



Naturopathic* Chiropractic * Counselling * Laboratory *Natural Pharmacy

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BALANCE

VITALITY

EMPOWERMENT

Adult Intake Form Brief(C-A2)

The following information is confidential and will only be released if you authorize us to do so.

This is a brief intake form for Food Intolerances & Physical Treatment Naturopathic Visits

It will take about 15 minutes to fill out.

Contact Information:

Name: _____ Male ___ Female ___			
Address: _____			
City: _____		Province: _____	
Telephone Number- Home: _____		Cell: _____	
Telephone Number-Work: _____		Email Address: _____	
Emergency Contact Name: _____			
Telephone Number _____			
<input type="checkbox"/> Yes I would like to be added to your list to receive the monthly Optihealth Newsletter and Specials. I have a special interest in :			
Allergies, Asthma, Eczema		Fitness	
Cardiovascular		Immunity	
Cancer		Kids Health	
Chronic Fatigue Syndrome/Fibromyalgia		Lab Testing	
Detox		Mens Health	
Diabetes		Pain & Inflammation	
		Recipes	
		Stress & Insomnia	
		Weight	
		Womans Health	
		Other:	
		Other:	
Referred by:			
Family Medical Doctor:			
Chiropractor			
Other Health Team Specialists:			
Secondary Insurance Company:			
(Naturopathic Coverage With)			

Name: _____

Allergies/Sensitivities & Medications/Supplements- (Please repeat information)

Allergies:

Allergy To	Symptoms	Last Reaction

Sensitivities:

Sensitivity To	Symptoms	Last Reaction

Medications/Supplements: List all medications/Supplements you are currently taking and those you have taken in the last year

Medication/Supplement	Strength	Dose	Treatment For	Date Begun	Date Discontinued
Antibiotics				# times used in last 10 years _____	
Birth Control Pill					

Health Goals:

What is your primary health concern?

How long have you had this condition? _____

What is the Medical Diagnosis? _____ When was the diagnosis made? _____

What specialists have you seen? _____

What had the treatment been to date? _____

Name: _____

Other Health Concerns	Onset Date	Diagnosis Made By	Degree (% of Health Concern with 100% being totally well)	Treatment To Date

Review of Systems :(HWS QUESTIONNAIRE LONG) Rate each of the following symptoms based upon your typical health profile for the past year. If you do not experience the symptom now but have experienced it in the past please put P in the score section with the year you experienced it. Once completed please total your score in each section and then overall score.

Point Scale

- 0 - Never or almost never have the symptom
- 1 - Occasionally have it, effect is not severe
- 2 - Occasionally have it, effect is severe
- 3 Frequently have it, effect is not severe
- 4 Frequently have it, effect is severe
- P Have experienced this in the past (year (s) experienced symptom

Health Condition(Circle which one)	Score	Past (Year)	Health Condition(Circle which one)	Score	Past (Year)
HEAD			DIGESTION		
Headaches or Head Injury			Nausea or Vomiting		
Whiplash			Diarrhea or Constipation		
Faintness or Dizziness or Vertigo			Bloated Feeling		
TOTAL HEAD			Belching or Passing Gas		
EYES			Heartburn or trouble swallowing or indigestion		
Watery or Itchy or Dry			Intestinal /stomach pain		
Swollen or Reddened or Sticky Eyelids or Sun Sensitive			IBS or Colitis or Chron’s or Celiac or Gall Bladder Disease		
Darkness under eyes			Change in appetite or thirst		
Blurred or Tunnel Vision(does not include near- or far-sightedness)			Ulcer		
Contacts or Glasses or Cataracts or Glaucoma			Frequency of Bowl Movements/day? _____	No score needed in this section	No score needed in this section
			Quality of Stool: Hard & Knotted?_____		
			Pieces?_____		
			Pencil Thin?____		
			Soft?_____		
			Bleeding?____		
			Black tarry stool?		

			Hemorrhoids? ____ Hernias? ____		
TOTAL EYES			TOTAL DIGESTION		
EARS			JOINTS/MUSCLE		
Itchy Ears			Pains/Aches in Joints or Muscles		
Earaches or Ear Infections or Discharge or Tubes in Ears			Rheumatoid Arthritis or Osteoarthritis or Fibromyalgia or Chronic Fatigue Syndrome		
Impaired Hearing			Stiffness or Limitation of Movement		
ringing			Easily Injured		
TOTAL EARS			Feeling of Weakness or Tiredness in the Joints or Muscles		
NOSE/SINUS			Broken Bones or Muscular Cramps		
Stuffy Nose or Sinus Problems or Frequent Colds			TOTAL JOINTS/MUSCLE		
Sinus Headaches			WEIGHT		
Hay fever			Binge eating/drinking		
Sneezing Attacks			Craving Certain Foods		
Excessive Mucus Formation			Excess Weight		
TOTAL NOSE/SINUS			Wide Fluctuations in Weight		
MOUTH/THROAT			Water Retention		
Chronic Coughing from Throat Irritation			Under Weight		
Gagging or Frequent Need to Clear Throat			TOTAL WEIGHT		
Sore Throat or Hoarseness or Loss of Voice			ENERGY		
Swollen or Discoloured Tongue, Gums, Lips			Fatigue/Sluggishness		
Canker Sores			Apathy/Lethargy		
TOTAL MOUTH/THROAT			Hyperactivity		
HAIR/SKIN			Restlessness		
Acne or Boils or Eczema or Psoriasis or Colour Change			TOTAL ENERGY		
Hives or Rashes or Dry Skin or Itching			MIND		
Hair loss or Nail Changes			Poor memory		
Flushing or Hot Flashes			Confusion, poor comprehension		
Excessive Sweating			Poor concentration		
TOTAL HAIR/SKIN			Poor physical coordination		
HEART			Difficulty in making decisions		
Hi or low blood pressure or Cholesterol			Stuttering or stammering		
Rapid or Pounding heartbeat, Irregular or Skipped Heartbeat or Chest Pain or Palpitations			Slurred speech		
Anemia or Fainting or Platelet Disorder or Swelling in Ankles or Varicose Veins or Extremity Ulcers			Learning disabilities		
Deep Leg Pain or Cold Hand/Feet			TOTAL MIND		
Murmurs			EMOTIONS		
Rheumatic Fever			Mood swings		
Stroke or heart attack			Anxiety, fear, nervousness or Overwhelmed or Stressed		
TOTAL HEART			Anger, irritability, aggressiveness		
LUNGS			Depression		
Chest congestion			Insomnia or Early Morning Waking		

Asthma, bronchitis, emphysema, pleurisy or pneumonia			TOTAL EMOTIONS		
Shortness of breath					
Difficulty breathing			BLOOD /LYMPH		
Cough			Anemia		
Tuberculosis			Easy bleeding or bruising or Past Transfusions		
History of smoking			Swollen lymph nodes or glands		
TOTAL LUNGS			TOTAL BLOOD/LYMPH		
IMMUNE/LIVER					
Chronic Fatigue Syndrome or Intolerance to Medications			ENDOCRINE		
Allergies			Heat or Cold Intolerance		
Cancer Type_____			Thyroid Imbalance		
Hepatitis Type_____			Excess Thirst, Hunger or Urination		
Lupus or Scleroderma or Myesthenia Gravis			Excess Sweating		
Jaundice (Yellow skin or eyes)			Blood Sugar Imbalance ie Diabetes or Hypoglycemia		
TOTAL IMMUNE/LIVER			Cushing's or Addison's Disease		
			TOTAL ENDOCRINE		
URINARY			MALE		
Frequent or Urgency or Hesitancy of Urination			Enlarged Prostate (BPH) or Prostate Cancer		
Infections			Genital Sores		
Kidney Stones			Hernia		
Blood in Urine			Impotence		
Pain on urination			TOTAL MALE		
TOTAL URINARY			STDs		
FEMALE			Gonorrhea or Chlamydia or Syphilis or Genital Warts or Genital Herpes or HIV or Human Papillovirus (HPV)		
Perimenopausal or Menopausal or Post Menopausal			TOTAL STDs		
Uterine Fibroids or Endometriosis or Ovarian Cysts			NEUROLOGIC		
Infertility or Abortion or D & C			Multiple Sclerosis or Parkinson's		
Irregular Cycle			Fainting		
PMS			Involuntary Movements or Twitches or Paralysis or Muscle Weakness or Numbness or Tingling or Loss of Memory or Loss of Balance or Speech Problems		
Heavy Flow			Seizures/Convulsions		
Clotting			TOTAL NEUROLOGIC		
Vaginal Discharge or Itching			OTHER		
Difficulty Conceiving					
Menses: Age began: _____ Average Length of Flow : _____ Average Length of Cycle (day 1 to day 1 with day 1 first day of bleed) _____ Number of Pregnancies : _____ Number of Live Births: _____ Number of Abortions: _____	No score needed in this section	No score needed in this section			

Number of Miscarriages: _____ Date of Last PAP: _____ Do you do monthly breast exams? _____ Do you experience lumps or fibrocystic breasts? _____ Do you have nipple discharge? _____					
TOTAL FEMALE					
TOTAL REVIEW OF SYSTEMS SCORE					

Other or Comments : (For any of the above symptoms)

Detox Protocol Part 1: For Office Use Only (T 720)

Category	MSQ Total Score	Digestion Section Total Score	Target Organ
I.	50-100	<10	Liver-Light
II.	50-100	>10	Liver and Digestion
III.	>100	<10	Liver-Deep
IV.	>100	>10	Inflammation, Liver and Digestion
V.	150-500		Inflammation-Deep, Liver and Digestion
VI	>500	<10	Body Phases
VII	>500	>10	Body Phases Digestion

Nutritional Summary

Food/Beverage	Servings/Day	Food/Beverage	Servings/Day
Protein-Beef/Pork		Carbohydrates-1 slice bread or ½ cup grains (pasta, cereal,grains)	
Protein-Poultry		Fruit	
Protein-Fish		Vegetables	
Protein-Beans/Legumes ½ cup		Water 8oz	
Protein- Nuts /Seeds Handful		Coffee/Tea (circle)	
		Other Beverage	

Name: _____ **Page 7 of 7 Family Health History** -Our vision is to Facilitate Optimal Family Health. Included in your New Patient(NP) Visit is a Complimentary Metabolic Urine Test (MUT) for any of your family members to help determine their health status (a value of 60 for each test). Call to book their MUT, offer valid for 2 weeks after your NP visit. I don't know my family history_____ If that family member has passed away please note as D

Illness	PGF or MGF	PGM or PGM	Father	Mother	Sibling Age: ____	Sibling Age: ____	Sibling Age: ____
Allergies							
Arm/Hand Pain							
Arthritis							
Asthma							
Attention Deficit							
Bloating/Gas							
Belching/Burping							
Colds/Flus							
Congestion							
Constipation							
Diabetes							
Diarrhea							
Dizziness/Vertigo							
Ear Infections/Ringing							
Fatigue							
Fertility Concerns							
Leg Pain/Numbness							
Low Back Pain							
Low/High Blood Pressure							
Menstrual Difficulties							
Mid Back Pain							
Muscle Cramps							
Neck Pain							
Nervousness/Anxiety							
Respiratory Problems							
Sciatica							
Sinusitus							
Sleeplessness							
Throat Problems							
Thyroid							
Ulcers/Digestive							
Weight Concerns							

PGF= Paternal Grandfather PGM= Paternal Grandmother MGF= Maternal Grandfather MGM= Maternal Grandmother

Is there anything else? _____

Thank you for taking the time to fill out the requested information. It will help greatly in our study of your present health and will assist us in choosing an appropriate direction to take in working toward your desired restoration of health.

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