



Fish Creek Naturopathic Medicine

Patient-Centred Holistic Medicine

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (H): _____ (W): _____

(C): _____ Email: _____

Would you like receive our quarterly email newsletter? Y N

Occupation: _____ Employer: _____

How do you prefer we contact you with test results and to confirm appointments? _____

Please let us know who referred you to us or how you found our clinic: _____

Primary Health Concerns (in order of importance):

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Are there any traumatic events (surgeries, drug reactions, life trauma, major illnesses) that you feel may have caused, or contributed to your health problems?

What is the goal of your visit today?

Please list all former treatments that you have used (both conventional and alternative) and the degree of effectiveness of each treatment:

Are you currently pregnant? Yes No

Medical History: Have you had any of the following illnesses:

Rubella	Measles	Mumps
Chicken Pox	Whooping Cough	Rheumatic Fever
Roseola	Polio	Other: _____
Asthma	Scarlet Fever	_____

	Now	Past	Never		Now	Past	Never
Anemia				Heart Murmur			
Allergies				↑ Blood pres.			
Alcohol Abuse				Hyperthyroid			
Arthritis				Hyperglycemia			
Asthma				Hypothyroid			
Bleeding				Kidney Disease			
Cancer				Liver Disease			
Candida				Jaundice			
Colitis				Overweight			
Diabetes				Pneumonia			
Drug use				Rheumatism			
Eczema				Tuberculosis			
Emphysema				Ulcers			
Headache							

Please indicate any serious conditions, illnesses or injuries and any hospitalizations; along with approximate dates:

Medications/ Supplements: Please list all of your present medications including drugs, supplements, homeopathics and herbs along with dosages. (if possible, please bring containers in for your first visit)

Please list all past prescription medications:

How many times have you been treated with antibiotics? _____

Please list allergies & your symptoms with exposure to allergens:

Have you had any of the following allergy tests:

Intradermal	Food	Blood IgG
Scratch	Intolerance	Blood IgE
Muscle Testing	Testing	Inhalant/ Food
	(Elimination Diet)	

Do you frequently use any of the following:

Aspirin	Laxatives
Diet Pills	Antacids
Alcohol	How much per day/ week? _____
Tobacco	Form and amount/ day _____
Caffeine	Form and amount/ day _____
Recreational	Form and frequency _____

Drugs _____

Are you exposed to a significant amount of tobacco smoke, chemicals or solvents at home or at work? Yes No

Have you ever been exposed to any toxic chemicals, solvents or any other possible toxins? _____

Immunizations: (please indicate which immunizations you have had)

DPT	Hepatitis A
(diphtheria, pertussis, tetanus)	MMR

(measles, mumps, rubella)

Polio

Flu

Haemophilus Influenza

Hepatitis B

Smallpox

Tetanus (booster)

Other

Did any of the vaccinations cause adverse reactions? Please describe: _____

Family Doctor: _____ Phone: _____

AHC #: _____

Do you have regular check-ups? _____

When was your last annual exam? _____

When was your last blood test? _____

Have there been any abnormal test results? _____

Family History: Describe your family history using the following

designations: Mother=M, Maternal Grandmother=MGM, Maternal Granfather=MGF, Father=F, Paternal Grandfather=PGF, Paternal Grandmother=PGM, Brother=B, Sister=S

Please indicate if a close relative has had any of the following:

Condition	Who?	Condition	Who?
Allergies		Hay Fever	
Anemia		Heart Disease	
Arthritis		High Blood Pressure	
Asthma		Kidney Disease	
Bleeding		Seizure/ Epilepsy	
Cancer		Sickle cell anemia	
Diabetes		Stroke	
Depression		Thyroid (hyper/hypo)	
Drug/ Alcohol Abuse		Tuberculosis	
Eczema		STD	
Glaucoma		Mental health	

Below are groups of symptoms. Please identify any that you may have experienced in the last 6 months with an "R", those longer ago with a "P". Please also indicate number of times you have experienced them.

GENERALS:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Bleed/bruise easily | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Peculiar taste/smells | |
| <input type="checkbox"/> Sudden Energy Drop (time of day) _____ | | |

SKIN AND HAIR:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Non-healing wounds | |
| <input type="checkbox"/> Recent changes in moles | <input type="checkbox"/> Itching | <input type="checkbox"/> Other: _____ |

HEAD, EYES, EARS, NOSE AND THROAT:

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Colour blindness | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Tooth pain |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Mercury fillings |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Using glasses | <input type="checkbox"/> Sores on lip/tongue | <input type="checkbox"/> Facial pain |

CARDIOVASCULAR:

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blood clots | |

RESPIRATORY:

- | | | |
|---|--|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain with a deep breath | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Production of Phlegm | <input type="checkbox"/> Other |

GASTROINTESTINAL:

<input type="checkbox"/> Indigestion	<input type="checkbox"/> Abdominal pain /cramps	<input type="checkbox"/> Rectal pain
<input type="checkbox"/> Gas	<input type="checkbox"/> Nausea	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Constipation	<input type="checkbox"/> Laxative use	<input type="checkbox"/> Diarrhea

Bowel movements: _____ per day Formed / loose / hard

URINARY:

<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> Decrease in flow	<input type="checkbox"/> Impotency
<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Odd color/smell	<input type="checkbox"/> Sores on genitals
<input type="checkbox"/> Wake to urinate	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Other

GYNECOLOGICAL:

<input type="checkbox"/> Age of first menses	<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Heavy flow
<input type="checkbox"/> Duration of menses	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Light flow
<input type="checkbox"/> Days between menses	<input type="checkbox"/> Breast tenderness	
<input type="checkbox"/> Date of start of last menses	<input type="checkbox"/> Vaginal discharge	
<input type="checkbox"/> Date of last PAP	<input type="checkbox"/> Vaginal sores	

Are there changes in body or emotions prior to or during menstruation?
Describe: _____

Do you practice birth control? Y / N
What type of birth control and for how long? _____

Are you content with this method? _____
 Number of pregnancies Number of births Miscarriages
 Abortions

NEURO-PSYCHOLOGICAL:

<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Depression
<input type="checkbox"/> Poor memory	<input type="checkbox"/> Lack of co-ordination	<input type="checkbox"/> Anxiety

Have you ever been treated for psychological issues before? _____

Do you fear causing any harm to yourself or others? _____



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INFORMED CONSENT

We would like to take this opportunity to welcome you to Fish Creek Naturopathic Medicine. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. If you are working with a naturopathic doctor, a physical exam, specific blood and/or urinary laboratory reports may be used as part of the assessment. Any practitioner with whom you choose to work will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

As a patient of this clinic I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

PRINT NAME

DATE

(By typing your name in the blank you are agreeing to the above paragraphs)

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