patient name

signature

date