Dr. Brandon Spletzer, ND

COMPREHENSIVE HEALTH HISTORY INTAKE FORM

Name:_____ **Age**:_____

Birth Date:____/____/____ **Sex**: ☐**M or** ☐**F** **Personal Health Number:**_____

Current Height:_____ **Current Weight**:_____

Home Address:_____

City:_____ **Province**:_____ **Postal Code**:_____

Home Phone:_____ **Cell Phone**:_____

E-Mail:_____ **I Authorize Email Communication:** ☐**YES or** ☐**NO**

Occupation:_____ **Shift Work:** ☐**YES or** ☐**NO**

Person to Notify in Case of an Emergency:_____

Relation:_____ **Phone Number**:_____

How did you hear about Dr. Spletzer?_____

Please List Your Main Health Concerns in Order of Importance:

1)_____ 3)_____

Treatments tried: _____ Treatments tried: _____

2)_____ 4)_____

Treatments tried: _____ Treatments tried: _____

Please List Any Medical Conditions and When They Occurred (i.e. Diabetes, Hypertension, etc.):

1) _____ 3) _____

2) _____ 4) _____

Please List All Prescriptions, Over the Counter Drugs, Vitamins, Herbs, etc.:

Medications (Include Dosage): **Supplements (Include Brand and Dosage):**

_____ _____

_____ _____

_____ _____

Please List Any Allergies or Sensitivities, and How Your Body Reacts:

Drug:_____

Food:_____

Environmental:_____

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REVIEW OF SYSTEMS

Please check all symptoms you have experienced in the last 6 months:

GENERAL

- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Heat / Cold Intolerance
- ☐ Insomnia
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Other:_____

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Headaches / Migraines
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Itchy / Watery Eyes
- ☐ Dry / Red Eyes
- ☐ Changes in Vision
- ☐ Throat Pain
- ☐ Difficulty Swallowing
- ☐ Sinus Infection / Pain
- ☐ Nasal Congestion
- ☐ Other:_____

RESPIRATORY SYSTEM

- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Hoarse Voice
- ☐ Snoring
- ☐ Asthma or Wheezing
- ☐ Other: _____

CARDIOVASCULAR SYSTEM

- ☐ Chest Pain
- ☐ Palpitations
- ☐ High Blood Pressure
- ☐ Easy Bruising
- ☐ Varicose Veins
- ☐ Swollen Feet / Ankles
- ☐ Cold Hands / Feet
- ☐ Other:_____

GASTROINTESTINAL SYSTEM

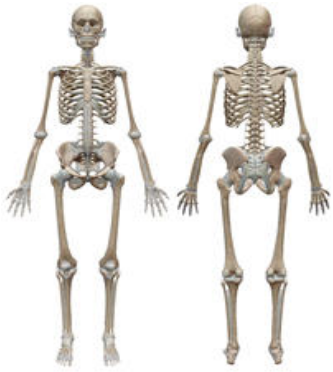
- ☐ Gas, Belching &/or Bloating
- ☐ Indigestion
- ☐ Constipation or Diarrhea
- ☐ Blood and/or Mucous in Stool
- ☐ Painful Bowel Movements
- ☐ Acid Reflux
- ☐ Nausea / Vomiting
- ☐ Hemorrhoids
- ☐ Anal Fissures
- ☐ Other:_____

URINARY SYSTEM

- ☐ Urinary Tract Infections
- ☐ Incontinence
- ☐ Pain / Burning on Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Other:_____

MUSCULOSKELETAL SYSTEM

- ☐ Joint Pain – Please indicate on diagram below
- ☐ Muscle Cramps / Weakness
- ☐ Restless Legs
- ☐ Tendonitis
- ☐ Jaw Pain / TMJ
- ☐ Other:_____



NERVOUS SYSTEM

- ☐ Anxiety
- ☐ Depression
- ☐ Poor Memory
- ☐ Difficulty Concentrating
- ☐ Numbness / Tingling
- ☐ Speech Difficulty
- ☐ Seizures
- ☐ Tremors
- ☐ Dizziness / Vertigo
- ☐ Fainting / Lightheadedness
- ☐ Decreased Balance
- ☐ Other:_____

SKIN & NAILS

- ☐ Acne
- ☐ Excessive Sweating
- ☐ Rashes / Hives
- ☐ Eczema or Psoriasis
- ☐ Dry / Itchy Skin
- ☐ New Moles / Changes in Colour
- ☐ Hair Loss or Brittle Nails
- ☐ White Spots on Nails
- ☐ Other:_____

IMMUNE SYSTEM

- ☐ Enlarged / Painful Lymph Nodes
- ☐ Frequent Infections
- ☐ Frequent / Persistent Cold / Flu
- ☐ Slow Wound Healing
- ☐ Other:_____

MENS HEALTH

- ☐ Prostate Enlargement
- ☐ Change in Libido
- ☐ Erectile Dysfunction
- ☐ Testicular Mass / Pain
- ☐ Urinary Changes
- ☐ Sexually Transmitted Infections
- ☐ Date of Last Prostate Exam:

  _____

  - Abnormal Results? ☐ YES ☐ NO

WOMENS HEALTH

- ☐ Sexually Active?
- ☐ Using Birth Control – Method?

  _____
- ☐ Currently Pregnant?

  ☐ YES ☐ NO
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ History of a Sexually Transmitted Infection
- ☐ Cramping with Periods
- ☐ Bleeding Between Periods
- ☐ Irregular Periods
- ☐ PMS (Breast Tenderness, Headaches, Cravings)
- ☐ Nipple Discharge
- ☐ Lumps / Pain in Breast
- ☐ Menopausal Symptoms (Hot Flashes, Mood Swings, Insomnia, etc.)
- ☐ Menses:
  - ☐ Age of First Period

    _____
  - ☐ Duration of Bleeding:

    _____ Days
  - ☐ Length of Cycle:

    _____ Days
- ☐ Date of Last PAP:

  _____
  - Previously Abnormal?

    ☐ YES ☐ NO
- ☐ Number of Pregnancies

  _____
- ☐ Number of Births

  _____

Persons seeking care in this office must understand that Naturopathic Doctors are **NOT** Medical Doctors. Naturopathic Medicine uses minimally-invasive methods for the assessment and treatment of bodily dysfunctions, emphasizing the removal of the underlying cause of disease as opposed to short term alleviation of symptoms. Therefore, treatment is usually more detailed and requires longer term commitment and lifestyle change.

We ask that each person read in detail the following document and ask any questions that he/she may have before treatment is rendered. Please sign below to acknowledge the following:

1. I understand that Dr. Spletzer is a Naturopathic Doctor, **NOT** a medical doctor. As such, Dr. Brandon Spletzer works within the Naturopathic Scope of Practice and employs some methods which are not orthodox medical practice. If I have any questions regarding the Naturopathic Scope of Practice, it is my responsibility to ask.
2. I understand that the practice of Naturopathic Medicine requires a comprehensive health history intake and may require a physical exam. In some cases, diagnostic testing may be required, including the collection of blood, urine, breath and/or saliva.
3. I understand that treatment here and/or referrals to other health care practitioners is based upon the assessment of conditions revealed through my personal health history and interview, physical exam and assessment, and laboratory testing (where appropriate).
4. I am accepting or rejecting this care of my own free will and choice.
5. I understand that I have asked Dr. Spletzer for Naturopathic Care and that Dr. Brandon Spletzer will help me to the best of his ability.
6. I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating my intentions.
7. I understand that **under no circumstances** may any recordings be taken at any time, including, but not limited to, video and/or audio recordings. Any attempt to obtain recordings will result in the immediate termination of the doctor-patient relationship. I acknowledge that I am responsible for any and all financial responsibilities, including but not limited to, legal fees and/or loss of income, that are associated with recordings taken of Dr. Brandon Spletzer.
8. I acknowledge that these services are not covered by MSP. I accept full responsibility for any fees incurred during care and treatment, and agree to fully discharge this responsibility at the time of my visit.
9. I acknowledge that there is a **24-hour cancellation policy** and Dr. Brandon Spletzer reserves the right to **charge the full cost** of the visit for missed appointments, or if insufficient time is given for cancellations. Additionally, I understand that fees are subject to change, without notice, and that all treatments and supplements are non-refundable.
10. I understand that Dr. Brandon Spletzer reserves the right to determine which cases fall outside his Scope of Practice, in which case, a referral will be recommended.

I,_____, have read, understood and acknowledge the above statements.
(please print your name)

_____ _____
Signature (or of parent/guardian if under 18 years old) Date