Refined Health

Re-find Health ... Discover Life

Dr. Nicole Krapp ND
Box 60
Roland, MB R0G 1T0
204-343-2018

Patient Intake Form

Date (dd/mm/yy): ________________

First Name: ____________________________ **Date of Birth (dd/mm/yy):** ___________________
Last Name: ____________________________ **Gender:** Male ☐ Female ☐

Full Mailing Address: ____
____
____
____

E-mail Address: ____

Home Phone Number: ____________________________
Other Phone Number: ____________________________
May we leave messages relating to your visits? Yes ☐ No ☐
How did you hear about Refined Health? ___________________________________

Emergency Contact **Name:** ___________________________
Relation: _________________________
Phone Number: ____________________

Marital Status: Single Relationship Married Separated Divorced Widowed
Number of Children:___________ **Ages of Children:** ______________________________

If patient is a child:
Mother's name: _________________________ Father's name: __________________________
Occupation: _________________________ Occupation: __________________________

Other Healthcare Providers
Name: ___________________________ **Name:** ___________________________
Specialty: _________________________ **Specialty:** _________________________
Phone Number: ____________________ **Phone Number:** ____________________
If needed, may we contact your other healthcare providers for information regarding your health, current/previous care, tests, prescriptions, or diagnosis? Yes ☐ No ☐

List your health concerns in order of importance:

1. ____
2. ____
3. ____
4. ____
5. ____

If you are female, are you pregnant? Yes ☐ No ☐ Trying ☐

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Please list any diagnosed medical conditions:

1. ______________________________ Year diagnosed: ____________
2. ______________________________ Year diagnosed: ____________
3. ______________________________ Year diagnosed: ____________
4. ______________________________ Year diagnosed: ____________

Please list any previous accidents, surgeries, hospitalization, or medical procedures or tests:

1. ______________________________ Year: ____________
2. ______________________________ Year: ____________
3. ______________________________ Year: ____________
4. ______________________________ Year: ____________

Please list any allergies (food, environmental, medications, etc):

1. ______________________________ Reaction: ____________
2. ______________________________ Reaction: ____________
3. ______________________________ Reaction: ____________
4. ______________________________ Reaction: ____________

Please list all prescription drugs, over-the-counter medications, herbs, and/or supplements you are taking:

1. ____________ Dose:____________
2. ____________ Dose:____________
3. ____________ Dose:____________
4. ____________ Dose:____________
5. ____________ Dose:____________
6. ____________ Dose:____________
7. ____________ Dose:____________
8. ____________ Dose:____________

Vaccinations/ Immunization Record (check all that apply):

☐ DPT (Diptheria, Pertussis, Tetanus)
☐ Pneumococcal Conjugate (Meningitis, Pneumonia)
☐ Meningococcal C Conjugate (Meningitis)
☐ Hib (Haemophilus influenza type b)

☐ Flu
☐ Hepatitis A

☐ Varicella (Chicken Pox)
☐ MMR (Measles, Mumps, Rubella)
☐ Varicella
☐ Hepatitis B

☐ Tetanus Booster
☐ HPV (Human Papillomavirus)

☐ I don't know

Please indicate if you had any reaction:

____

____

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Family History

Please indicate if there is a history of any of the following in your family and the relationship of family member.

Alcoholism	______	Heart Disease	______
Allergies	______	Heart attack	______
Arthritis	______	High blood pressure	______
Asthma	______	Kidney disease	______
Autoimmune Disease	______	Mental disease (type?)	______
Cancer (type?)	______	Multiple Sclerosis	______
Celiac	______	Osteoporosis	______
Colitis	______	Stomach Ulcers	______
Depression	______	Stroke	______
Diabetes	______	Thyroid dysfunction	______
	______		

Lifestyle

Smoking (amount/day): ______ #of years: ______
Alcohol: type ______ amount/week ______
Caffeine (drinks/day): coffee ______ tea ______ soda ______
Recreational drugs: type ______ amount ______

Are you constipated? ______ Number of movements/day ______
Do you use antacids? ______ Frequency ______ Type ______
Do you use laxatives? ______ Frequency ______ Type ______
Do you exercise regularly? ______ Frequency ______ Type ______
Do you use pain medications? ______ Frequency ______ Type ______
On average, how many hours of sleep do you get per night? ______
Do you have troubles falling asleep? ______
Do you have trouble staying asleep? ______
Are you sexually active? ______ If you use contraceptives, please indicate type ______
What are the things you find stressful and how do you react? ______

______

______

What are your hobbies and how do you relax? ______

______

Are you satisfied with your present weight? ______
Have you ever had weight problems? ______
Height: ______ Current Weight: ______
Min Adult weight: ______ Max Weight: ______

Is there anything else that you feel is important for us to know?

______

______

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Informed Consent to Treatment

1. I understand that Dr. Nicole Krapp is a naturopathic doctor who uses natural, non-invasive methods of assessment and treatment.
2. I understand that any health related advice from Dr. Nicole Krapp ND does not negate other advice received from another health care provider.
3. I understand that I may continue or begin care with any other qualified health care provider while seeing Dr. Nicole Krapp and will not be required to discontinue in order to be a patient with Dr. Krapp.
4. I understand that Dr. Nicole Krapp ND will treat within her scope of practice and will refer out to other medical providers when needed.
5. I understand that I am accepting or rejecting care of my own free will.
6. I understand that service offered at Refined Health are not covered by Manitoba Health and that fees are payable at the time of appointment or upon receiving supplements or tests.
7. I understand that 24hrs notice is required for cancelling an appointment and will otherwise be charged a cancellation fee.
8. I understand that recommended treatments will be explained and I can choose to use or not to use any treatment that has been recommended.

Informed Consent for Communication

We want to make things as easy as possible for you at Refined Health and would like to send you information electronically. This would include **appointment reminders** or any other important notifications or changes in services/ hours. Otherwise we will only communicate with you electronically in response to emails you might send to Refined Health. Please check one of the following:

☐ Yes, you can send me electronic information. ☐ No, do not send me electronic information.

I, ______________________________________ have read, understood and agree to the above statements
First Name Last Name

Signature or legal guardian: ____ Today's Date: ___ /____ /________
DD MM YYYY

Patient name if signed by parent/ legal guardian: ____
First Name Last Name