

File #: _____

Date: _____

General Information

Last Name: _____ D.O.B. _____

First Name: _____

How do you wish to be addressed in our office? (First Name, Mr., Mrs., Dr., Nickname, Etc...)

Identify as? M F Other: _____ Sex at birth: M F

Address: _____

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

Home Phone: _____ Cell Phone: _____

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

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

Email Phone

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: _____

Current / Previous Wellness Care? (check all that apply)

Chiropractic Physiotherapy Naturopathy Massage Therapy Osteopathy

Location: _____

How did you hear about us? (referral, ad, Google) _____

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.

Naturopathic Adult

File #: _____

Date: _____

Medical Information

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

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 known or suspected food or environmental allergies/sensitivities:

1. _____
2. _____
3. _____

Date and type of last vaccinations: _____

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 +

#: _____

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?

Excellent Very Good Average Poor

How many times per week do you engage in physical activity? Not including a physical job.

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

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? 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

ENERGY

How would you rate your energy level on a scale of 1 to 10? (10 being the MOST energetic)

Does your energy fluctuate during the course of a day? Yes No

MOOD

How would you describe your general moods?

Have you ever been concerned about your moods? Yes No

STRESS

On a scale of 1-10 (10 = most stressful) how would you rate your stress level:

At home? _____ At work? _____

Do you feel you are able to manage your stress?
 Yes No

DAILY DIET SUMMARY

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Preferences: (keto, paleo, vegan, gluten-free)

#: _____

Do/did you smoke cigarettes? Yes No Date quit: _____

Do/did you vape? Yes No Date quit: _____

Do you drink alcohol Yes No

If yes, how much 0-5 drinks: week month

5-10 drinks: week month

10+ drinks: week month

Do/did you use CBD oil? Yes No Date quit: _____

Do you use recreational drugs? (For example, marijuana, cocaine, etc...)

Yes No 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 you experience before/during your period:

- | | | | |
|-------------------|--------------|-----------|--------------|
| Cramping | Clots | Bloating | Swelling |
| Breast tenderness | Irritability | Weepiness | Constipation |
| Diarrhea | Depression | | |

Date of last bloodwork? _____

Have you received the HPV Vaccine? Yes No

Date of last pap? _____

Date of last breast exam: _____

PREGNANCY HISTORY

Number of pregnancies _____

Number of live births? _____

Number of miscarriages? _____

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: _____

Do / did you breastfeed? Yes No Duration of breastfeeding? _____

#: _____



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INFORMED CONSENT TO NATUROPATHIC CARE

A worsening or aggravation of symptoms with homeopathic Naturopathic Medicine is the treatment and prevention of diseases with natural medicines. Our Naturopathic Doctors (NDs) assess you as a *whole* person by taking into consideration your physical, mental, and emotional health. Gentle, non-invasive medicines 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.

These therapeutic approaches include nutritional and lifestyle counseling, nutritional supplementation, Traditional Chinese Medicine (TCM) and acupuncture, botanical medicine, homeopathy, hydrotherapy B12 injections, and physical medicine. Your Naturopathic Doctor will take a thorough health history, perform a screening physical examination if needed, and request laboratory testing when necessary.

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 treatment in naturopathic medicine. These include, but are not limited to:

An adverse reaction to a supplement and/or herb

An aggravation of symptoms with homeopathic medicine. The duration is usually short and self-limiting.

Discomfort or bruising with acupuncture.

I, _____ **(please type/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.

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: _____

(Typed name/signature implies consent)

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