Naturopathic – Adult

File #: _____

Date: _____

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

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? Email ☐ Phone ☐

Last name:_____ **First name:**_____

Date of birth (D/M/Y):_____

Address:_____

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

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

Email:_____ _____ Initial here to consent to email communication from the clinic

How would you describe your gender identity?_____

Gender at birth: ☐ M ☐ F

Occupation:_____

Children: ☐ Y ☐ N **Number and ages of children:**_____

Are you pregnant? ☐ Y ☐ N **How many weeks?**_____

Are you breastfeeding? ☐ Y ☐ N

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

Previous Naturopathic Care? ☐ Y ☐ N **If Yes, ND's name**:_____

How did you hear about us?_____

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 to insure the problem does not return.
☐ After my specific problem has been resolved and I understand methods to insure 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.

File #: _____

Medical Information

Please list any current prescription or over the counter medication, including contraceptives/birth control or fertility medications

Medication name	Dosage	Reason	Duration of use

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

Supp. and brand name	Dosage	Reason	Duration of use

Please list any current or past illnesses, surgeries or conditions, include diagnosis date:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any known or suspected food or environmental allergies/sensitivities:

1. _____
2. _____
3. _____

File #: _____

Number of antibiotic prescriptions in the past year (please check): ☐ 0 ☐ 1-4 ☐ 5-9 ☐ 10+

Number of antibiotic prescriptions in the past 5 years (please check): ☐ 0 ☐ 1-4 ☐ 5-9 ☐ 10+

Family History

Has anyone in your family been diagnosed with any of the following conditions?

☐ Alcoholism	☐ Diabetes	☐ Heart disease	☐ Multiple Sclerosis	☐ Alzheimer's disease
☐ Drug abuse	☐ High blood cholesterol	☐ Osteoporosis	☐ Asthma	☐ Eczema
☐ High blood pressure	☐ Osteoarthritis	☐ Cancer	☐ Epilepsy	☐ Kidney disease
☐ Psoriasis	☐ Depression	☐ Fibromyalgia	☐ Mental illness	☐ Thyroid disorder

Please list any other illnesses of your relatives, such as parents, siblings, grandparents, aunts and uncles:

_____

_____

Chief Health Concerns

Please list, in order of importance to you, the areas of your health you would like me to help you address:

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

Current Health

How would you describe your current state of health? (check one)

☐ Excellent ☐ Very Good ☐ Average ☐ Fair ☐ Poor

How many times per week do you engage in physical activity?_____

Do you eat regular meals and/or snacks? ☐ Y ☐ N

Do you consume caffeine? ☐ Y ☐ N

File #: _____

Please check any of the following that are sources of caffeine for you:

☐ Coffee ☐ Tea ☐ Chocolate ☐ Cola

Sleep

How many hours of sleep do you get nightly?_____

Do you have trouble falling asleep? ☐ Y ☐ N

Do you wake during the night? ☐ Y ☐ N

Do you wake feeling refreshed? ☐ Y ☐ N

Bowel Movements (BM)

How many BMs do you have a day?_____

Do you experience difficulty passing a BM? ☐ Y ☐ N

Do you take anything to assist your bowels? ☐ Y ☐ N

Have you noticed blood in your stool? ☐ Y ☐ N

Have you noticed mucus in your stool? ☐ Y ☐ N

Have you noticed undigested food in your stool? ☐ Y ☐ N

Daily Diet Summary

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Drinks:_____

Energy

On a scale of 1-10 (10 being the MOST energetic), how would you rate your energy level?_____

Does your energy fluctuate during the course of a day? ☐ Y ☐ N

Mood

How would you describe your general mood?_____

Have you ever been concerned about your moods? ☐ Y ☐ N

Stress (10 = most stressful)

File #: _____

On a scale of 1-10 how would you rate your stress level at home?_____

On a scale of 1-10 how would you rate your stress level at work?_____

Do you feel you are able to manage your stress? ☐ Y ☐ N

Do you smoke cigarettes? ☐ Y ☐ N

Do you drink alcohol? ☐ Y ☐ N

If yes, how much?

☐ 0-5 drinks/week ☐ 5-10 drinks/week ☐ 10+ drinks/week ☐ 0-5 drinks/month ☐ 5-10 drinks/month

☐ 10+ drinks/month

Do you use recreational drugs? (ie. Marijuana, cocaine etc.) ☐ Y ☐ N

If yes, how often?_____

****FOR WOMEN****

Menstrual Cycle

Date of last menstrual cycle_____

How many days between each menstrual cycle?_____ days

How many days of flow/bleeding?_____ days

Please check any of the following that are applicable before/during your period:

☐ Cramping ☐ Clots ☐ Bloating ☐ Breast tenderness ☐ Irritability ☐ Weepiness

☐ Swelling ☐ Constipation ☐ Diarrhea ☐ Depression

Pregnancy History

Number of pregnancies_____ Number of miscarriages_____

Number of live births_____ Number of abortions_____

Please check any of the following in your history:

☐ In vitro fertilization/medical fertility treatments ☐ C-section ☐ Epidural ☐ Antibiotics during birth

☐ Vacuum delivery ☐ Forceps delivery

Please list any pregnancy or birth related complications:

_____

_____

File #: _____

INFORMED CONSENT TO NATUROPATHIC CARE

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors (ND's) assess the whole person by taking into consideration the physical, mental and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to promote healing. ND's use a variety of therapeutic approaches, either alone, or in combination. These approaches include nutritional and lifestyle counselling, nutritional supplementation, Traditional Chinese Medicine (TCM) and acupuncture, botanical medicine, homeopathy, hydrotherapy and physical medicine. Your ND will take a thorough health history, perform screening physical examinations and request laboratory testing when necessary.

It is very important that you inform your ND of any disease you are suffering from, any known allergies you have, and any medications or over-the-counter drugs you are currently taking. Please advise your ND if you are pregnant, suspect you are pregnant, or if you are breastfeeding. As a patient, you will receive information about your diagnosis, your treatment, and alternative courses of action. You will also be advised of the material effects, costs, expected benefits, risks, side effects, and consequences of not acting upon your diagnosis or treatment.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- An allergic reaction to a supplement and/or herb
- A worsening or aggravation of symptoms with homeopathic medicine. The duration is usually short and self-limiting
- Pain, bruising, or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles

STATEMENT OF ACKNOWLEDGEMENT

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 ND to my satisfaction. I also recognize that even the gentlest forms of therapies have potential side effects and I release my ND from any responsibility or 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 understand that this record will be kept confidential and will not be released to others unless so directed by myself or unless required by law. If seeing more than one practitioner at Waterdown Village Chiropractic and Wellness Group, I imply consent for them to share and discuss my file as deemed necessary by the practitioners to ensure that I receive the most appropriate care for my condition.

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 ND 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 ND may be different from those usually offered by a medical doctor or other licensed health care provider.
5. I acknowledge that full payment is required at the time services are provided or supplements are purchased.

File #: _____

I declare that my ND 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):_____

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)**