

PLEASE READ FIRST

Dear New Patient,

Thank you for the confidence and commitment you are demonstrating through your decision to pursue Naturopathic health care. You only have one life and one body, so congratulations for taking a step towards health. The benefits of optimal health will be proportional to the efforts and dedication that you put into your daily choices. You have the option to feel better, live healthier, look and act younger and live longer. It is found that lasting improvements in one's health take place in the presence of heightened focus, dedication and education.

As Naturopaths, we commit to helping you achieve your health goals through consultation, laboratory testing and educational material.

Your careful consideration of each of the enclosed forms will enhance my efficiency and accuracy, and ensure that we get the most out of our consultation time. There is a lot of material to cover, so please leave yourself enough time. If you would like your package reviewed before your appointment, please drop it off at the office ahead of time, otherwise bring all the completed forms with you to your initial visit.

Please read and complete the materials in the order that you have received them in the package. If you need further clarification on any of the material in the package, please feel free to call the office at 886-4814 or email us at our contacts below

Thank you for your time, and we look forward to working with you to achieve your health goals.

Robin Walsh BSc, ND	robin@vibrant-living.ca
Kristijana Rakic BSc, ND	kristijana@vibrant-living.ca
Tina Rogers BSc, ND	tina@vibrant-living.ca

NOTE – Please start the diet diary as soon as you get this package, as it takes time. It is also more valuable if the diary reflects your usual dietary habits.

*Vibrant Living Wellness Centre
168K Lexington Court
Waterloo, Ontario
www.vibrant-living.ca*

*Robin Walsh BSc, ND
Kristijana Rakic BSc, ND
Tina Rogers BSc, ND*

(within the Goldsworthy Chiropractic Centre)

Office Policies

To facilitate the efficiency of the office, and to ensure that you will derive the maximum benefit for the care provided, the following office policies have been established:

1. In order to keep accounts to a minimum full payment is required at the time of your visit. We accept cash, cheque, debit, Visa and Mastercard. Thank you for your cooperation.
2. If at all possible, we have a 24-hour cancellation policy in effect in the event that you cannot make your appointment so that someone on the waiting list could be accommodated. We understand that there are extenuating circumstances, which will be taken into consideration; however chronic missed appointments will be billed for 50% of the appointment fee. Our answering machine is available during off hours to take any messages.
3. With the number of patients that are thoroughly interviewed, timing is crucial. For the respect and convenience of our clients and for the efficiency of the clinic we are required to keep scheduled appointments on time. However, complications and emergencies do arise on both ends, which again will be taken into consideration. Please note that when you arrive late for your appointment, only the balance of time that was booked for you can be used.
4. We reserve the right to discharge any case where,
 - The Naturopath feels that the case is beyond the scope of practice of this clinic
 - The patient refuses to cooperate with the recommendations mutually agreed upon
5. Telephone consultations provide a professional service and such may be subjected to a fee on the discretion of the Naturopathic Doctor.

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Fee Schedule - As of January 1, 2011

Naturopathic Care

**These services are not currently covered by OHIP, but are covered by extended health care plans

**GST not included

Initial Consult	\$160.00
Naturopathic Follow Up	\$70.00
Naturopathic Review	\$40.00
Acupuncture	\$40.00-70
Forms	\$10.00

Lab Services

Zinc Tally	\$3.00
Koenisburg Test	\$8.00
Urinary Indican	\$20.00
Urinary Chemstrip	\$4.00
Oxidata	\$15.00
Hair Analysis, Salivary Hormone Testing, Food Allergy Testing – prices vary based on tests.	

I have read and fully understand the above description of this fee system and agree to honour it.

Client/Guardian's Signature

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NATUROPATHIC PATIENT INTAKE

PATIENT INFORMATION

Date _____

Name _____ Sex: M F

Age _____ Date of Birth _____ (day/month/year)

Address _____

Phone (home) _____ (work) _____ May we leave messages? Y N

Occupation _____ Full time or Part time? _____

Marital status _____ Name of Spouse _____ No. of children _____

Email: _____

Name(s) of other health care providers _____

EMERGENCY CONTACT

Name _____ Relationship _____

Phone (home) _____ (work) _____ (cell) _____

Address _____

How did you hear about the clinic? _____

Would you like to join our free e-health newsletter : Y N

CURRENT HEALTH INFORMATION

What is your chief concern about your health? _____

Please list any other health concerns (physical, emotional or mental) that you would like to address:

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

MEDICATIONS

Please list all **prescribed or over the counter medications** you are presently taking. Indicate the name of the drug, dosage, frequency and how long you've taken it.

Have you ever had a bad reaction to any medication? _____

How many courses of antibiotics have you had in the past 10 years? _____

Please list any vitamins/minerals, herbs or homeopathic remedies that you are taking.

Are you allergic to any medications or other substances? Y N

If yes, please list: _____

LIFESTYLE FACTORS

<p>Health Habits</p> <p>q Tobacco: Cigarettes: #/day _____ Cigars: #/day _____ q Alcohol: Wine: #glasses/d or wk _____ Liquor: #ounces/d or wk _____ Beer: #glasses/d or wk _____ q Caffeine: Coffee: #6 oz cups/d _____ Tea: #6 oz cups/d _____ Soda w/caffeine: #cans/d _____ Other sources _____ q Water: #glasses/d _____</p>	<p>Exercise</p> <p>q 5-7 days per week q 3-4 days per week q 1-2 days per week q 45 minutes or more duration per workout q 30-45 minutes duration per workout q Less than 30 minutes q Walk - #days/wk _____ q Run, jog, other aerobic - #days/wk _____ _____</p> <p>q Weight lift - #days/wk _____ q Stretch - #days/wk _____ q Other _____</p>
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Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

What areas of your life contribute most to your stress (please circle)?

Work Health Family Money Marriage Other: _____

DIET

Food Allergies/Sensitivities

Check all that apply

- Vegan
- Vegetarian
- Celiac/Gluten Intolerant
- Lactose Intolerant

PAST MEDICAL HISTORY

Please list the most significant stressful or traumatic events of your life (include childhood).

1. _____
2. _____
3. _____

Have you ever been diagnosed with a serious illness? When?

What hospitalizations or surgeries have you had? When did they occur?

Have you ever had any serious accidents? Indicate injuries, when it occurred, and treatment.

CHILDHOOD ILLNESSES

Chicken pox _____ Mumps _____ Measles _____ Rubella (German measles) _____ Polio _____

Whooping cough _____ Rheumatic fever _____ Scarlet fever _____ Eczema _____

Asthma _____

Frequent ear infections or colds _____ Other: _____

Were you a colicky baby? Y N

Were you breastfed? Y N Until What Age? _____

Are you Immunized? Y N If so any reactions? _____

FAMILY HISTORY

<p>Family Health History (Parents and Siblings)</p> <p>q Arthritis</p> <p>q Asthma</p> <p>q Alcoholism</p> <p>q Alzheimer's disease</p> <p>q Cancer</p> <p>q Depression</p> <p>q Diabetes</p> <p>q Drug addiction</p> <p>q Eating disorder</p> <p>q Genetic disorder</p>	<p>q Glaucoma</p> <p>q Heart disease</p> <p>q Infertility</p> <p>q Learning disabilities</p> <p>q Mental illness</p> <p>q Mental retardation</p> <p>q Migraine headaches</p> <p>q Neurological disorders (Parkinson's, paralysis)</p> <p>q Obesity</p> <p>q Osteoporosis</p> <p>q Stroke</p> <p>q Suicide</p> <p>Other _____</p>
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To Achieve My Health Goals, I am willing to:

- do what is necessary
- do anything but change diet
- do anything but exercise

REVIEW OF SYSTEMS

Please circle any conditions which you are presently causing you a problem. Please checkmark those conditions, which were a problem to you in the past.

Skin

Rashes
Eczema
Psoriasis
Hives
Acne
Boils
Change in mole
Skin cancer
Dry skin
Itchy skin

Eyes

Near sighted
Far sighted
Eye pain
Double vision
Blind spot
Glaucoma
Cataracts
Blurry vision
Dry eyes
Itchy eyes
Tearing
Red eyes
Discharge

Head

Headache
Migraine
Trauma to head
Excessive hair loss
Dandruff

Peripheral Vascular Disease

Extremity swelling
Varicose veins
Spider veins
Extremity numbness
Extremity coldness
Phlebitis
Raynodes syndrome

Cardiovascular

High blood pressure
High cholesterol
Angina
Heart murmur
Chest pains
Heart palpitations
Swelling of the ankles
Abnormal heart tests
Do you like your job Y N

Urinary

Frequent urination
Pain/burning
Increased frequency
Increased urgency
Incontinence
Kidney stones
Hesitancy
Strong odor
Cloudy urine
Bloody urine

Ears

Ringing
Impaired hearing
Earache
Discharge
Wax build up
Itchy

Neurological

Fainting
Seizures
Tingling/numbness
Involuntary movement
Loss of balance
Speech problems
Loss of memory
paralysis

Musculoskeletal

Joint pain/stiffness
Joint swelling
Osteoarthritis
Rheumatoid arthritis
Muscle cramps
Backache
Neck stiffness/pain
Foot pain
Sprain joint easily
Heel spur

Upper Respiratory

Frequent colds
Frequent sore throat
Tonsillitis
Swollen neck and glands
Sinusitis
Nasal discharge
Post nasal drip
Seasonal allergies
Nose bleeds
Coughing
Sputum
Hoarseness
Wheezing
Asthma

Spitting up blood
Shortness of breath
Pain on breathing
Difficulty breathing
Bronchitis
Pneumonia
Tuberculosis

Endocrine

Thyroid problems
Heat/cold intolerance
Excess sweating
Hypoglycemia
Chronic fatigue
Hormone therapy
Diabetes
Seasonal depression
Shift work

Gastrointestinal

Food allergies
Heartburn
Hernia
Nausea
Vomiting
Excessive belching
Excessive passing gas
Bloating
Jaundice
Liver disease
Gallbladder disease
Gallstones
Ulcer
Indigestion
of bowel movements/day _____
loose stools
hard stools
mucous in stool
blood in stool
black, tarry stool
yellow, pale stool
greenish stool
irritable bowel syndrome
colitis
crohn's disease
rectal bleeding
hemorrhoids
anal fissure
diarrhea
abdominal pain
stomach pain
pancreas disease

Eating disorder
Explain _____
Motor vehicle accident
How Many _____
When _____

Blood/Lymphatic

Anemia
Easy bruising
Easy bleeding
Past transfusions
Lymph node swelling
Lymphatic disease
Blood disease

Emotional
Depression
Anxiety
Mood swings
Nervousness
Panic attacks
Phobia
Irritable
Angry
Insomnia
worrier

Males Only

Prostate problems
Prostate surgery
Hernia
Testicular masses
Discharge or sores
Venereal disease
Sexual difficulties

Female Only

Have your periods stopped Y N
Hysterectomy Y N
Why?
Birth Control Y N
Type?
Age of menses _____yrs
Average length of cycle
_____days
days of menstruation

irregular cycles
bleeding between periods
PMS
Symptoms _____

painful menses
excessive flow
fibroids
ovarian cysts
cervical dysplasia
cervical/uterine cancer
ovarian cancer
vaginal discharge
venereal disease
pain on intercourse
hot flashes
night sweats
estrogen replacement
pregnancies

#miscarriages

#abortions

difficulty conceiving Y N
breast lumps
breast tenderness
nipple discharge
sexual difficulties
Last PAP _____

Diary for: _____

Date Started: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Liquids							
General Feeling/Specific Health Concern							

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