FOUNDATION STONE MEDICINE

Dr. Sandy Musclow
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NEW PATIENT INTAKE

Patient Information:

Name: _____ Date: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Primary Phone: _____ Alternate Phone: _____
May we leave a voice mail for you? Yes / No (Circle One) Preferred Contact: Phone / Email
Email address: _____ Interested in Newsletters? Yes / No

Emergency Contact: _____ Relationship to you: _____
Address: _____ Phone: _____

How did you hear about Foundation Stone Medicine? _____

Date of Birth (DD/MM/YYYY): _____ Age: _____ Sex: Male / Female / Other
What gender do you identify as: Male / Female / Other What pronouns do you use: Male / Female / Other
Relationship Status: Married ____ Partnered ____ Separated ____ Divorced ____ Widowed ____ Single ____
Housing Situation:
Spouse/Partner ____ Parents ____ Roommate ____ Children ____ Friend ____ Alone ____

Employment: _____ Hours/Week: _____ Retired: Yes / No

Currently receiving healthcare? Yes / No
If yes, where and from whom? _____
If no, when was your last visit, why, and with whom? _____

Please list your primary health concerns, in order of importance:

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

ALLERGIES

Are you allergic, or hypersensitive to the following?

Any drugs: _____ Any foods: _____
Environmental: _____ Chemicals: _____

MEDICATIONS, VITAMINS & SUPPLEMENTS

Please list **any** prescription medications, over the counter medications, vitamins or other supplements that you are currently taking, as well as the brand, frequency and dosage (ie. Aspirin 81 mg, 3x/day)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

List any medications that you have taken in the past: _____
Any adverse side effects or problems arise? _____

Prolonged or regular use of NSAIDs (Aleve, Aspirin)?	Yes	No
Prolonged or regular use of Tylenol (acetaminophen)?	Yes	No
Prolonged or regular use of acid blockers (Tagamet, Zantac, Prilosec, etc)?	Yes	No
Frequent or prolonged use of steroids (prednisone, allergy inhalers)?	Yes	No
Frequent or prolonged use of antibiotics?	Yes	No
Oral contraceptives (birth control)?	Yes	No

MEDICAL HISTORY

Please circle any of the following conditions that you experienced as a child:

Chicken Pox	German Measles	Mumps	Scarlet Fever
Diphtheria	Measles	Rheumatic Fever	

Which immunizations/vaccinations have you had, if any? _____

List any negative reactions you may have had: _____

Please list the vaccinations you believe you need: _____

Procedures: Hospitalization, Imaging, Surgery

Please list all hospitalizations, surgeries, dental work, X-rays, CT scans, ultrasounds, EKG, EEG, DEXA, mammograms, bone scans, colonoscopies, endoscopies and other tests.

1. _____ Year: _____
2. _____ Year: _____
3. _____ Year: _____
4. _____Year: _____
5. _____ Year: _____
6. _____ Year: _____

Please list the major life events or health conditions you experienced in your lifetime:

Birth – 5 years old	
5 yo – 10 yo	
10 yo – 20 yo	
20 yo – 30 yo	
30 yo – 40 yo	
40 yo – 50 yo	
50 yo – 60 yo	
+ 60 yo	

REVIEW OF SYSTEMS

CONDITION	Current (C)	Past (P)	CONDITION	Current (C)	Past (P)
Skin					
Rashes			Acne, Boils, Sores		
Itching			Hair Loss		
Colour Changes			Lumps, Growths		
Skin Cancer			Night Sweats		
Eczema/Hives			Excessive Sweating		
Head					
Headaches			Lightheadedness		
Migraines			Head Injury		
Eyes					
Floaters or Spots in Vision			Blurriness		

Impaired Vision			Double Vision		
Corrective Lenses			Excessive tearing or dryness		
Glaucoma or Cataracts			Eye Pain/Strain		

Ears					
Hearing Loss			Ringing		
Earache, Pain or Itching			Frequent Ear Infections		

Nose and Sinuses					
Frequent Colds			Nose Bleeds		
Hay Fever/Seasonal Allergies			Stuffiness or Discharge		
Loss of Smell			Sinus Pain/Infection		

Mouth and Throat					
Sore Tongue/Lips			Frequent Sore Throat		
Mouth Sores			Hoarseness		
Dry Mouth			TMJ Disease/Teeth Grinding		
Gum Problems			Dental Cavities		

Neck					
Swollen Glands			Goiter		
Lumps			Pain and Stiffness		

Respiratory					
Cough			Emphysema		
Asthma or Wheezing			Chronic Bronchitis		
Sputum or Mucous			Pneumonia		
Spitting up Blood			Difficulty breathing		
Tuberculosis			Pain with breathing		

Cardiovascular					
Heart Disease			Chest Pain		
Murmurs			High/Low Blood Pressure		
Rheumatic Fever			Palpitations/Fluttering		
Ankle Swelling			High Cholesterol		

Blood & Peripheral Vascular					
Anemia			Easy Bleeding/Bruising		

Blood Clots			Cold Hands/Feet		
Varicose Veins			Past Transfusions		

Immune					
Chronic Infections			Autoimmune Disease		
Chronic Fatigue			Fever		
Slow Wound Healing			Chills		

Gastrointestinal					
Difficulty Swallowing			Number of bowel movements daily:		
Heartburn/Reflux			Hemorrhoids / blood in the toilet		
Belching or Passing Gas			Constipation		
Ulcer			Diarrhea		
Abdominal Pain			Change in bowel habits		
Abdominal Cramps			Dark/black stools		
Nausea/Vomiting			Light/white stools		
Change in Appetite			Liver disease/hepatitis		
Jaundice (yellowed skin)			Gallbladder disease		

Urinary					
Pain with urination			Kidney stones		
Increased frequency (day / night)			Frequent urinary infections		
Urgency			Cloudy urine		
Inability to hold urine			Blood in urine		
Hesitancy or dribbling			Change in force of stream		

General Reproductive					
Are you sexually active			Type of contraception:		
Are you using protection?			Sleep with men / women / both:		
Low sex drive			Herpes (oral or genital)		
Genital warts			Other sexually transmitted diseases (STDs)		
Chlamydia or Gonorrhea			Recent testing for STDs/STIs?		

Male Reproductive					
Hernia			Sores on penis or testicles		
Testicular pain			Premature ejaculation		
Lump in testicles			Erectile Dysfunction		
Prostate disease			Impotence		

Prostate removal			Discharge		
Fertility issues			Low sperm count		

Female Reproductive					
Age of first menses:			Diagnosed with PCOS?		
Date of last menses:			Abnormal PAP ever?		
Age of last menses (if menopausal):			Cervical dysplasia		
Length of cycle in days (usu 25-35)			Vaginal discharge		
Duration of bleeding in days			Vaginal itching, pain, burning		
Cycles regular			Vaginal sores or lumps		
Spotting between cycles			Pain with intercourse		
Pain with menses			Ovarian cysts/fibroids		
Clotting with menses			Difficulty conceiving		
Heavy flow with menses			Number of pregnancies:		
PMS/PMDD			Number of live births:		
Menopausal symptoms			Number of abortions:		
Endometriosis			Number of miscarriages:		

Breasts/Chest					
Regular self breast exams			Breast Lumps		
Breast pain/tenderness			Nipple Discharge		

Neurologic					
Fainting			Vertigo or Dizziness		
Paralysis			Seizures		
Tremors or twitches			Muscle Weakness		
Loss of Memory			Numbness/Tingling		
Loss of Balance			Nerve/Sciatic Pain		

Endocrine					
Diabetes/High blood sugar			Excessive thirst or hunger		
Hypoglycemia/Low blood sugar			Fatigue		
Hypo or hyper thyroid			Heat or cold intolerance		

Mental/Emotional					
Depression			Anxiety or nervousness		
Mood Swings			Tension		

Considered/Attempted suicide			Poor concentration		
Any major traumas			History of counseling?		
Have a history of abuse			Eating Disorder		

Sleep					
Insomnia			Difficulty falling asleep?		
Wake rested?			Difficulty staying asleep?		
Number of hours you sleep per night?			Do you have low energy during the day?		

Musculoskeletal					
Arthritis			Gout		
Osteopenia/osteoporosis			Joint pain/stiffness		
Broken bones			Muscle spasms or cramps		
Heaviness of the limbs			Muscle weakness		

HABITS & LIFESTYLE

Diet

Do you eat a special diet? _____

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____

QUESTION	Yes	No	QUESTION	Yes	No
Do you exercise?			Do you use tobacco?		
How often do you exercise?			Smoked for how many years?		
How much do you watch TV/screens?			How many packs per day?		
Do you enjoy your work?			Do you drink alcohol?		
Do you take vacations?			How many drinks per week?		
Do you have a spiritual practice?			Do you use recreational drugs?		
Do you eat 3 meals a day?			Treated for dependency?		
Do you eat protein at each meal?			Do you drink coffee?		
Do you think you are over/underweight?			Do you drink soda/pop?		

What are your goals/expectations for **this visit**? _____

What long-term health goals do you have? _____

What personal behaviors do you believe contribute to your health in a positive way? _____

What behaviors do you believe are detrimental to your health? _____

What else would you like to tell me? _____

FAMILY HISTORY

Please **circle** the conditions that run in your family:

Cancer	Epilepsy	Asthma
Diabetes	Arthritis	Anemia
Heart Disease/ Heart Attack	Glaucoma	Autoimmune disease
High Blood Pressure	Kidney Disease	Tuberculosis
High Cholesterol	Stroke	Mental Illness (ie depression)

Family Member	Age	Major Health Issues	Age of Death & Cause (if applicable)
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other			

Thank you for taking the time to consider all of these questions. I am looking forward to working with you and supporting you in attaining your health and life goals.

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INFORMED CONSENT FOR TREATMENT

Naturopathic medicine is a distinct system of primary care that addresses the whole body and root cause of illness and disease. It promotes health by assisting the body's own healing mechanisms according to current medical research and ancient healing knowledge. Naturopathic doctors are primary care providers who integrate standard medical diagnostics with a broad range of natural therapies, including clinical nutrition, herbal medicine, acupuncture, homeopathy and counseling. They work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

Your first naturopathic appointment will generally last 60-90 minutes and may include a physical exam and referral for laboratory tests. Follow-up appointments may range from 15-60 minutes each according to individual health requirements. The first consultation fee is generally $175 to $200 and does *not* include the cost of laboratory testing or prescription items. Follow-up consultation fees are prorated at $150 per hour. OHIP does *not* cover the fees of a naturopathic doctor, however many extended healthcare insurance providers do.

I, _____, as a patient of Dr. Sandy Musclow (ND, MAc, MSc) understand that this form of medical care is based on naturopathic principles and practices. I will inform Dr. Musclow of all health concerns, medications and medical interventions, including over-the-counter drugs and supplements, because safe care requires that I truthfully and completely disclose this information. I will also inform Dr. Musclow if I am pregnant or breastfeeding.

I understand that I am entitled to know about my diagnosis and treatment, including costs, benefits, risks and potential side-effects. I am entitled to know the consequences of *not* accepting treatment and of alternative courses of action. I am encouraged to request more information as needed, and to take an active role in my care. I am aware that I am always at liberty to seek or continue care from another healthcare provider.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs and bruising or injury during acupuncture.

I understand that Dr. Musclow is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at any time. I accept full responsibility for any fees incurred during care and treatment, including a **50% cancellation fee if providing less that 48 hours notice for cancelling appointments** _____ (please initial).

Signature _____ Date: _____

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CONSENT FOR COLLECTION, USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION

Your health privacy is a primary concern. The personal health information you disclose to Dr. Sandy Musclow (ND, MAc, MSc) during your appointments will be handled in accordance with current privacy legislation and standards determined by the naturopathic regulatory body, the College of Naturopaths of Ontario. Personal health information includes identifiable information such as age, gender, family status and health history.

Dr. Musclow and administrative staff of Foundation Stone Medicine will collect, use and disclose information about you for the following purposes:

- To assess your health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Administrative staff of Foundation Stone Medicine will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. They will collect, use and disclose your personal health information so as to protect your privacy and the confidentiality of your information.

I have reviewed the above information and authorize Dr. Sandy Musclow (ND, MAc, MSc) and administrative staff of Foundation Stone Medicine to collect, use and disclose my personal health information as outlined above.

Signature _____ Date: _____

Printed Name _____