Arc INTEGRATED MEDICINE

Full Name: _____ Preferred Pronouns**:** _____

Date of Birth: _____ Age: _____

Current gender identity:_____ Gender assigned at birth: _____

Mailing Address: _____

Phone# _____ Alternate Phone# _____

Email: _____

Emergency Contact:_____ Relation_____

Phone# _____ Alternate Phone# _____

Medical Doctor:_____Phone#:_____

Address**:**_____

Personal Health Number (Care Card) _____

How did you hear about *Arc Integrated Medicine*?

_____

CURRENT HEALTH CONCERNS AND/OR GOALS

Please list your concerns in order of importance, when the symptoms began and any treatments that you have tried.

1. _____Onset: _____

Treatments: _____

2. _____Onset: _____

Treatments: _____

3. _____Onset: _____

Treatments: _____

ALLERGIES & SENSITIVITIES

Please list any known drug, environmental or food reactions that you have experienced and what kind of reaction you had.

_____

_____

MEDICATIONS (Prescription drugs and over-the-counter preparations)

Please list all medications that you are currently taking, and any other information you can provide.

Drug	Dose	Reason for Taking	Year Started

SUPPLEMENTS (Vitamins, minerals, amino acids, herbal medicines, homeopathic preparations)

Please list all supplements that you are currently taking, and any other information you can provide.

Supplement *(Including brand if known)*	Dose	Reason for taking *(Including who prescribed this to you)*	Year Started

Past Medical History

Conditions

Please list any previous medical conditions, and when you suffered from them

1. _____

2. _____

3. _____

Other Medical Events

Please list any hospitalizations, major injuries or surgeries you've experience and the year in which they occurred

Year: _____Condition: _____

Year: _____Condition: _____

Year: _____Condition: _____

Review of Symptoms

Please check all symptoms that you have experienced during the last 6 months

GENERAL
- ○ Weight gain
- ○ Weight loss
- ○ Heat/Cold Intolerance
- ○ Insomnia
- ○ Fatigue
- ○ Night sweats

HEAD, EYES, EARS, NOSE & THROAT
- ○ Headache
- ○ Migraine
- ○ Ear pain
- ○ Ringing in ears
- ○ Changes in hearing
- ○ Itching or watery eyes
- ○ Dry or red eyes
- ○ Eye pain
- ○ Changes in vision
- ○ Throat pain
- ○ Difficulty swallowing
- ○ Sinus infection/pain
- ○ Nasal congestion

CARDIOVASCULAR
- ○ Chest pain
- ○ Heart palpitations
- ○ High blood pressure
- ○ Easy bruising
- ○ Varicose veins
- ○ Swollen feet/ankles
- ○ Cold hands/feet

RESPIRATORY
- ○ Difficulty breathing
- ○ Exercise intolerance
- ○ Cough
- ○ Hoarseness of voice
- ○ Sleep apnea
- ○ Snoring
- ○ Asthma or wheezing

GASTROINTESTINAL
- ○ Bloating & Flatulence
- ○ Indigestion
- ○ Constipation
- ○ Diarrhea
- ○ Blood and/or mucous in stool
- ○ Pain during bowel movements
- ○ Belching
- ○ Acid reflux
- ○ Hemorrhoids
- ○ Anal fissures
- ○ Nausea

EATING & APPETITE
- ○ Difficulty gaining weight
- ○ Difficulty losing weight
- ○ Frequent dieting
- ○ Poor appetite
- ○ Always hungry
- ○ Emotional eating
- ○ Cravings

Specify _____
- ○ Disordered eating

PSYCHOLOGY & NERVOUS SYSTEM
- ○ Anxiety or panic attacks
- ○ Depression
- ○ Difficulty concentrating
- ○ Poor memory
- ○ Numbness or tingling
- ○ Difficulty with speech
- ○ Seizures
- ○ Trembling or tremor
- ○ Dizziness or vertigo
- ○ Fainting or feeling lightheaded
- ○ Loss of balance
- ○ Difficulty walking

MUSCULOSKELETAL
- ○ Joint pain, redness, or stiffness

Specify _____
- ○ Neck or back pain
- ○ Foot cramps or pain
- ○ Wrist or hand pain
- ○ Joint deformity
- ○ Muscle pain or cramps
- ○ Muscle weakness
- ○ Restless legs
- ○ Tendonitis
- ○ TMJ /Jaw pain

URINARY
- ○ Acute or Chronic UTI's
- ○ Incontinence or Dribbling
- ○ Pain or burning on urination
- ○ Frequent urination
- ○ Blood in urine

IMMUNE
- ○ Enlarged lymph nodes
- ○ Painful or tender lymph nodes
- ○ Frequent infections
- ○ Frequent colds or flu
- ○ Slow wound healing

SKIN & NAILS
- ○ Acne
- ○ Athlete's foot
- ○ Dandruff
- ○ Dark circles under eyes
- ○ Profuse sweating
- ○ Rashes or hives
- ○ Dry or itchy skin
- ○ Bumps on the back of arms
- ○ Suspicious moles
- ○ Changes in pigment
- ○ Hair loss
- ○ Brittle or breaking nails
- ○ White spots or ridges on nails

MEN'S HEALTH

Please check all boxes that apply

- ○ Prostate enlargement
- ○ Change in libido
- ○ Hernia
- ○ Erectile dysfunction
- ○ Testicular mass or pain
- ○ Prostate or urinary infection
- ○ Urinary urgency, hesitancy or dribbling
- ○ Sexually transmitted infections

Other: _____

Have you ever had a prostate exam? Y/N

WOMEN'S HEALTH

Please provide the numbers as they apply

- ○ Pregnancy _____
- ○ Miscarriage _____
- ○ Caesarean _____
- ○ Vaginal Delivery _____
- ○ Gestational Diabetes _____
- ○ Postpartum Depression_____

When was your last PAP? _____

When was your last mammogram? _____

MENSTRUAL HISTORY

Length of cycle _____ Irregular Y N
Date of last period _____

- ○ Blood Clots
- ○ Menstrual Cramping
- ○ Breast Tenderness
- ○ Mood Swings/Irritability
- ○ Water retention

GYNECOLOGICAL CONDITIONS

- ○ Endometriosis
- ○ PCOS
- ○ Uterine Fibroids
- ○ Pain with Intercourse
- ○ Bleeding between periods
- ○ Infertility
- ○ Low libido
- ○ Sexually transmitted infections
- ○ Menopause, since age _____
  - ○ Hot flashes
  - ○ Vaginal dryness
  - ○ Night sweats
  - ○ Mood swings
  - ○ Difficulty concentrating
  - ○ Depression
- ○ Perimenopause, since age _____

Family History

Please list any significant medical history for immediate family and grandparents

_____

_____

Social History

What is your occupation? _____

Do you smoke? YES NO **How many alcoholic drinks do you consume per week?** _____
Please list any recreational drug use: _____

Psychosocial

Please rate on a scale from 0-10 (10=best) how satisfied you are with the following areas of your life

Work/School _____
Financial Security _____
Social Life/Friends _____
Relationship _____
Family _____

Informed Consent for Naturopathic Care

- I understand that the practice of naturopathic medicine requires taking a thorough case history, and may require a physical exam. In some cases, diagnostic testing including the collection of blood, urine and/or saliva may be required.

- I confirm that the information I have provided to *Arc Integrated Medicine* is complete and inclusive of all health concerns including the possibility of pregnancy and use of all current medications, including over-the-counter drugs.

- I understand that naturopathic medicine carries a risk of complications and that a resolution of symptoms is not guaranteed. Health risks of some naturopathic treatments include, but are not limited to:
    - Temporary aggravation of pre-existing symptoms
    - Allergic reactions and other adverse effects to botanical medicines or supplements
    - Pain, fainting, bruising or injury from venipuncture, acupuncture or cupping treatments
    - Muscle sprain, ligament strain, swelling and/or pain from spinal manipulation

- I confirm that I have the ability to accept or reject the recommended treatment at my own free will.

- I understand that I have the ability to seek and/or continue medical care from another qualified health care practitioner. I recognize that I am encouraged to speak freely regarding the treatments received and recommendations made at *Arc Integrated Medicine*.

- I understand that a record of my visits and medical history will be kept, that this record will be strictly confidential and will not be released to any persons without my written consent.

- I have read and understood the fee schedule and I acknowledge that these services are not covered by MSP and I am responsible for payment of goods and services in full at each visit.

- I understand the following return policy regarding products/supplements/herbal tinctures:

    - Unopened products can be returned for full refund up to 60 days after purchase.
    - Opened products CANNOT be returned unless there has been an adverse reaction, which must be reported to your naturopathic doctor within 30 days of occurrence. If the product has caused an adverse reaction, a full refund will be processed.

- I understand that there is a cancellation fee for appointments missed without notice or cancelled with less than 24 hours notice. I acknowledge that if I arrive late for my scheduled appointment, the visit will be shortened to ensure that other patient visits are kept on time.
    - Late cancellation or no-show fee (100%) of visit cost **(Initial) _____**

- I understand that I may be required to provide my credit card number in advance of my visit to secure my appointment. I agree to have Arc Integrated Medicine securely store my credit card information for future appointments and I understand and agree to be charged for any missed appointments that breach the cancellation policy. **(Initial) _____**

- I understand that the doctors at *Arc Integrated Medicine* reserve the right to determine which cases fall outside their scope of practice, in which case an appropriate referral will be recommended.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____