holly giannatselis
NATUROPATHIC DOCTOR

Dr. Holly Giannatselis, HBsc, MSc, ND
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Intake Form

Note: This record is confidential. The information helps in providing you with the best healthcare possible.

Name:_____ **Date:**_____

Date of Birth:_____ **Gender:** ☐ Male ☐ Female ☐ Transgender

Address:_____**City:**_____**Province:**_____**Postal Code**:_____

Telephone Numbers: Home:_____ **Cell:**_____ **Work:**_____

May we leave messages relating to your visits: ☐ Yes ☐ No **Which Phone Number:**_____

Email Address:_____

May we communicate with you via email regarding your visits and healthcare _____

Emergency Contact:_____ **Relation:**_____**Phone Number:**_____

Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

Ethnicity: _____

Please list all other healthcare providers you are seeing (include name, specialty, address, and fax):

May we contact your other practitioners, within this clinic or otherwise, about your care? _____

How did you hear about this clinic?

Health Goals_____

Please list most important health concerns and goals in their order of significance	***Prior diagnosis of the health concern? If so, what was it?***
1.	
2.	
3.	

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Medical History_____

Please indicate any serious conditions, illnesses or injuries as well as any hospitalizations along with approximate dates and the healthcare professional responsible for your care.

Conditions/Illness/Injury/Hospitalization	***Approximate Date***	***Practitioner***

Do you have any non-food allergies? List below.

Please check off Yes or No or Past regarding use of the following:

Aspirin, Tylenol, Advil, other pain relievers ☐ Yes ☐ No ☐ Past
Laxatives ☐ Yes ☐ No ☐ Past *Antacids* ☐ Yes ☐ No ☐ Past *Diet Pills* ☐ Yes ☐ No ☐ Past
Birth Control ☐ Yes ☐ No ☐ Past *Type (Please Circle): Pills / Implants / Injections*
Antibiotics ☐ Yes ☐ No ☐ Past *Approximate number of prescriptions*:_____
*Alcohol – How much/day or week*_____
*Tobacco – Form and amount/day*_____
*Caffeine – Form and amount/day*_____
*Recreational Drugs – What and how often*_____

Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus) ☐ Flu ☐ Tetanus booster; When?_____
☐ Haemophilius influenza B ☐ Hepatitis A ☐ Hepatitis B
☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Smallpox
☐ Other:_____ Indicate if any caused adverse reactions:_____

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Dietary Information_____

Do you have any food allergies, intolerances or dietary restrictions (religious/choice)? Please list

Allergies	Intolerances	Dietary restrictions

Describe a typical day's diet.

	Items
Breakfast	
Lunch	
Dinner	
Snacks	
Beverages (& total amount)	

Men Only_____

Do you have: ☐Prostrate problems ☐Testicular caner ☐Vasectomy ☐Sexual dysfunction

Women Only_____

Age at first menstrual period:_____ **First day of most recent menstrual period**:_____

Usual Flow: ☐Heavy ☐Moderate ☐Light **Length of period in days**:_____

Number of days between periods:_____**Clots in menstrual flow:** ☐ Yes ☐ No **Colour of flow**:_____

Do you have: ☐Painful periods ☐ Missed periods ☐Spotting between periods

☐ Vaginal bleeding ☐ Unusual discharge/infection ☐ Recurring vaginal infections

If you have gone through menopause, have you had any post-menopausal bleeding? ☐ Yes ☐ No

Date of last Pap_____ **History of abnormal Pap?** ☐ Yes ☐ No

Number of: Pregnancies_____ Live Births_____ Abortions_____ Miscarriages_____

Have you ever experienced complications during pregnancy/delivery/other problems? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No **Are you currently lactating?** ☐ Yes ☐ No

What type of contraception do you use? List all that apply. _____

Any problems with the current method(s)? ☐ Yes ☐ No **If so, explain:** _____

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Environmental_____

Occupation:_____ **Hobbies**:_____
Do you exercise regularly? ☐ Yes ☐ No
If so, what type of exercise do you do, how much and how often?

Have you traveled outside of Canada? ☐ Yes ☐ No **If so, complete the chart below.**

Where?	When?	How Long?

Are you exposed to tobacco smoke (work/home/other)? ☐ Yes ☐ No
Are you exposed to animals (work/pets/other)? ☐ Yes ☐ No
Are you exposed to solvents, heavy metals, fumes, pesticides/herbicides or other toxins? ☐ Yes☐ No
How is your home heated?_____
Are you particularly sensitive to perfumes, gasoline or other vapours? ☐ Yes ☐ No
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 stress levels?

_____

_____

Do you see a counselor? _____

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

_____

_____

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For Patients Seeking Fertility Support_____

Have you had any of the following testing (please check all that apply):

□ Blood test
□ Cycle monitoring
□ Laprascopy
□ Hysteroscopy
□ Ultrasound
□ Hysterosalphinogram (HSG)
□ Sonohysterogram

How many months have you been trying to achieve pregnancy (without birth control)?_____

Have you had any tubal/ectopic pregnancies?_____

How often do you have intercourse?_____

Do you have pain during intercourse?_____

Have you ever had any of the following sexually transmitted infections?:

□ Chlamydia □ Gonorrhea □ Syphilis □Genital herpes/warts□HIV/AIDS

Have you ever used ovulation predictor kits/strips to time intercourse?_____

Have you ever used basal body temperature charts to predict ovulation?_____

Do you track cervical fluid changes to time intercourse? _____

List any lubricants you use during intercourse:

On a scale of 1-10, estimate the level of stress you feel due to difficulty conceiving?

1 2 3 4 5 6 7 8 9 10

Do you have anxiety or depression associated with difficulty conceiving?_____

Do you have a history of:

□ Anemia
□ Blood clotting disorders
□ Diabetes
□ PCOS
□ Abnormal sperm parameters
□ High cholesterol
□ Recurrent pregnancy loss
□ Endometriosis
□ Uterine fibroids
□ Thyroid imbalance
□ Hypertension