HEALTH HISTORY FORM

How did you hear about our clinic?
Yellow Pages _____Website _____Our sign_____ Facebook_____Other?_____
Family/Friend/Co-Worker___ WHO?_____
Permission to acknowledge the person who referred you_____(Initials)

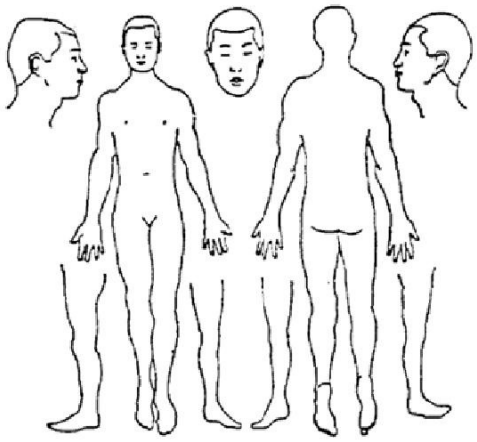
Name:_____ Date:_____
Address:_____ Telephone:(Home)_____
City:_____ Postal Code:_____ (Cell)_____
(Work)_____
Occupation:_____ Company:_____
Email Address:_____ Date of Birth(mm/dd/yy)_____
Emergency Contact:_____ Telephone:_____
Do you have Extended Health Care Insurance Coverage for Naturopathy? Yes No

Doctor's Name:_____ Telephone #:_____
Permission to consult with your Doctor: Yes No Initials:_____

Primary Complaint?_____ Aggravates/Relieves?_____
Have you seen a Doctor for this problem? Yes No When?_____
Overall, how is your general health?_____

Health Goals

What are your health concerns and goals, in order of importance to you:

Please list most important health concerns and goals in their order of significance:	Prior diagnosis of this problem? If so, what?	**Indicate Painful or distressed areas:**
1.		
2.		
3.		
4.		
5.		

Please indicate conditions you are experiencing or have experienced:

Respiratory
- Chronic Cough
- Shortness of Breath
- Sinus Problems
- Emphysema
- Asthma
- Allergies
- Other_____

Cardiovascular
- High/Low Blood Pressure
- Blood Clots
- Heart Disease/Heart Failure
- Myocardial Infarction
- Stroke/CVA
- Pacemaker or similar device
- Other_____

Digestive
- Constipation/Diarrhea
- Gas/Bloating
- IBS
- Other_____

Nervous System
- Herpes/Shingles
- Numbness/Tingling

  Where?_____
- Chronic Pain
- Loss of Sensation

  Where?_____
- Other_____

Musculo-Skeletal
- Bone or Joint Disease
- Arthritis-Type_____
- Family Hx:_____
- Tendonitis
- Bursitis
- Sprains/Strains
- Low back/Hip/Leg pain
- Neck/Shoulder/Arm pain
- Jaw Pain/TMJ
- Other:_____

Reproductive
- Pregnant
- Due Date:_____
- Gynaecological:_____

Infections:
- Allergies- _____
- TB
- HIV/AIDS
- Other:_____
- Eczema/Psoriasis

Skin
- Bruise Easily
- Allergy to creams/lotions
- Athletes Foot
- Warts
- CFS/Fibromyalgia
- Other:_____
- Cancer-_____

Other
- Hepatitis
- Depression
- Diabetes-Type_____
- Vision/Hearing Loss
- Headaches/Migraines
- Epilepsy
- Kidney Disease _____
- Other:_____

Personal and Family History

Please check the "yes" box next to each condition that applies to you and/or one of your family members. Please circle all who the condition applies to: "**Self**" if it relates to you and/or Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**), your child (**C**). Please circle **Past** if the condition is resolved, or **Current** if it is on-going and current

	Yes (□)	Relation Please circle	Dates Resolved		Yes (□)	Relation Please circle	Dates Resolved
Alcoholism/Drug Addiction		Self F M S G C	Past Current	High Blood pressure		Self F M S G C	Past Current
Allergies		Self F M S G C	Past Current	Heart Disease		Self F M S G C	Past Current
Anemia		Self F M S G C	Past Current	Hepatitis		Self F M S G C	Past Current
Arthritis		Self F M S G C	Past Current	Headaches		Self F M S G C	Past Current
Asthma		Self F M S G C	Past Current	Kidney disease		Self F M S G C	Past Current
Cancer		Self F M S G C	Past Current	Stroke		Self F M S G C	Past Current
Diabetes		Self F M S G C	Past Current	Tuberculosis		Self F M S G C	Past Current
Eczema		Self F M S G C	Past Current	Osteoporosis		Self F M S G C	Past Current
Epilepsy		Self F M S G C	Past Current	Others:		Self F M S G C	Past Current
Depression/other Mental Illness		Self F M S G C	Past Current				

□ I don't know my family medical history

Diet

Do you have any food allergies or intolerances? Please list.

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

Environment

Occupation _____
Hobbies_____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____
_____
_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N Are you frequently exposed to animals (work, pets, etc.)? Y / N
How is your home heated?_____

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

_____
_____

Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)? _____

How would you describe the emotional climate of your home?

_____
_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____
_____

Is there anything that you feel is important that has not been covered?

_____
_____
_____

Please turn over and complete other side⇒

Current Medications, Vitamins, Herbal Remedies & Conditions they treat:

Name:_____ Condition:_____
Name:_____ Condition:_____
Name:_____ Condition:_____
Name:_____ Condition:_____

Surgeries and Approximate Date:
Surgery:_____ Date:_____
Surgery:_____ Date:_____
Surgery:_____ Date:_____

Motor Vehicle Accidents and Date
Accident & Injuries:_____ Date:_____
Accident & Injuries:_____ Date:_____

Other Accidents and Injuries:_____ Date:_____
Presence of Internal Pins, Wires, Artificial Joints, Special Equipment, Etc.:_____

Other Therapies (Massage Therapy, Chiropractic, Physiotherapy
etc.):_____

Do you have any other conditions not listed or is there anything about yourself you feel would be important for your naturopathic doctor to know:_____

Consent Form: Naturopathic medicine focuses on treatment and prevention of diseases by natural means. Gentle, noninvasive techniques are generally used in order to promote healing. 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, expected benefits, risks, side effects, and consequences of not acting upon your diagnosis or treatment.
There are some slight risks associated with treatment by naturopathic therapies. These include but are not limited to:

- Some patients may experience allergic reactions to some supplements and herbs.
- Pain, bruising from acupuncture.

Your ND will explain risks associated with the treatment with you when these exist.
I UNDERSTAND:

- Any treatment or advice provided to me as a patient of the clinic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider.
- I am at liberty to seek or continue medical care from a medical doctor or other healthcare provider licensed to practice in Ontario.
- My naturopathic doctor does not guarantee treatment results.
- No part of my treatment or testing is covered by OHIP. I am solely responsible for payment at the time of each visit or treatment.
- I am free to withdraw my consent and to discontinue treatment at any time. I declare that I have received a full and complete explanation of all of the treatments and services offered by my Naturopathic Doctor and hereby authorize and consent to treatments by Dr.Sunil Mam,ND_____ _____ _____

Signature:_____ **Date:**_____
Parent/Guardian Signature:_____ **Date:**_____
(if under 16 years of age)

Cancellation Policy: There is a $25.00 charge for the first missed appointment, or appointments cancelled with less than 24 hours notice. There will be a full treatment charge for the 2nd and subsequent missed appointments. The 30-60 min. time slot is reserved specifically for you. If you are unable to keep your appointment please notify the office at least 24 hours before your appointment to enable others to attend a treatment. If you are receiving treatment resulting from an automobile accident that is covered by an insurance claim, any missed appointments will be billed to you personally.
Signature:_____ **Date:**_____