TO:	FROM:
Dr Brooke Kalanick	
COMPANY:	DATE:
BETTER By Dr Brooke	
FAX NUMBER:	TOTAL NO. OF PAGES, INCLUDING COVER:
646-607-0127	
PHONE NUMBER:	SENDER'S REFERENCE:
646-348-0133	
RE: PATIENT INTAKE FORM	

FACSIMILE TRANSMITTAL SHEET

1. Fax in this entire intake form to **646-607-0127 or email to drbrooke@betterbydrbrooke**
2. Please also fax or email your most recent blood work or any other pertinent testing from other doctors.
3. **ALL INTAKE FORMS AND LAB WORK MUST BE RECEIVED BY NOON THE DAY PRIOR TO YOUR APPOINTMENT** (if your appointment is 5pm Tuesday, all paperwork needs to be received by Dr Brooke by 12noon on Monday, for example).

Name: _____

Address: _____
(street) *(suite/apt)*

_____
(city) *(state)* *(zip)*

Phone: _____ Fax: _____

Email: _____ Date of Birth: _____

___ Yes I am interested in Dr Brooke's newsletter

Patient Introduction & Informed Consent

Welcome to the naturopathic and acupuncture practice of Dr Brooke Kalanick. Our work together is very much an active process between doctor and patient; and both parties have an important role play in implementing your successful treatment. Getting BETTER isn't a one step process, but rather your health will be addressed on multiple levels and the cause of your issues will be treated vs. simply dealing with any one symptom. You lifestyle, diet and unique biochemistry will be addressed and soon you'll be feeling and looking BETTER than ever. The next several paragraphs are meant to educate you on the unique care of naturopathic doctor, particularly in states which as of yet do not yet license graduates of federally accredited naturopathic medical schools full scopes of practice as primary care physicians. We work steadfastly in theses unlicensed states to gain regulation and licensure to provide you with the safest, best options for alternative medical care. For more information visit www.nyanp.com and www.naturopathic.org (professional associations for NY state and the U.S., respectively)

Naturopathic doctors obtain a doctorate in naturopathic medicine after graduating from an accredited naturopathic medical institution. Naturopathic doctors complete training in the study of biological sciences and conventional medical diagnosis and treatment. In addition, naturopathic doctors receive extensive training in clinical nutrition, homeopathy, botanical medicine, physical medicine and counseling. Naturopathic doctors concentrate on whole-patient wellness. Recommendations are specific to each patient and emphasize prevention and self-care. Naturopathic doctors focus on the underlying cause of the patient's illness rather than focusing solely on symptoms. Naturopathic therapies may require more time to be effective, yet often provide long-lasting health improvements and don't sacrifice one system for another.

A Naturopathic Doctor (ND) is trained as a primary care provider and is a board-certified physician in states where licensure is applicable. Dr. Brooke Kalanick is a licensed naturopathic physician in the Washington State. Currently licensure for naturopathic doctors is not available in New York. Therefore, Dr. Brooke Kalanick does not practice medicine, and does not diagnose or treat diseases or medical conditions in the state of New York. Dr. Brooke Kalanick focuses her practice on health coaching. Dr. Brooke Kalanick's services are not meant to substitute or replace those of a licensed physician and clients seeking her consultation are advised to be under the care of a licensed physician. Dr. Brooke Kalanick encourages open communication between a patient's current licensed medical professional and himself for any and all suggestions the patient receives.

I understand that Dr Brooke Kalanick uses her education and experiences to make suggestions and recommendations. I hereby request out of my own volition and consent to meet and consult with Dr. Brooke Kalanick. I take full personal responsibility for taking any natural remedy that she may recommend. I do not hold the naturopathic doctor responsible or liable for any adverse effects or complications from the natural remedies that I consume. If I feel any adverse effects I agree to cease

taking all natural remedies immediately. I take responsibility for informing my licensed medical practitioner about any and all natural remedies that I choose to consume. I request Dr. Brooke Kalanick to make suggestions which she feels appropriate at the time, based on the facts known, in the interest of my overall well-being. I will be given the opportunity to discuss with her, the nature and purpose of such recommendations.

I agree to pay my full account at the time of each visit. **I understand that missed and/or cancelled appointments not given 24 hours advanced notice will be billed at the full rate of consultation (whether intial or follow up, please see Dr Brooke's pricing sheet for more info).** I have read the above consent.

I have been given the opportunity to ask questions about this consent, and by signing below I agree to the terms above regarding my consultation(s) with Dr. Brooke Kalanick. This consent form shall be in effect during the entire duration of consultations between Dr. Brooke Kalanick and myself.

All therapies including the naturopathic and acupuncture modalities, as does any conventional medical treatment, have the potential to create both desirable and undesirable effects. Of the latter, such effects can include the following: allergic reactions or sensitivities to natural supplements, slight bruising from acupuncture and potential discomfort as you adjust to new lifestyle modifications.

Please Initial and Sign

____ I understand that Dr. Brooke Kalanick is a Licensed Naturopathic Doctor in the state of Washington.

_____ I understand that Naturopathic treatments and modalities may be different than those offered by other licensed health care providers and I am at liberty to seek other care.

_____ I understand that payment is expected at the time of service and I will be billed in full for missed appointments or late cancellations.

_____ I have read and the understood the information on this consent form.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Brooke Kalanick regarding cure or improvement of my condition. I understand that I am free to withdraw this consent and discontinue participation of these procedures at any time.

Date ____ / ____ / ____

Name _____

Signature _____

Adult Intake Form

Thank you for your interest in becoming a patient. This form is designed to help me get to know you better and your reasons for seeing health consulting. The more time you spend answering the questions on this form, more quickly we can get started on helping you achieve your health goals and in the most time-efficient manner possible.

Please take time to answer the following questions to the best of your knowledge. All questions contained in this questionnaire are strictly confidential and will become part of your medical record. *Please note there will be some repetition of questions on various forms, please fill them out on each form when asked.*

Patient Information

Name: _____ Date: ___/___/_____
(Last name) (First name) (Middle name)

Age: _____ Gender: M F Height: _____ Weight: _____ Date of Birth: ___/___/_____
(dd/mm/yyyy)

Address: _____
(Street)

_____
(City) (State) (Zip Code)

_____
(Home Number) (Work Number) (Mobile Number)

_____
(email address) (Fax)

May we leave messages on your phone line? □ Y □ N Preference: Home / Work / Cell

Occupation: _____ How long at current job? _____

Do you work full-time? □ Y □ N Level of satisfaction at work: 10 9 8 7 6 5 4 3 2 1

Are you: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with a Partner ☐ Same Sex ☐ Other

Do you have any children: □ Y □ N If yes, how many? _____ Age(s): _____

Blood Type (if known): _____ How did you hear about us? _____

Emergency Contact Information

Name: _____
(Name) *(Relationship)*

_____
(Home Phone) *(Work Phone)* *(Mobile Phone)*

Physician Information

Primary Care Physician: _____
(Name) *(Phone Number)* *(Date of last exam)*

Specialty Physician: _____
(Name) *(Phone Number)* *(Type of Care)*

Specialty Physician: _____
(Name) *(Phone Number)* *(Type of Care)*

Are you currently seeking the care of any other healthcare practitioners or have in the past year (please list reason)?

Chiropractor _____ Acupuncturist _____

Massage Therapist _____ Physiotherapist _____

Counselor _____ Homeopath _____

Health Information

What is your primary goal for today's visit? _____

Who diagnosed this condition? _____ When was it diagnosed? _____

How has it been treated? _____

Describe your symptoms, including when they feel better/worse, related symptoms, etc.

_____

_____

Other health concerns you would like to address. Please list any current or past treatments used.

1. _____
   (Concern) *(Treatment)* *(Outcome)*

2. _____
   (Concern) *(Treatment)* *(Outcome)*

3. _____
   (Concern) *(Treatment)* *(Outcome)*

Medical History

Prenatal Influences (if known, e.g. alcohol, coffee, cigarettes, drugs, stress): _____

Nature of birth (if known, e.g. trauma, forceps, natural, etc.) _____

Breast Fed: _____ months Health as infant (colic, earaches, etc.): _____

Immunizations: Indicate if you were immunized (I), had the disease (D), or neither (N). Specify when, if known.

I	D	N		I	D	N		I	D	N	
☐	☐	☐	Asthma	☐	☐	☐	Chicken Pox	☐	☐	☐	Flu
☐	☐	☐	Diptheria	☐	☐	☐	Measles	☐	☐	☐	Hepatitis B.
☐	☐	☐	Mono	☐	☐	☐	Mumps	☐	☐	☐	Pertussis
☐	☐	☐	Polio	☐	☐	☐	Rheumatic Fever	☐	☐	☐	Rubella
☐	☐	☐	Scarlet Fever	☐	☐	☐	Roseola	☐	☐	☐	Tetanus

Reactions to vaccinations? _____

List all past **surgeries** and **medical procedures**:

Year Reason

_____ _____

_____ _____

_____ _____

_____ _____

Tests: Have you had any of the following exams in the past year?

Test	Yes/No	Result
PAP Test	Y N	_____
Mammogram	Y N	_____
Colonoscopy	Y N	_____
Testicular/Prostate Exam	Y N	_____
Cholesterol check	Y N	_____
Blood pressure check	Y N	_____
Blood sugar check	Y N	_____

Medications:

Drug and other medication allergies: _____

Do you take currently or use recurrently: (Please indicate Yes, No or Past)

Yes	No	Past		Yes	No	Past		Yes	No	Past	
☐	☐	☐	Laxatives	☐	☐	☐	Sleep Aids	☐	☐	☐	Pain Relievers
☐	☐	☐	Cortisone/Steroids	☐	☐	☐	Appetite Suppressants	☐	☐	☐	Antibiotics
☐	☐	☐	Antacids								

Please list all prescription, over the counter medications and supplements, including daily dose (e.g. Lanoxin 0.25mg) **that you have used in the past 1 year:**

Medication

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

How many times have you been treated with antibiotics in the last 5 years? _____

Supplements

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

Please note if you have ever had any of the following currently (C), intermittently (I), or in the past (P)

C	I	P		C	I	P	
☐	☐	☐	Alcoholism or Substance Abuse	☐	☐	☐	Heart Disease
☐	☐	☐	Allergies	☐	☐	☐	Heart Murmur
☐	☐	☐	Anemia	☐	☐	☐	High Blood Pressure
☐	☐	☐	Anxiety/Depression	☐	☐	☐	Hypoglycemia
☐	☐	☐	Arthritis	☐	☐	☐	Injury (serious)
☐	☐	☐	Asthma	☐	☐	☐	Jaundice
☐	☐	☐	Autoimmune Disease	☐	☐	☐	Kidney Disease
☐	☐	☐	Bleeding	☐	☐	☐	Liver Disease
☐	☐	☐	Bronchitis	☐	☐	☐	Mental Illness
☐	☐	☐	Cancer	☐	☐	☐	Overweight
☐	☐	☐	Candida (yeast)	☐	☐	☐	Pneumonia
☐	☐	☐	Colitis	☐	☐	☐	Rheumatism/Arthritis
☐	☐	☐	Diabetes (type ?)	☐	☐	☐	Stroke
☐	☐	☐	Eczema/Psoriasis	☐	☐	☐	Thyroid
☐	☐	☐	Emphysema	☐	☐	☐	Tuberculosis
☐	☐	☐	Headache	☐	☐	☐	Ulcers
☐	☐	☐	Heart Attack	☐	☐	☐	Venereal Disease

Other: _____ Other: _____

Family History

Has any **blood relative** had any of the following:

Yes	No	?		Yes	No	?		Yes	No	?	
☐	☐	☐	Anemia	☐	☐	☐	Hay fever	☐	☐	☐	Arthritis
☐	☐	☐	Heart Attack	☐	☐	☐	Asthma	☐	☐	☐	Diabetes
☐	☐	☐	Stroke	☐	☐	☐	Bleeding (easily)	☐	☐	☐	Seizure/Epilepsy
☐	☐	☐	Eczema	☐	☐	☐	Glaucoma	☐	☐	☐	High Blood Pressure
☐	☐	☐	Tuberculosis	☐	☐	☐	Thyroid Issues	☐	☐	☐	Mental Disorder
☐	☐	☐	Cancer (type: _____)								

Other: _____ Other: _____

	Age (if alive)	Age(at death)	Health Problems
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Maternal			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunts/Uncles	_____	_____	_____
Paternal			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunts/Uncles	_____	_____	_____

Female Health

Age at onset of menstruation: _____ Date of last menstruation: _____ Period every _____ days

Do you have the following (check all that apply):

□ Heavy periods	□ Irregularities	□ Spotting Pain	□ Discharge	□ Blood in the urine
□ Hot flashes	□ Night sweats	□ Bloating	□ Irritability	□ Menstrual pain
□ Lumps	□ Nipple discharge	□ Breast tenderness	□ Libido (sex drive) High/low/normal	
□ Bladder, kidney or urinary tract infections		□ Problems with control of urination		

Number of pregnancies: _____ Number of live births _____
Miscarriages _____ Abortions _____ Stillbirths _____

Do you perform self breast exams? □ Yes □ No

Sleep & Stress

On average, how many hours a day do you sleep? _____ What time do you typically go to bed? _____
What time do you go to bed? _____ Do you fall asleep easily? _____ Do you stay asleep easily? _____

How much effort are you willing to put into your health? 1 2 3 4 5 6 7 8 9 10 (10= maximum effort)

Stress:
Please list the three most significant, stressful events in your life, from the most recent to the most distant. Include the stressful event, date and how it is still impacting you (if it is).

1. _____
   _____
2. _____
   _____
3. _____
   _____

What is the level of stress you are currently experiencing in your life? 1 2 3 4 5 6 7 8 9 10 (high)

How do you manage stress? _____

Nutrition

Please list the foods that you typically eat for each meal. Option 1 being the foods you eat most frequently for that meal, Option 2 the next most frequent, etc. Include details such as if you put sugar or creamer in your coffee, what kind of salad dressing you choose, how the chicken is prepared (fried, grilled, poached, etc).

BREAKFAST time typically eaten: _____ where typically eaten: _____

Option 1: _____

Option 2: _____

Option 3: _____

Do you feel better or worse with any of the above meal choices? If so which one? _____

LUNCH time typically eaten: _____ where typically eaten: _____

Option 1: _____

Option 2: _____

Option 3: _____

Do you feel better or worse with any of the above meal choices? If so which one? _____

DINNER time typically eaten: _____ where typically eaten: _____

Option 1: _____

Option 2: _____

Option 3: _____

Do you feel better or worse with any of the above meal choices? If so which one? _____

MORNING SNACK time typically eaten: _____ where typically eaten: _____

Option 1: _____

Option 2: _____

Option 3: _____

Do you feel better or worse with any of the above meal choices? If so which one? _____

AFTERNOON SNACK time typically eaten: _____ where typically eaten: _____

Option 1: _____

Option 2: _____

Option 3: _____

Do you feel better or worse with any of the above meal choices? If so which one? _____

Do you have any known food allergies or sensitivities? If so, please list food and reaction. _____

_____

Do you follow any particular diet philosophy (vegan, paleo, etc)? If so which one _____

What is your weight loss/dieting history (for example, has weight loss been a non-issue or a lifelong struggle, what diets have you tried in the past and what were the results, have you/do you have an eating disorder, etc)

_____

_____

_____

_____

_____