Waterdown Village Chiropractic & Wellness Group

255 Dundas Street East
Unit #14A
Waterdown, ON L8B 0E5
T 905·689·4440
F 905·689·4441
E info@wvchirogroup.ca

wvchirogroup.ca

Naturopathic – Acupuncture

File #: _____

Date: _____

General Information

How do you wish to be addressed in our office?

☐ First name ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

How do you wish to be contacted by our office regarding your appointments?

☐ Email ☐ Phone

Last Name: _____ **D.O.B.** _____

First Name: _____ **Sex:** ☐ M ☐ F

Address: _____

Town/City: _____ **Province:** _____ **Postal Code:** _____

Home Phone: ( ) _____ **Cell Phone: ( )** _____

Email: _____ _____ **Consent to receive email communication from the clinic** **Please Initial**

Occupation: _____ **Spouse's name (if applicable):** _____

Children: Y N **Number:** _____ **Ages:** _____

(Females) Are you pregnant? Y N **How many weeks?** _____ **Estimated Due Date:** _____

Family Dr. Name: _____ **Phone: ( )** _____

Previous Wellness Care? (check all that apply)

☐ Chiropractic ☐ Physiotherapy ☐ Naturopathy ☐ Massage Therapy ☐ Osteopathy

Location: _____

Referred by: _____

How did you decide to choose our office? _____

Reason for consulting the office:

- ☐ I have a specific problem and require help only with this problem.
- ☐ After my specific problem has been relieved, I am interested in strategies for maintenance.
- ☐ After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.
- ☐ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

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Medical Information

Please list any current prescription or over-the-counter medications (please include contraceptives/birth control, pain relievers, digestive aids etc. here)

1. _____
Reason **Duration of use**

2. _____
Reason **Duration of use**

3. _____
Reason **Duration of use**

4. _____
Reason **Duration of use**

Current Supplements (multivitamin, herbs, vitamins, minerals, etc.)

Supplement & Brand Name	Dose/Amount	Reason	Duration of use

Please list any current or past illnesses, surgeries, or conditions:

1. _____
Diagnosis Date

2. _____
Diagnosis Date

3. _____
Diagnosis Date

4. _____
Diagnosis Date

5. _____
Diagnosis Date

Please list any other therapies or practitioners you are seeing for your health concern (e.g. chiropractor, osteopath, physiotherapist, etc.)

1. _____

2. _____

3. _____

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Chief Health Concerns

Please list the reasons, in order of importance, you are seeking acupuncture treatment(s).

1. _____

2. _____

3. _____

4. _____

5. _____

Current Health

How would you describe your current state of health? (check one)
□ Excellent □ Very Good □ Average □ Fair □ Poor

Do you eat regular meals and/or snacks? □ Yes □ No
Do you consume caffeine? □ Yes □ No

SLEEP
How many hours of sleep do you get nightly? _____
Do you have trouble falling asleep? □ Yes □ No
Do you wake during the night? □ Yes □ No
Do you wake feeling refreshed? □ Yes □ No

BOWEL MOVEMENTS (BM)
How many BM do you have a day? _____
Do you experience difficulty passing a BM? □ Yes □ No
Do you take anything to assist your bowels? □ Yes □ No
Have you noticed blood in your stool? □ Yes □ No
Have you noticed mucus in your stool? □ Yes □ No
Have you noticed undigested food in your stool? □ Yes □ No

PAIN (complete ONLY if applicable)
Check the areas of your body that are painful.

□ Neck
□ Shoulders
□ Upper Back
□ Lower Back
□ Small joints (wrists, fingers, ankles)
□ Large joints (elbows, hips, knees)

Have you been diagnosed with arthritis or an arthritis related

Do you smoke cigarettes □ Yes □ No

Do you drink alcohol □ Yes □ No
(Please check) □ 0-5 drinks/week
□ 5-10 drinks/week
□ 10+ drinks/week

Do you use recreational drugs?
(i.e. marijuana, cocaine, etc…)
□ Yes □No

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condition? □ Yes □ No
****FOR WOMEN****
MENSTRUAL CYCLE

Date of last menstrual cycle: _____

How long is your menstrual cycle? _____ days

How many days of flow/bleeding? _____ days

Please circle any of the following that apply to you:

Cramping Clots Bloating

Breast tenderness Irritability Weepiness

Swelling Constipation Loose stools

Depression

PREGNANCY HISTORY

Number of pregnancies? _____

Number of live births?_____

Number of miscarriages? _____

Number of abortions? _____

Please circle any of the following in your history:

In vitro fertilization or medical fertility treatments

C-section Epidural Antibiotics during birth

Vacuum delivery Forceps delivery

Please list any pregnancy or birth-related complications
_____
_____
_____
_____

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INFORMED CONSENT TO NATUROPATHIC CARE

Our Naturopathic Doctors (NDs) assess you as a *whole* person by taking into consideration your physical, mental, and emotional health. Gentle, non-invasive medicines, including acupuncture, are used in order to treat the underlying causes of your illness & disease, while promoting and supporting your healing process. Our Naturopathic Doctors use a variety of therapeutic approaches, either alone, or in combination.

It is very important you inform your Naturopathic Doctor of any diseases you are suffering from, any known allergies you have, and any prescriptions medications or over the counter drugs you are currently taking.

Please advise your Naturopathic Doctor if you are pregnant, suspect you are pregnant, or if you are breastfeeding, as your treatment plan may change in these stages of life. As a patient of Naturopathic Medicine, you will receive information about your diagnosis, your treatment, and alternative courses of action. You will also be advised of the expected benefits, risks, side effects, and consequences of not acting upon your diagnosis or treatment.

There are some slight health risks associated with acupuncture treatment. These include, but are not limited to:

- Pain or bruising
- Vasovagal response (feeling faint or dizzy)
- Organ puncture (with deep needling)

I, _____ *(please print name)* understand that the form of medical care I will be receiving is based on Naturopathic principles and practices. I hereby acknowledge that I have been informed and understand the recommended diagnostic and therapeutic procedure(s)/plan and have discussed them with my Naturopathic Doctor to my satisfaction. I also recognize that even the gentlest forms of therapies have potential side effects, and I release my Naturopathic Doctor from any responsibility of side effects. I acknowledge and confirm I have been informed of the diagnostic/therapeutic procedures with respect to potential risks and side effects, expected benefits, financial costs, and the likely consequences of not having/following the provided recommendations and what alternative course(s) of action are available to me.

I also acknowledge that:
1.) Any treatment or advice provided to me as a patient of Naturopathic Medicine is not mutually exclusive of any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider;
2.) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider qualified to practice in Ontario;
3.) My Naturopathic Doctor. has not suggested or recommended to me to refrain from seeking or following the advice of another licensed health care provider;
4.) The treatment and therapies rendered or recommended by my Naturopathic Doctor may be different from those usually offered by a medical doctor or other licensed health care provider.

I acknowledge that full payment is required at the time services are provided or supplements are purchased.

File #: _____

CANCELLATION POLICY

While the clinic does provide regular appointment reminders, I acknowledge that I am responsible for my attendance and that 24 hours' notice is required should I wish to cancel or reschedule my appointment. If less than 24 hours' notice is given, or if I fail to show for my scheduled appointment, I understand that one of the following charges will be applied to my account:

- ☐ **A cancellation fee of $25.00** should I cancel an appointment with less than 24 hours' notice
- ☐ **A full appointment** fee should I not show for my scheduled appointment without notice

Please initial to confirm that you have read the cancellation policy and agree to pay any outstanding balances owing. _____ **(Initial Here)**

I declare that my Naturopathic Doctor has explained, to the best of her ability, the treatment or services that I may receive and hereby authorize and consent to treatment.

I intend this consent to apply to all my present and future naturopathic treatments.

Patient Name (print): _____ Date:_____

Signature: _____

Parent/Guardian Signature (if under 16 years old): _____