

## Confidential Adult Case History

Please help me to understand your health needs by carefully completing this intake form.  
All information is strictly confidential.

### Patient Information:

Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
(First) (Last)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Care Card # (PHN): \_\_\_\_\_  
(Month) (Day) (Year)

### Contact Information:

Phone #: \_\_\_\_\_ Alt. Phone #: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ E-mail: \_\_\_\_\_ Relationship Status: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have a family doctor? Yes  No  Doctor/Clinic Name: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### Current Health:

Do you have any **known allergies**? Yes  No  If yes, please list: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Any recent weight changes? \_\_\_\_\_

Your main health concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Please list any medications and natural supplements you are currently taking, with dosages: \_\_\_\_\_

### Diet and Lifestyle:

Please describe a typical day of eating for you:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks/Beverages: \_\_\_\_\_

How often do you consume the following? (daily, weekly, monthly, yearly, in the past, never)

Alcohol? \_\_\_\_\_ Cigarettes? \_\_\_\_\_ Marijuana? \_\_\_\_\_ Recreational drugs? \_\_\_\_\_

Coffee? \_\_\_\_\_ Pop? \_\_\_\_\_ Sugar? \_\_\_\_\_

### Past Medical History:

Please list all past hospitalizations, surgeries, accidents and major illnesses:

\_\_\_\_\_ Year: \_\_\_\_\_ Year: \_\_\_\_\_  
 \_\_\_\_\_ Year: \_\_\_\_\_ Year: \_\_\_\_\_

### Family Medical History:

Has anyone in your immediate family been diagnosed with any of the following?

- Autoimmune condition       Diabetes       Heart Disease       Cancer: type(s) \_\_\_\_\_  
 Mental illness       Thyroid disease       Other \_\_\_\_\_

### Overview of Body Systems:

Please check any boxes that are current or recurrent concerns:

#### General

- Fatigue
- Weight loss
- Night sweats
- Headaches
- Sweat easily
- Numbness or tingling
- Lightheadedness
- Dizziness
- Fainting

#### Eyes

- Eye pain
- Light sensitivity
- Hearing loss/impairment
- Visual loss/impairment
- Blurred vision

#### Ears

- Ear aches/infections
- Ringing in ears

#### Nose & Sinuses

- Loss of smell
- Nosebleeds
- Sinus infections
- Post-nasal drip
- Chronic congestion

#### Mouth

- Loss of taste
- Tooth problems
- Mercury fillings
- Sores on lips or mouth
- Painful/Bleeding gums
- Sores on/painful tongue

#### Throat

- Swollen/enlarged glands
- Sore throat
- Hoarseness
- Feeling of lump in throat
- Difficulty swallowing
- Thyroid condition

#### Respiratory

- Shortness of breath
- Chronic cough
- Coughing blood
- Pneumonia/bronchitis
- Asthma
- Allergies (pollen, pets)

#### Blood

- Easy bruising
- Anemia

#### Cardiovascular

- High/low blood pressure
- Heart flutters/skips
- Chest pain
- Swelling of limbs
- Murmurs
- Varicose veins

#### Skin, Hair and Nails

- Eczema/Psoriasis
- Rashes/Hives
- Itching
- Acne, boils
- Irregular moles
- Hair loss
- Weak/brittle nails

#### Musculoskeletal

- Muscle pain/spasm  
where? \_\_\_\_\_
- Chronic Injury
- Joint pain
- Bone pain

#### Gastrointestinal

- Low appetite
- Heartburn/reflux
- Gas
- Blood in stool
- Undigested food in stool
- Diarrhea
- Constipation
- Rectal pain
- Hemorrhoids
- Bowel movements:  
how often: \_\_\_\_\_

#### Urinary

- Pain on urination
- Frequent urination
- Recurrent urinary infections
- Urinary incontinence
- Waking to urinate
- Decrease in urine flow
- Kidney stones

#### Sexual

- Pain during intercourse
- Sexually transmitted infection
- Low/high sex drive
- Birth control use

#### Emotional

- Depression
- Irritability/quick temper
- Anxiety
- Abuse of any form

#### Male

- Hernia
- Testicular pain/mass
- Difficulty with erections
- Prostate problems

#### Female - Gynecologic

- Menopause
- # Births \_\_\_\_\_
- # Pregnancies \_\_\_\_\_
- # days menstruating \_\_\_\_\_
- # days in cycle \_\_\_\_\_
- Date of last PAP \_\_\_\_\_
- Recurrent yeast infections
- Vaginal discharge
- Bleeding between periods
- Excessive/light flow
- Painful periods/cramps
- Missed Periods

#### Female - Breast

- Breast pain / tenderness
- Breast lumps
- Nipple discharge
- Pain during intercourse

#### Neurological

- Poor memory
- Difficulty concentrating
- Headaches/Migraines



### Consent to Naturopathic Treatment

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, stroke, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure result.

I understand the visit costs for Naturopathic treatment are as follows:

Initial Naturopathic Basic \$175.00

Initial Naturopathic Plus \$205.00

The Initial visit is 1 hour with Dr. Rauscher

Subsequent Naturopathic Basic \$90

Subsequent Naturopathic Plus \$115.00

Subsequent Esoteric Acupuncture \$115.00

Subsequent visits are 30 minutes with Dr. Rauscher

I also understand that if I miss an appointment or cancel on short notice (less than 24 hours), I may be charged a fee for the missed appointment.

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Patient Name

Patient Signature

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Guardian Signature (If patient is under 16 years old)

Date

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Doctor's Signature

Doctor's Name

**Welcome!** Thank you for taking the time to fill out this extensive questionnaire. Your time and care is appreciated.