NATUROPATHIC TREATMENT FORM

Please complete this form as thoroughly as possible. The information provided is confidential. The completed form is required prior to your naturopathic appointment.

Name: Date of birth: Today's Date:

Address:_____

_____ Apt # _____ Postal Code _____

Telephone: ( )_____(H) ( )_____(B) ( )_____(C)

Email: _____

Occupation:_____

How did you hear about us? Please specify: _____

Have you ever seen a naturopathic doctor before? _____ Yes _____ No

If so, name of previous naturopath: _____

When was your last visit?_____

Briefly describe your experience:

_____

_____

_____

Please list your health concerns that you want us to address:

Health Concern **How long have you had this condition?**

_____

_____

_____

_____

_____

_____

_____

_____

YOUR HEALTHCARE TEAM		
Please list all healthcare practitioners who help treat you:		
Name	Type of practitioner (eg. family doctor, cousellor, acupuncturist, RMT)	Phone and fax number
		Phone: Fax
		Phone: Fax:
		Phone: Fax:

MEDICATION YOU ARE CURRENTLY TAKING			
Name/ brand/ type	Dose	For what condition	Since when
PAST MEDICATION			
Name/ brand/ type	Dose	For what condition	For how long?

NATURAL HEALTH PRODUCTS YOU ARE CURRENTLY TAKING			
Product/ brand	Dose	Reason	Since when

MEDICAL HISTORY		
Have you ever been hospitalized/ had surgery?		
Date:	Reason	Problems experienced since

For each item, please circle or check (√) symptoms that you are experiencing or have experienced. Also include when you last had that symptom and any additional information.

SKIN			
Rashes/ eczema/ hives/ itching		Hair changes (colour, shine, loss)	
Acne/ boils/ bumps/ lumps		Nail changes (shape, strength, thickness)	
Excess dryness/ moistness		Temperature/ Night sweats	
Colour change/ mole changes		Skin ulcers/ Skin cancer	
Have you ever had a complete skin exam?		Date:	
HEAD			
Headache		Problems with jaw joint? (TMJ)	
Head injury		Dizziness	
Have you ever had an MRI, CT Scan etc?		Date: Result:	
EYES			
Impaired vision/ double vision/ blurring		Floaters/ Blindspot	
Glasses/ contact lenses		Sensitive to sunlight	
Eye pain/ itching/ discharge		Excess tearing/ dryness/ redness	
Glaucoma/ cataracts			
When did you last visit your eye doctor?		Do you use eye drops, artificial tears or other eye products?	
EARS			
Ringing		Ruptured ear drum	
Impaired hearing/ hearing aid/ Ear tubes		Excess ear wax / Discharge	
Earache/ Infection		Do you use Q-tips?	
NOSE AND SINUSES			
Frequent colds/ stuffiness		Sinus problems	
Nose bleeds		Sensitive to smells	
Allergies/ hay fever		Change in ability to taste	
MOUTH, THROAT AND NECK			
Frequent sore throat/ hoarseness		Lumps/ swollen glands in neck	
Sore or dry tongue/ mouth		Thyroid problems/ goiter	
Gum problems/ bleeding		Pain/ stiffness in neck	
How often do you brush? How often do you floss?		Dental cavities How many? What type of filling?	
When was your last visit to the dentist?			
RESPIRATORY			
Cough/ wheezing		Shortness of breath at night/ apnea	
Sputum/ mucous		Bronchitis/ Pneumonia	
Spitting up blood		Pleurisy (inflammation of lungs)	
Asthma		Emphysema	
Pain/ difficulty on breathing/ Shortness of breath		Tuberculosis	
Do you / have you smoke(d)?		How long? How many?	
Tuberculin test		Date: Test result:	
Date of last chest x-ray			

CARDIOVASCULAR			
Heart disease		High blood cholesterol	
Angina/ chest pain		Rheumatic fever	
High blood pressure		Swelling in ankles	
Murmur/ irregular heart beat/ palpitations/ fluttering		Cyanosis (blueness)	
Past ECG/ Stress test/ other imaging		Date: Result:	
BREASTS			
Lumps/ skin puckering		Nipple discharge/ changes	
Pain or tenderness		Implants/ reduction/ surgery	
Have you ever breast fed? Any problems breast feeding?		Do you do self exams? How often?	
Is there is history of breast cancer in your family?			
GASTROINTESTINAL			
Heartburn/ acid reflux		Belching/ passing gas	
Trouble swallowing		Offensive breath/ bad taste in mouth	
Changes in appetite/ thirst		Bloating/ abdominal pain	
Nausea/ vomiting		Yellow skin	
Vomiting blood		Hernia	
How often are your bowel movements?		Is this a change?	
Blood/ mucous/ undigested food in stool		Indigestion	
Liver disease/ hepatitis		Diarrhea/ constipation	
Gall bladder disease/ stones/ removal		Rectal bleeding/ hemorrhoids	
Ulcer		Black tarry stool	
Food allergies/ sensitivities		Please list offending foods:	

How is your appetite?

a) I'm hungry all the time and can't seem to satisfy my hunger (regular meals aren't enough)
b) It seems normal to me (eat regular meals)
c) I'm not often hungry and I sometimes have to force myself to eat (can easily skip meals)

How is your thirst?

a) I've noticed an increased thirst that I can't satisfy (drink a lot of fluids throughout the day)
b) It seems normal to me (drink fluids throughout the day)
c) I'm not usually thirsty (I forget to drink fluids)

What food restrictions do you have?

Do you have any food cravings?
Please list the foods that you crave most: What affects your food cravings?

How much water do you drink? (do not include caffeinated drinks or alcohol)

Do you drink tea, coffee, or pop? How much?

Do you drink alcohol? What kind? How much?

Please circle what additives/ condiments you use and check frequency of use:		
	Often (daily)	Sometimes (not everyday)
Salt	☐	☐
Butter / margarine	☐	☐
Sugar	☐	☐
Artificial sweetener	☐	☐
Mayonnaise	☐	☐
Soy sauce	☐	☐
Spice mixes	☐	☐
Other _____	☐	☐

Have you had any gastrointestinal surgeries/ tests?	Do you take antacids/ special digestive aids?

Is there a history of colorectal cancer in you family?

URINARY

Pain/ pressure/ blood with urination		Inability to hold urine/ incontinent	
Urgency/ hesitancy		Frequent urinary infections	
Increased frequency, day or night		Kidney problems (stones, infections)	

MALE REPRODUCTIVE

Testicular masses/ pain		Prostate problems	
When was last prostate exam?		Do you do testicular self-exams?	
Any sexual difficulties/ erectile dysfunction		Discharge/ sores	
Problems with sperm/ conceiving			

FEMALE REPRODUCTIVE

Age of first period		Average number of days of bleeding	
Length of cycle (# of days from first day of period to day before next period)			
Bleeding between periods/ Irregular cycles/ excess flow		Endometriosis	
Ovarian cysts		Hormonal birth control	
Sexual difficulties/ pain during intercourse			
Number of pregnancies		Number of miscarriages/ abortions	
Number of live births		Difficulties conceiving	
Menopause at what age?		Yeast/ candida infections	
Hot flashes/ dryness/ other problems with menopause		Cervical cancer/ abnormal PAP results	
Hormonal therapy for menopause		Vaginal itching/ redness	
PMS (circle those that apply) a) Cramps/ muscle achiness b) cravings c) mood changes d) water retention/ bloating e) tender breasts f) other:		Vaginal discharge (circle those that apply) a) clear fluid b) white c) thick or sticky d) greenish/ yellow e) grey f) strong odour (fishy)	
Date of last PAP		Result	

MALE AND FEMALE SEXUAL

Are you sexually active?		
Age of first sexual encounter		
Do you use barrier contraception?	What type?	
Sexually transmitted disease		
Sexual orientation		

MUSCULOSKELETAL			
Joint pain or stiffness/ swelling/Arthritis		Muscle weakness/ spasms/ cramps	
Bone fractures		Back pain	
Sciatica		Have you ever had a bone density test?	
History of injury/ accidents			
PERIPHERAL VASCULAR			
Cold hands/ feet		Vein pain (thrombophlebitis)	
Varicose veins		Extremity numbness/ swelling/ pain/ ulcers	
Deep leg pain/ leg cramps			
NEUROLOGIC			
Fainting / loss of balance		Numbness or tingling	
Seizures/ convulsions/ involuntary movement		Speech problems/ slurring	
Paralysis		Loss of memory	
ENDOCRINE			
Sensitive to heat or cold		Diabetes	
Thyroid problems		Hypoglycemia (low blood sugar)	
Excessive thirst/ hunger		Hormone/ steroid therapy	
Excessive urination/ sweating			
BLOOD/ LYMPHATIC			
Anemia		Lymph node swelling	
Easy bleeding/ bruising		Hemophilia/ clotting problems	
Blood transfusions		What is your blood type?	
ALLERGIES			
Any reactions to vaccines?		Drug sensitivities	
Please list all allergies			
MENTAL EMOTIONAL			
Mood swings		Depression	
Sleeping difficulties/ insomnia		Phobia	
Anxiety		Excess stress	
Have you experienced past trauma/ significant grief? Are you still affected by it today?			
Substance abuse		Have you been treated for substance abuse?	
Thoughts of suicides/ attempts			
Have you ever sought help or used medication to deal with personal problems?			
SLEEP			
How many hours do you usually sleep? How many hours of sleep do you *need*? If you have trouble sleeping, please circle all that apply a) I have problems **falling** asleep b) I have problems **staying** asleep. If so, what time(s) do you usually wake up? _____ c) I take medication or other substances to help me sleep			
Do you awake well rested?		Do you take naps during the day?	

Do you fall asleep during the day?		Do you talk/ walk in your sleep?	
Grind teeth while sleeping		Have vivid dreams	
Sleep apnea		Shift work	

ENERGY

How is your energy? (please choose one)

a) I have plenty of energy for work and for all my daily activities
b) I have enough energy during work, but feel tired for the rest of the day
c) I don't have enough energy for work or any other activities

What affects your energy level?

EXERCISE

How would you describe your daily activity level?

a) very active
b) moderately active
c) sedentary

Do you exercise regularly?	How frequently?
What kind?	How long?

FAMILY MEDICAL HISTORY

Has anyone in your family (siblings, parents, grandparents) had the following conditions?		Which member was affected by this condition	Age
Heart disease			
High blood pressure			
Diabetes/ blood sugar problems			
Asthma			
Allergies			
Cancer (breast, colon, lung, liver, skin, prostate etc)			
Psychiatric (depression, anxiety, addiction etc)			
Kidney problems			
Hormonal problems (thyroid, pituitary, estrogen, testosterone, adrenal (cortisol) etc)			
Congenital (birth)/ developmental problem			
Neurologic problems (eg. MS, parkinson's, Alzeimer's)			
Arthritis			
Digestive (Celiac's disease, Crohn's, Ulcerative colitis, Irritable Bowel Syndrome, Diverticulitis, Lactose intolerance, Gall stones etc)			
Other			

In case of emergency call:

Name: Relationship:

Phone:

Do you have any life threatening allergies (ie. anaphylaxis, medication)?

Medications:

Informed consent to Naturopathic Therapeutic Procedures

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors (ND) assess the whole person, taking into consideration physical, mental and emotional aspects of the individual.

A number of different approaches are used. Naturopathic Therapeutic procedures may include the following:

Lifestyle counseling: Lifestyle is considered relevant to most health problems. The naturopath will help you identify risk factors and make recommendations to help you optimize your physical, mental and emotional environment.

Nutrition: Individualized diets and nutritional supplements may be recommended to address deficiencies, treat disease processes and promote health.

Botanical Medicine: The use of plant based medicines and compounds to treat conditions.

Asian medicine: Includes the use of acupuncture, botanical formulas, dietary changes and other hands on therapies to balance body functions. Acupuncture treatments are performed using sterilized single-use needles.

Homeopathy: A form of medicine that originated from Europe. It is based on the energetics of minute doses of naturally derived substances that help the body expel disease and attain balance.

Physical medicine: Refers to the use of hands-on techniques, exercise and hydrotherapy (applications of hot and cold water)

Diagnostic tests: When appropriate, the naturopath may recommend tests. Some tests are carried out in-house. In some cases you may be referred to your medical doctor or other professional for additional tests.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, those with compromised immune functioning or those with multiple medications. Some therapies must be used with caution in certain conditions such as diabetes, heart, liver or kidney disease. Therefore, it is very important that you inform the ND immediately of any condition that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant or you are breast feeding, please advise the ND immediately.

There is the possibility of health risks from any medical treatment. In naturopathic medicine these may include, but are not limited to:

- Aggravation of a pre-existing condition
- Adverse reactions to supplements or herbs
- Pain, bruising or injury from acupuncture, injections or other administrated tests

I,_____, do hereby acknowledge and I have been informed of and understand the recommended naturopathic therapeutic procedures as listed above and have discussed with satisfaction this and any related information with the ND named below. I understand that the ND will answer my questions, to the best of her ability, regarding all therapeutic procedures with respect to financial costs, expected benefits, potential risks and side effects; the likely consequences of not having/ following the procedure(s)/ plan, and what alternative course(s) of action are available to me.

I further understand that Meera Dossa ND will keep a record of all health services provided to me at the clinic. This record will be kept confidential and will not be released to others unless so directed by myself or required by law.

As a result, I do hereby voluntarily consent to naturopathic treatments for my conditions from time to time. I understand that I may withdraw my consent at any time and in doing so I understand that I will not continue to receive naturopathic treatment.

Lastly, I understand that email is **only** used for the sending of attachments. I cannot be treated or diagnosed via phone or email. I understand that I must be assessed in person and **no** advice will be provided through any other form of transmission.

Patient/ lawful representative Print	Signature	Date
Naturopathic doctor Print	Signature	Date
Witness Signature*: Relation to patient: Date:		

*Witness signature is advised but not necessary