JENNIFER RUMANCIK, ND

Website: www.drJenniferRumancik.com
Email: info@drjenniferrumancik.com
Phone: 778-244-8524

Please complete the following form as thoroughly as possible. All information is confidential.

ADULT INTAKE FORM:

Name: _____ Todays Date:_____

Address:_____

Phone: _____

E-mail: _____

Date of Birth (age): _____

Current Occupation: _____ Past Occupations:_____

_____

Emergency Contact:_____ Relationship: _____ Phone:_____

Extended health care plan? Y / N Provider: _____

Other health care providers your currently seeing:

Name: _____ Profession: _____ Phone: _____

Name: _____ Profession: _____ Phone: _____

Name: _____ Profession: _____ Phone: _____

Name: _____ Profession: _____ Phone: _____

How did you hear about the clinic?

_____

TOP FIVE HEALTH CONCERNS:

1. _____
2. _____
3. _____
4. _____
5. _____

What do you believe is the root cause of your most important health concern? _____

_____

Commitment level (check all that apply):

- ☐ Willing to do anything and everything – all energy and focus is towards getting well
- ☐ Somewhat committed, but have other obligations
- ☐ Prefer to add in / change things bit by bit - already have a health program, but looking to optimize it

What type of patient are you? (check all that apply):

- ☐ Like to understand and see evidence before committing to a treatment plan (scientific journals, test results, reports, etc.)
- ☐ Prefer not to know and let your Dr. chose the best route of action
- ☐ Very sensitive and find the most benefit from gentle energy type treatments (acupuncture, homeopathy, meditation, body talk, reiki, etc.?)

What are your top goals for today's visit:_____

MEDICAL HISTORY:

Please check all that are applicable to you and your immediate family (grandparents, parents, and siblings):

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Diabetes
- ☐ Lung Disease
- ☐ Bleeding Disorders
- ☐ Cancer; type:_____
- ☐ Autoimmune conditions
- ☐ Celiac
- ☐ Asthma
- ☐ Eczema / Psoriasis
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Anorexia / Bulimia
- ☐ Alcoholism
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other:_____

Do you have any life threatening allergies? Y/ N Please indicate: _____

List all allergies or sensitivities to foods, medications, supplements, beauty products, etc.

1._____ Reaction:_____

2._____ Reaction:_____

3._____ Reaction:_____

4._____ Reaction:_____

5._____ Reaction:_____

Do you take or use any of the following:

- ☐ Laxatives
- ☐ Appetite suppressants
- ☐ Tranquilizers
- ☐ Sleeping aids
- ☐ Antacids
- ☐ Thyroid medications
- ☐ Cortisone
- ☐ Pain relievers
- ☐ Birth control

Please list any prescriptions, over the counter medications, or naturopathic remedies (herbal, vitamin, mineral, nutritional, homeopathic, etc.) you are currently taking or have taken in the past year:

Medication / Remedy:	Dosage:	Duration:	Reason for taking:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any past surgeries, hospitalizations, X-rays, CAT scans, EEG, EKG's, ultrasounds, or dental work (root canals, fillings, implants, caps, dentures, etc) you have had:

_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

# of times on oral Antibiotics? _____ Last dose was:_____ months ago Reason: _____

SCREENING:

When was your last:	**Date:**	**Results:**
Full physical exam (yearly)	_____	_____
Screening lab tests (yearly)	_____	_____
Thyroid testing (every 5 years)	_____	_____
Mole exam (monthly - yearly)	_____	_____
Dental exam (yearly)	_____	_____
Hearing test (every 3 years)	_____	_____
Eye exam (every 2 years)	_____	_____
Diabetic testing (age 45+)	_____	_____
Fecal Occult Blood (age 50+)	_____	_____
Colonoscopy (age 50+)	_____	_____
Bone density test (age 65+)	_____	_____

Women:

Breast exam (yearly)	_____	_____
Pap test (every 1-3 years)	_____	_____
Mammogram (age 40+)	_____	_____

Men:

Prostate -DRE (every 5-10 years):	_____	_____
Testicular (monthly)	_____	_____

REVIEW OF SYSTEMS:

Please check if you have had any of the following within the past year:

General:
Height_____
Weight:_____
Weight 1 year ago:_____
Maximum weight:_____
Year:_____
___ fatigue
___ night sweats
___ cold intolerance
___ heat intolerance
___ decreased metabolism
___ recurrent infections: location _____
___ insomnia
___ early waking
___ nausea
___ increased appetite
___ decreased appetite

Blood & Immunity
___ anemia / low ferritin
___ bruise easily
___ bleed easily
___ itchy after hot shower
___ dark circles under eyes
___ pale nails and eyes
___ slow wound healing
___ enlarged lymph nodes
___ frequent infections
___chronic yeast overgrowths

Skin:
___ acne
Hairline: y/n (hair products / hats)
Cheeks: y/n (clean pillows and phone)
Chin and jawline: y/n (hormones = increased androgens)
Forehead and nose = stress and poor sleep plus touching
___ bumps on arms
___ open sore/ulcer
___ hives
___ eczema/dermatitis
___ psoriasis
___ rashes
___ suspicious moles
___ brittle hair or nails (break easily)
___ dry skin
___ oily skin
___ itchy skin
___red patches around mouth, nose or eyes
___ sweat easily
___ difficulty sweating
___ cellulite (age and fat accumulation)
___ dandruff

Eyes:
___ glasses/contacts
___ changes in vision
___ sensitive to light/sun
___ burning eyes
___ itchy / watery eyes
___ dry eyes
___ floaters
___ cataracts
___ glaucoma
___ eye pain
___redness in corners of eyes

Head & Hair
___ headaches
___ migraines
___ head injury/concussion
___ dizziness/vertigo
___ hair loss on head
___ hair loss on big toes
___ hair growth on face & body
___ brittle hair
___ lateral thinning of the eyebrows
___ leg hair loss

Mouth & Throat:
___ tooth pain
___ mercury fillings
___ dentures
___ gum problems/bleeding
___ canker sores
___ hoarse voice
___ frequent sore throat
_ __ tonsils removed
___ loss of taste
___ bad taste in mouth
___ grinding teeth
___ difficulty swallowing
___ goiter
___ lumps on neck
___ swollen glands
___ sore tongue

Nose & Sinuses:
___ changes in smell
___ hay fever/allergies
___ polyps
___ frequent nose bleeds
___ congestion

Ears:
___ changes in hearing
___ ringing in ears
___ excess wax
___ frequent infections
___ ear pain

Respiratory:
___ sputum/excess mucous
___ difficulty breathing
___ pain with breathing
___ short of breath (SOB)
___ SOB lying down
___ SOB on exertion
___ wheezing
___ asthma
___ frequent lung infections
___ Emphysema / Bronchitis
___ Pneumonia
___spitting up blood
___ chronic cough

Musculoskeletal:
___ muscle pain
___ muscle weakness
___ cramps
___ tendonitis
___ joint pain
___ joint deformities
___ jaw pain/clicking
___ bone pain

Gastrointestinal:
___ heartburn/acid reflux
___ stomach ulcer
___ bad breath
___ persistent vomiting
___ indigestion
___ excess bloating
___ excess belching
___ excess gas
___ abdominal pain
___ jaundice
___ gallstones
___ gallbladder removed
___ fatty food intolerance
___ constipation
___ diarrhea
___ pale stool
___ dark / black stool
___ blood in stool
___ pencil thin stool
___ undigested food in stool

Endocrine:
___ excessive thirst
___ excessive sweating
___ sugar cravings
___ afternoon crash
___ diabetes
___ adrenal fatigue
___ hypoglycemic episodes

Urinary:
___ wake up to urinate
___ kidney infections
___ kidney stones
___ bladder infections
___ urgency
___ painful urination
___ slow/difficult stream
___ dribbling
___ incontinence

Cardiovascular:
___ high blood pressure
___ low blood pressure
___ high or low cholesterol
___ heart murmur
___ chest pain
___ palpitations
___ irregular heart beat
___ pacemaker
___ heart surgery

Peripheral Vascular:
___ cold hands/feet
___ cyanosis (blue lips, skin)
___ deep leg pain/cramps
___ skin ulcers on feet
___ swollen ankles
___ varicose veins
___ hemorrhoids
___ horizontal creases on earlobes

Nervous System:
___ seizures
___ stroke
___ paralysis
___ local weakness
___ tremors
___ numbness/tingling

___ fainting/blackouts
___ memory problems
___ learning difficulties

Mind & Mood:
___ excess sadness
___ seasonal depression
___ anxiety/nervousness
___ mood swings
___ mania/hyperactivity
___ panic attacks
___ excess anger/irritability
___ difficulty expressing emotions
___ lack of concentration
___ foggy thinking

Sexual:
___ sexually active
___ increased libido
___ decreased libido
___ painful intercourse
___ sexual difficulties
___ STIs
___ birth control; methods:
_____
_____
_____

Breast (male & female):
___ breast tenderness
___ breast lumps
___ fibrocystic breasts
___ nipple discharge

Female Reproductive:
Age of first period ____
Cycle length _____
___ excessive flow
___ bleeding between periods
___ clots
___ PMS
___ cramping/painful periods
___ bleeding after intercourse
___ excess vaginal discharge
___ itch
___ yeast infections
___ endometriosis
___ fibroids
___ ovarian cysts
___ cervical dysplasia
___ difficulty conceiving
# of pregnancies ____
# of deliveries ____
# of miscarriages ____
# of abortions ____

pregnancy complications:

_____

___ tubal ligation
___ hysterectomy
___ vaginal dryness
___ hot flashes
___night sweats

Male Reproductive:
___ urinary pain
___ urinary urgency
___ urinary hesitancy
___ enlarged prostate
___ hernia
___ testicular pain
___ testicular lump
___ sores on penis
___ discharges
___ infertility

Any other health concerns or symptoms: _____

HEALTH & LIFESTYLE:

What do you typically eat for:

Breakfast	Lunch	Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Snacks:_____
Please list the top foods you crave on a daily basis:_____
Do you have any dietary restrictions (religious, vegetarian/vegan, etc)? _____

Please indicate your use of the following:

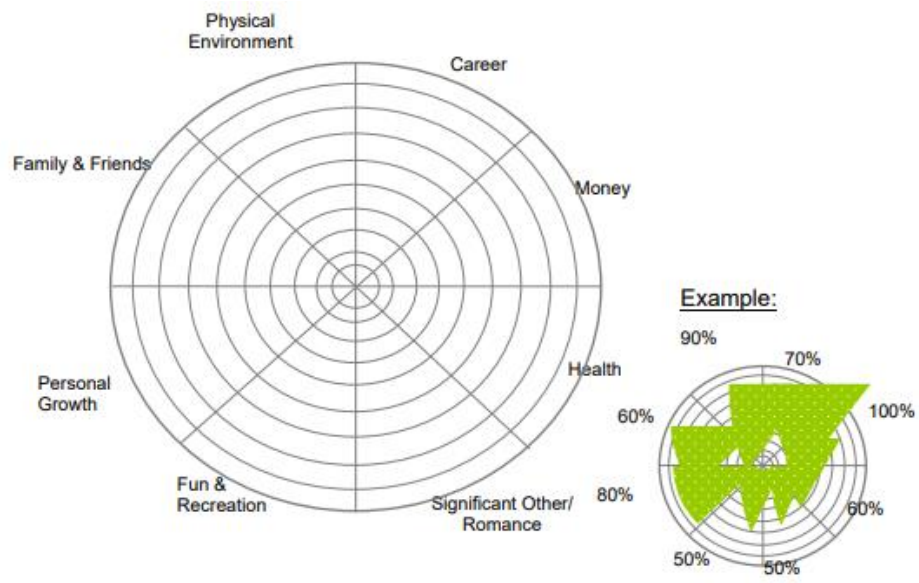
Water: □ Never □ Occasionally □ _____ /day
Coffee: □ Never □ Occasionally □ _____ /day or wk
Soda: □ Never □ Occasionally □ _____ /day or wk
Alcohol: □ Never □ Occasionally □ _____ /day or wk
Tobacco: □ Never □ Occasionally □ _____ /day or wk Have you ever been a smoker? _____
Recreational drugs: □ Never □ Occasionally □ _____ /day or wk What kind(s)? _____

Please list any chemicals, toxins, or environmental factors potentially affecting your health: □ pesticides □ herbicides □ asbestos □ solvents □ gas fumes □ cigarette smoke □ mold □ heavy metals □ other:_____

Do you have a regular exercise program? _____
Type(s): _____ Amount per week: _____

Marital Status: □ Married □ Widowed □ Divorced □ Single □ Living with significant other
Who lives with you? _____
Favorite hobbies & activities:_____

WHEEL OF HEALTH & BALANCE:



Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For Example, if you are extremely happy in your career, shade the entire pie shape for career. Do the same for each area, starting from the center point radiating outwards.

The information I have provided is accurate and true to the best of my knowledge.

Signature: _____ Date:_____

Informed Consent:

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your naturopathic doctor will take a thorough case history and perform a physical examination. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important that you inform your doctor immediately of any disease process that you are suffering from and any medications/over the counter drugs/supplements that you are currently taking. Please advise your doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

There are some slight health risks associated with treatment by naturopathic medicine.

These include but are not limited to:

- Possible aggravation of pre-existing symptoms
- Allergic reactions to certain supplements and herbs. Please advise your doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parental therapy.
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.
- Muscle strains and sprains, disc injuries from spinal manipulation.

Statement of Acknowledgement:

As a patient under the care of Dr. Jennifer Rumancik, I _____ have read the above information and understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself in writing or unless law requires it. I understand that I have access to my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

The information I have provided is complete and inclusive of all health concerns including risk of pregnancy and all medications, including over the counter drugs.

With this knowledge, I consent to diagnostic and therapeutic procedures mentioned above. I agree to information from my case being used for research and teaching purposes (name and details held completely confidential). I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I also confirm that I have the ability to accept or reject this care of my own free will and choice. I accept full responsibility for any fees incurred during care and treatment.

Patient Name: (Please print name): _____

Signature of Patient: _____ **Date:** _____