gaia naturopathic clinic
where nature meets science

Dr. Julia Gonen, N.D.
7 hate'ena street
bnei atarot 60991
p: 050.933.6004
e: julia@gaianaturopathic.com
www.gaianaturopathic.com

Adult Intake

Full name: _____ Date: _____
Day/Month/Year

Gender: _____ Date of birth: _____ Ethnicity _____
Day/Month/Year

Contact

Full address: _____

_____

Telephone: (home) _____ (work) _____ (mobile) _____

Email: _____

How can we best reach you? _____

May we leave you phone messages / call to confirm & cancel appointments? _____

Emergency contact: _____ Relationship: _____

Telephone: (home) _____ (work) _____ (mobile) _____

Family

Marital status: _____Single _____Married _____Divorced ____Separated _____Living with Partner ____Widowed

Do you have any children? Y N

If yes, list age and gender: _____ _____ _____ _____ _____

Name of medical doctor: _____ Tel: (____)_____

Address: _____ Fax: (____)_____

Date of last visit to Medical Doctor: _____ Date last physical: _____

Are you under the care of any specialists? _____ Specialists' names: _____

Specialty: _____ Contact: _____

How did you hear of this clinic/were referred by:

MEDICAL HISTORY

Please list your health concerns in order of importance.

Concern	Since	Concern	Since
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Have any of these issued changed or worsened over time?_____

What effect have these issues had on your life?_____

How would you describe your general state of health?_____

Please list any major trauma, injury, illness or accident (mental, emotional or physical) you have sustained.

Incident	Date	Long-term effects

Please list any surgical procedures you have undergone.

Procedure	Date	Complications / Results

Please list any other forms of treatment that you have used and describe their effectiveness.

CHILDHOOD ILLNESSES & VACCINATIONS: (check all that apply):

[ ] Chicken pox	[ ] Measles	[ ] Mumps	[ ] Rubella (German measles)	[ ] Roseola
[ ] Mononucleosis	[ ] Scarlet fever	[ ] Tuberculosis	[ ] Whooping Cough	[ ] Impetigo
[ ] Ear Infections	[ ] Strep Throat	[ ] Polio	[ ] Rheumatic Fever	[ ] Other

Were you vaccinated as a child? If so, any side effects?

Any additional vaccinations (i.e. Hepatitis A or B, “Flu shot”, HPV vaccine, etc)?

MEDICATIONS / SUPPLEMENTS / DRUGS

Please list all current medications and supplements you take including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

Drug / Supplement	Used For	Date Started	Dosage / Frequency

How often did you take antibiotics as a child? _____

In the last 5 years, how many courses of antibiotics have you taken? _____

Most recent course? _____

Which of the following have you used/do you currently use? Please include amount, frequency, duration of use.

Tobacco	Antacids
Alcohol	Sedatives
Recreational drugs	Cortisone
Steroids	Coffee
Laxatives	Other

FAMILY HISTORY

Please indicate if any of your immediate family (parents, siblings, maternal & paternal grandparents) suffers from or has suffered from any of the following conditions.

Condition	Family member(s)	Condition	Family member(s)
Alcoholism / drug use		Asthma	
Colitis		Diabetes	
Kidney disease		Overweight / obesity	
Allergies / hay fever		Arthritis	
Depression / mental health		Heart disease	
Liver disease		Prostate cancer	
Breast cancer		Colon cancer	
High blood pressure		Hyper / hypothyroidism	
Stroke		Other cancer	

Any other conditions of concern in your family?_____

ALLERGIES, SENSITIVIES, EXPOSURES

Please list any known or suspected allergies, sensitivities and/or intolerances.

Drugs	Food	Environmental/Chemical

Have you ever been exposed to toxic substances such as pesticides, herbicides, solvents, or sprays?
If yes, please give details:

Have you ever been exposed to heavy metals such as lead, mercury, arsenic, cadmium, or second hand smoke?
If yes, please give details:

Have you ever had to lower the regular dose of prescription, over-the-counter medication, homeopathic or herbal formula because you were too sensitive to the regular dose?

Do you avoid caffeine in the afternoon or altogether because it keeps you up at night?

Do you smell odours that others cannot? If so, which odours?

Do you have a sudden onset of symptoms (headaches, rashes, nausea, fatigue, shortness of breath, etc) when exposed to chemicals, mold, dust, pollen, or other environmental allergens? If so, please explain.

LIFESTYLE FACTORS

Energy

On a scale of 1-10, (10 = highest) rate your energy: /10 rate your stress level: /10
What time of day is your energy the best? _____ worst? _____
What affects your energy? (↑or↓)

Exercise

Do you exercise regularly? Y N What forms of exercise?
What duration/intensity?

Hobbies

What are your interests/hobbies?
How often do you enjoy them?

Sleep

How many hours of sleep do you get per night? _____ hrs
Difficulty falling asleep? Y N
Do you wake during the night? Y N How often? _____
Do you feel rested on waking? Y N
Do you take naps? Y N For how long? _____

DIET & DIGESTION

Height: _____ Current weight: _____ Desired weight if different? _____

Max. weight? _____ when? _____ Min. weight? _____ when? _____

Have you gained or lost any weight in the past 6-12 months? Y N

If so, how much? _____

Please recall what you eat in a typical 24 hour period:

Breakfast	
Lunch	
Dinner	
Snacks	

Are there any foods you exclude from your diet? For what reason?

Are there any foods that you crave specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy)
At what times?

How much water do you drink daily?

What is the primary source of your drinking water (bottled, filtered, tap, well, etc)?

What other beverages do you drink, and how much?

How often do you urinate? Every ____ hr(s)

How often do you have a bowel movement (per day or week)?

FEMALE (if applicable)

Age at menarche (first menses)? _____ Age at menopause (if reached)? _____

Number of days for typical menstrual flow? _____ Number of days in menstrual cycle? _____

Date of last menses? _____ Number of pregnancies? _____ Number of live births? _____

Any history of miscarriage, abortion, c-section, breech birth, twins?

With any previous pregnancies, were there any difficulties or complications to pregnancy or delivery?

Is there any chance you are pregnant now? Y N
Are you currently lactating? Y N

Do you perform regular (monthly) self breast exams?
Any history of breast lumps or masses?

Do you go for a yearly PAP test? Y N Last PAP test?
Any history of irregular PAP test (please explain)?

MALE (if applicable)

Do you go to a doctor or ND for an annual physical exam? Y N Date of last physical exam:
Do you get regular screening lab tests? Y N
Last DRE (digital rectal exam)?
Any irregularities found?

ADDITIONAL

Is there any other information relevant to your health that has not been addressed?

Thank you for taking the time to complete this intake form.
Its completion will help me to understand your whole health picture, and will assist me in providing you with the best care possible.

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INFORMED CONSENT

This clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's natural ability to heal and to improve the quality of life and health through natural means.

Dr. Gonen will conduct a thorough case history. Assessment of each patient's physical, mental, emotional and spiritual well-being is required to facilitate this work. A physical exam and specific blood and/or urinary laboratory reports may be used as part of the treatment work-up.

Therapies used may include: Clinical Nutrition, Botanical Medicine, Homeopathy, Traditional Asian Medicine & Acupuncture, Lifestyle Counseling & Stress Management, Hydrotherapy, and Physical Medicine including massage and soft tissue manipulation.

Statement of Acknowledgement

I, (print your name) _____ , acknowledge that as a patient of this clinic I have read the information included herein, and understand that the form of medical care is based on Naturopathic Medicine and other supportive principles and practices. I also recognize that even the gentlest therapies have potential complications in certain physiological conditions such as pregnancy, lactation, very young children, very elderly patients, or those on multiple medications. I therefore confirm that I have informed (and will continue to inform) my practitioner fully of my medical history, family history, medications and / or supplements I am currently taking (prescription and over-the-counter), or was previously taking. If female, I have advised my practitioner of any chance that I am pregnant or lactating, and will continue to do so.

Despite the low incidence, there are some slight risks to some Naturopathic treatments. These include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from intramuscular injections or acupuncture
- muscle strains and sprains, disc injuries from spinal manipulations.

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 without my consent, unless required by law. I understand that I may look at my medical record at any time and may request a copy of it by paying the appropriate fee.

I understand that my Naturopathic Doctor has not suggested or recommended to me to refrain from seeking or following the advice of another licensed health care provider.

I understand that my practitioner will answer any questions I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the practitioner to anticipate and explain all risks and/or complications. With this knowledge I voluntarily agree to the diagnostic and therapeutic treatments outlined above except:

_____

_____

_____

_____

(patient's signature & date)

I understand that charges are to be paid at the time of the visit unless previous arrangements have been made prior to my scheduled appointment. As the patient, I am responsible for the total charges incurred for each visit, and have been informed of the fee schedule and accepted methods of payment.

_____

(patient's signature & date)

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment I receive under the care of Julia Gonen, N.D. I understand that I am free to withdraw my consent with written notice and to discontinue treatment at any time.
I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, regional, state or government agency attempting to gather information without so stating.

_____ _____

(patient's signature) (date)

_____ _____

(witness' signature) (date)

Naturopathic Doctor: Julia Gonen, N.D. #1480

Signature: _____ _____

(date)

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I am aware that the Fee Schedule is as follows (as of December 1, 2007):

fee schedule

general fees

Initial consultation (90 minutes)	₪320
Follow-up visit (60 minutes)	₪260
Package of 10 acupuncture treatments	₪2000

children (16 and under) & **students**

Initial consultation (60-90 minutes)	₪260
Follow-up visit (45-60 minutes)	₪200

facial rejuvenation acupuncture

Initial consultation (90 minutes)	₪320
Single treatment (60 minutes)	₪320
Package of 12 treatments	₪2900

HypnoBirthing®
5 classes (2.5 hours each) ₪1500

Urinalysis ₪10

I am aware that Julia Gonen, N.D., is not a medical doctor, and her services are not covered by your Kupat Cholim.

I am aware that there is a 24-hour cancellation policy. Missed appointments without 24 hours notice of cancellation will be subject to a ₪120.00 missed appointment fee.

I am also aware that at this time, payments may only be made by cash or cheque.

By signing this declaration, I acknowledge that I have read the above, and that I agree to pay all costs incurred for treatment at the time of visit.

Name _____ Signature _____

Date _____