CANADIAN COLLEGE OF NATUROPATHIC MEDICINE

ROBERT SCHAD NATUROPATHIC CLINIC

Fertility Focus Shift Intake Form - Female

NOT ALL SECTIONS OF THIS FORM MAY BE RELEVANT TO YOU – PLEASE ONLY FILL OUT THE SECTIONS THAT ARE RELEVANT TO YOUR CURRENT SITUATION

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

(Please print clearly)

Name ______________________________ Date ______________

Date of birth ________________ (MM/DD/YY)

Preferred Gender Pronoun ☐ He ☐ She ☐ Other________ Sex: ☐Female ☐ Male

Address:______________________________ Apt/unit #________

City ________________ Province __________ Postal Code__________

E-mail Address:______________________________

Telephone number: Home:__________ Work:__________ Cell: __________

May we leave messages relating to your visits? Y / N Which Phone Number:__________

Emergency contact: Name: ______________________________

Phone number(s): (_____)________ or (_____)________ Relation:__________

Partner's name (if applicable) ________________ DOB (MM/DD/YY)________

How did you hear about our Clinic? Please check one of the following:

- ❑ A patient of the clinic (please provide name) ______________________
- ❑ My medical doctor/Specialist (please provide name) ______________________
- ❑ Other Health Care Provider (please provide name):______________________
- ❑ Advertising (newspaper, TTC, brochure)
- ❑ Social Media (Facebook, Twitter etc.)
- ❑ CCNM Website
- ❑ CCNM Student, staff or faculty
- ❑ Information Session
- ❑ External Sports Medicine event
- ❑ CCNM E-Newsletter
- ❑ Other: ______________________

Other health care providers you are seeing:

Name: ____________ Name: ____________ Name: ____________

Specialty: ____________ Specialty: ____________ Specialty: ____________

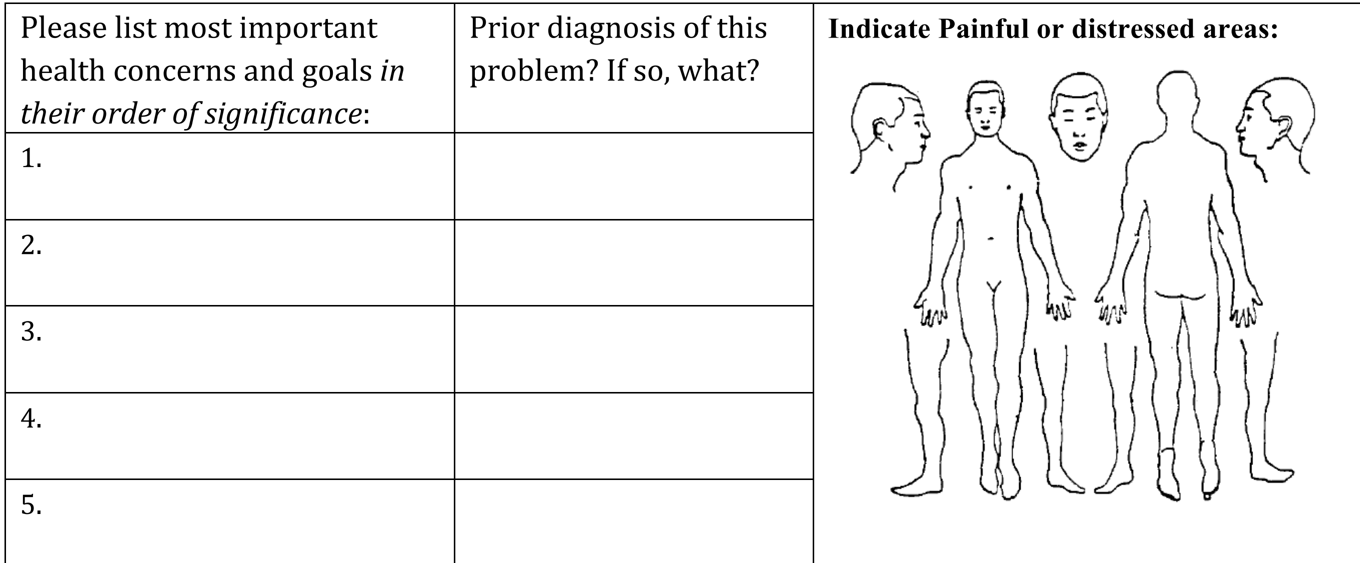
Phone: (_____) ________ Phone: (_____) ________ Phone: (_____) ________

Date of Last Visit: ________ Date of Last Visit: ________ Date of Last Visit: ________

Have you ever consulted (Please check all that apply):

☐ Naturopathic doctor ☐ Acupuncturist ☐ Nutritionist ☐ Counselor

Health Goals

Please list most important health concerns and goals *in their order of significance*:	Prior diagnosis of this problem? If so, what?	**Indicate Painful or distressed areas:** 
1.		
2.		
3.		
4.		
5.		

Medical history

How would you describe your general state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations or surgeries; along with approximate dates.

1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

Do you have any allergies (medicines, environmental, etc.)?

1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

Please list all current medications/natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

Are you taking Folic Acid? Y N If yes, please indicate dose and brand ______________________

Please list past prescription medications/natural health products:

____
____
____

Please circle Yes (Y), No (N) or Past (P) regarding use of the following:

Aspirin, Tylenol, Advil or other pain relievers Y N P
Laxatives Y N P Antacids Y N P Diet pills Y N P
Antibiotics Y N P Approximate number of prescriptions: ______________________
Alcohol—how much/day or week/type of alcohol ______________________
Tobacco—form and amount/day______________________
Caffeine (coffee, tea, soda) —form and amount/day______________________
Recreational drugs (marijuana or other)—what and how often______________________
Partners use of recreational drugs – what and how often ______________________

Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus)
☐ Tetanus booster; when? ________
☐ MMR (measles, mumps, rubella)
☐ Hepatitis A
☐ Hepatitis B
☐ Haemophilus influenza B
☐ "Flu"
☐ Polio
☐ Smallpox
☐ Chicken pox OR had chicken pox previously?
☐ Other: ______________________

Please indicate if any caused adverse reactions: ______________________

Have you been tested recently for Rubella titers? Y N If yes, when and result: ______________________
Have you been tested recently for Chicken pox titers? Y N If yes, when and result: ______________________

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? ☐ Yes ☐ No

Last time you had a Pap Smear__________ Were the results: ☐ Normal ☐ Abnormal ☐ I don't know
Procedures related to abnormal pap test: ______________________

Have you ever had a mammogram? Y N What were the results? ______________________

Have you travelled recently? Y N If yes, where: ______________________
Has your partner travelled recently? Y N If yes, where: ______________________

Prior fertility testing (please check all that apply)

☐ Blood tests ☐ Ultrasounds ☐ Cycle Monitoring ☐ Hysteroscopy
☐ Laparoscopy ☐ Sonohysterogram ☐ Hysterosalphingograms (HSG)

Pregnancy History

How many months have you been trying to get pregnant without using any form of birth control? ____
Have you had any:

Previous Miscarriages Y N If so, how many _______, When:______________________
Tubal/ectopic pregnancies Y N If so, how many _______, When:______________________
Full Term deliveries Y N If so, how many _______, When:______________________
Elective terminations (abortions) Y N If so, how many _______, When:______________________

Menstrual History

On a regular basis, do you have (please check all that applies):

☐ Irregular periods ☐ Regular periods ☐ Spotting before periods
☐ Heavy periods ☐ Light periods ☐ Bleeding between periods

Typically, how many days between the start of one period to the start of the next period? ____________
If your periods are irregular, how many periods do you have per year? ______________
What is the typical number of days of bleeding? _________
On heavy days, how many pads are tampons are you using in a day? ___________
Have you ever missed school or work due to menstrual pain? Y N
Have you ever been diagnosed with endometriosis? Y N
Age at which your periods first started: _____________
Do you experience discomfort with your period? Not Really Average Severe pain

Sexual History

How often do you have intercourse? _________________________
Have you ever used ovulation predictor kits to time intercourse? Y N
Have you ever used Basal body temperature charts to predict ovulation? Y N
List any lubricants you use during intercourse ____

Do you experience pain during intercourse?
☐ Always ☐ Often ☐ Occasionally ☐ Almost Never ☐ Never

Have you ever had the following sexually transmitted diseases? (Please check all that apply)
☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Genital Warts
☐ Genital Herpes ☐HIV/AIDS ☐Other__________

What types of contraception have you used in the past? (Please check all that apply)
☐ Condoms ☐ Oral Contraception ☐ IUD/IUS ☐ Depo Provera
☐ Withdrawal ☐Rhythm Method ☐Other________________
Have you ever experienced any complications? ____

Mental-Emotional History

On a scale of 1-10 (10 being the highest), estimate the level of stress you feel due to difficulty conceiving? ______________________
How stressful is your work, or other aspects of your life? How well do you handle these stresses?
____
____

Do you see a counselor? Y N
Would you consider yourself an anxious person? Y N
How would you describe the emotional climate of your home?
____

Over the past 2 weeks, how often have you been feeling bothered by the following problems?
(0=not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day)

1. Little interest or pleasure in doing things 0 1 2 3
2. Feeling down, depressed or hopeless 0 1 2 3

Total ___________ (Office Use)

Is there anything else that you feel is important that has not been covered?

____

____

____

Personal and Family History

Height: _______________ Weight (lbs) ________________

BMI ___________ (Office Use)

Have you experienced the following:

Recent weight gain or loss	Y	N	Please explain: ______________________
Disordered eating	Y	N	Please explain: ______________________
Lack of energy	Y	N	Please explain: ______________________

Head, Eyes, Ears, Nose and Throat

Lack of sense of smell	Y	N	Please explain: ______________________
Headaches	Y	N	Please explain: ______________________
Blurred vision	Y	N	Please explain: ______________________
Hearing loss/deafness	Y	N	Please explain: ______________________
Hair loss	Y	N	Please explain: ______________________

Breasts

Breast discharge	Y	N	Please explain: ______________________
Lumps	Y	N	Please explain: ______________________
Breast reduction	Y	N	Please explain: ______________________
Breast augmentation/implants	Y	N	Please explain: ______________________

Genitourinary

Bladder infections	Y	N	Please explain: ______________________
Vaginal infections	Y	N	Please explain: ______________________
Frequent Urination	Y	N	Please explain: ______________________
Leaking urine	Y	N	Please explain: ______________________
Blood in urine	Y	N	Please explain: ______________________

Hormonal

Hair loss	Y	N	Please explain: ______________________

Please check the "yes" box next to each condition that applies to you and/or one of your family members. Please circle all who the condition applies to: "**Self**" if it relates to you and/or Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**), your child (**C**). Please circle **Past** if the condition is resolved, or **Current** if it is on-going and current.

	Yes (✓)	Relation Please circle	Dates Resolved		Yes (✓)	Relation Please circle	Dates Resolved
Alcoholism/Drug addiction		Self F M S G C	Past Current	Depression/other Mental Illness		Self M S G C	Past Current
Allergies		Self F M S G C	Past Current	Fibroids		Self F M S G C	Past Current
Anemia		Self F M S G C	Past Current	High Blood pressure		Self F M S G C	Past Current
Arthritis		Self F M S G C	Past Current	Heart Disease		Self F M S G C	Past Current
Asthma		Self F M S G C	Past Current	Heart Attack		Self F M S G C	Past Current
Birth Defects		Self F M S G C	Past Current	Headaches		Self F M S G C	Past Current
Blood Clotting disorders		Self F M S G C	Past Current	Infertility		Self F M S G C	Past Current
Cancer: Breast Colon Ovarian Other: _______		Self F M S G C Self F M S G C Self F M S G C Self F M S G C Self F M S G C	Past Current	Polycystic Ovarian Syndrome		Self F M S G C	Past Current
Diabetes		Self F M S G C	Past Current	Menopause before age 40		Self F M S G C	Past Current
Endometriosis		Self F M S G C	Past Current	Thyroid problems		Self F M S G C	Past Current

☐ I don't know my family medical history

Any other personal or family health concerns you would like us to know? ______________________________

____

Please list any birth defects that have occurred in your family history: ______________________________

____

What is your blood type? ____________________ Rh factor (circle one): Negative Positive

Diet

Do you have any food allergies or intolerances? Please list.

1) ______________________________ 4) ______________________________
2) ______________________________ 5) ______________________________
3) ______________________________ 6) ______________________________

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____

Environment

Occupation ____

Do you do physical labour at work? Y N If yes, please describe : ________________________

Hobbies ____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

____

____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated? ____

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

____

____

Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)? ____

How would you describe the emotional climate of your home?

____

____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

____

____

____

Is there anything that you feel is important that has not been covered?

____

____

____

For file use only