PINNACLE OF HEALTH
NATUROPATHIC WELLNESS CENTRE
DR. FARYAL LUHAR, ND / Doctor of Naturopathic Medicine

PATIENT INTAKE AND INFORMED CONSENT FORM

FULL NAME:_____

ADDRESS: _____ PHONE NO.: _____ (H)
_____ _____ (C)
_____ _____ (W)

DATE OF BIRTH: _____ EMAIL: _____

FAMILY PHYSICIAN & PHONE NO.: _____

OCCUPATION: _____

HEIGHT: _____

WEIGHT: _____

Please answer the following questions to the best of your ability in order to aid in the assessment of your current health status and to facilitate the healing process.

What are your chief health concerns that you would like to address:

- _____
- _____
- _____

Briefly describe your general overall state of health at present:

_____
_____

List all your current medications including supplements and vitamins. Please indicate the dosage, strength and how long you have been taking them.

Prescription/Over-the-counter Medications	Supplements/Vitamins/Herbs/Homeopathics

List all major surgeries and dates:

_____
_____
_____
_____

List any allergies (food, medication)

_____
_____
_____
_____

How many courses of antiobiotics have you been on in the past 5 years?

_____

Have you received any of the following vaccinations:

- Chicken Pox (varicella)
- MMR (measles/mumps/rubella)
- DTP (diptheria)
- Hep A
- Hep B
- Influenza (flu)
- Meningococcal (meningitis)
- Polio
- Rabies
- Other:

Have you ever had an adverse reaction to any medications or vaccinations?

_____
_____

Have any of your family members had any of the following? If yes, indicate who:

Alcoholism	Eczema	Leukemia
Arthritis	High blood pressure	Mental disorders
Allergies	Heart disease	Tuberculosis
Asthma	Hyper/Hypothyroid	Seizures
Cancer	Hepatitis	Liver disease
Cold sores	Gallstones	Kidney disease
Diabetes	Depression	Nerve disorders

Describe your intake of food/beverage on a typical day:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Water/day: _____
Coffee/Tea: _____

Do you drink alcohol?_____ Do you smoke? _____

How many hours of sleep do you get per night? _____

How many hours do you work each day? _____

How often do you exercise/week? What type of exercise:

_____ _____

_____ _____

When was your last physical exam including blood analysis? _____

How many amalgams or silver fillings do you have on your teeth? _____

Besides cleaning supplies, are you exposed to environmental toxins at work? Please describe:_____

What level of personal stress are you experiencing at the present moment?
minimal average considerable unbearable

What are the main stressors in your life? Please describe briefly how this stressor is affecting you.

- Financial
- Job Related
- Marriage
- Health
- Spiritual
- Family
- Other: _____

INFORMED CONSENT

I, _____ give my full consent to Faryal Luhar, Doctor of Naturopathic Medicine to assess my health and utilize naturopathic modalities for treatment as deemed appropriate in order to provide me with the best naturopathic health care. Laboratory exams and other blood work may be ordered and shared with health professionals as necessary for treatment.

I understand that any information provided will be kept confidential and will not be divulged without my authorization.

I agree to render payment at the time of treatment unless other arrangements have been discussed.

Signature of patient: _____ Date: _____