

Adult Intake Form - Naturopathy



This confidential information of your medical record and health history will be kept in the Head to Toe Health Centre and will not be released to any individual except when you have authorized this release in writing or when required by law. Please complete this form as thoroughly as possible to optimize your health care outcomes.

Contact Information:

Name: _____ Age: _____ Date of Birth: _____ Gender: M F

Address: _____

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

Emergency contact: _____ Relationship: _____ Phone: _____

Medical doctor: _____ Phone: _____

Address: _____

How did you become aware of the Head to Toe Health Centre: _____

Email/E-newsletter:

Email Address:

Would you like to receive our e-newsletter* to this email? Yes No

*Periodically Head to Toe sends out an e-newsletter updating patients on clinic news and events providing helpful holistic health care information. Your email address will not be shared.

Health Goals/Concerns:

What main health goal/concern brought you to the clinic today? _____

How long have you had it? _____

Describe any factors you suspect may have played a role in the onset and perpetuation of your condition:

Previous practitioners consulted for this condition: MD ND Other _____

Please explain their diagnosis, therapy and results where applicable: _____

What types of therapy have you tried for this problem?

- Diet modification
- Vitamin/mineral supplements
- Herbs
- Homeopathy
- Chiropractor
- Acupuncture
- Conventional drugs
- Osteopathy
- Other _____

What makes it better? _____ What makes it worse? _____

Please list any other health concerns or goals in order of importance: _____

Personal Information/ Lifestyle:

Do you identify as: Straight Homosexual Bi-sexual Trans-gendered Other _____

Marital status: Single Married Separated Widowed With partner Number of dependants _____

Occupation: _____ Shift work? Y N Do you enjoy your work? Y N Sometimes

Is your job associated with potentially harmful chemicals (e.g. pesticides, solvents, radioactivity) or health and/or life threatening activities (e.g. firefighting, mining, etc.)? Please specify: _____

Hours/day you spend: Working: _____ Driving: _____ Watching TV: _____ In front of computer/screen: _____

Circle the level of stress you are presently experiencing in your life (10=highest): 1 2 3 4 5 6 7 8 9 10

Please list the major causes of stress for you (work, finances, relationship, health, etc.) _____

Have you experienced any major trauma, loss, or life changing significant events? _____

Have you worked with a counsellor, psychologist, or psychiatrist? No Currently In the past

Medical History:

How would you describe your general state of health: Excellent Good Fair Poor

Do you wear a medical alert bracelet/tag? Y N For what condition? _____ What is your blood type? _____

Do you wear: Corrective lenses Dentures Hearing aid Medical devices/prosthetics/implants

For the following tables, please use the back of this page if more room is required:

Medical Conditions: Please indicate any hospitalizations, surgeries and injuries you have experienced:

Hospitalization /Surgery/Injury	Date	Symptoms	Condition Resolved?

X-rays, CT Scans, EKGs, ECGs, MRIs, or other imaging scans you've had in the past:

Scan/Screen/Test	Date	Reason	Result

Allergies and/or food sensitivities:

Allergy/Sensitivity	Symptoms	Treatment/Avoidance?

Current medications/supplements: Please list ALL medications or supplements you take on a regular basis:

Medication/Supplement	Dose (if known)	Length of Use	Prescribing Practitioner	Are You Taking Presently?

Screening Tests: Please indicate when you had the following screening tests (if known):

Screen/Test*	Year	Screen/Test*	Year
PAP (Females)		DEXA Scan	
Digital Rectal Exam (Males)		Complete Blood Count (CBC)	
PSA Test (Males)		Cholesterol	
Breast Exam (Both)		Blood Glucose	
Mammogram		Other: _____	

** Please bring a copy of any test results you have to your first visit.*

Date of last complete physical exam: _____

Have you taken antibiotics within the last 5 years? Y N If yes, how many times? _____

Were you frequently given antibiotics as a child? Y N How often? _____

Diet and Health Habits:

General energy level out of 10 (1=lowest, 10=highest): _____ What time of day is it highest? _____ Lowest? _____

What time of day do you eat the following: Breakfast _____ Lunch: _____ Dinner: _____

Do you consume: Canned foods Pop Aspartame (e.g. diet pop, gum) Deli meats Margarine Juice

Are you on a special diet? Y N Explain: _____

Do you crave: Sugar Chocolate Salt Protein Fats Other: _____

How many glasses of water do you drink on an average day? _____ Do you drink purified water/filtered water? Y N

Diet and Health Habits (continued):

Please provide examples of things you typically consume at the following meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you have digestive difficulty with any specific foods? Please specify: _____

Do you smoke? Y N How long ago did you start? _____ Number of cigarettes per day: _____

Did you smoke in the past? Y N For how long? _____ Number of cigarettes per day: _____

Do you drink alcohol? Y N What type? _____ How frequently? _____

Do you take recreational drugs? Y N What type? _____ How frequently? _____

Do you drink coffee? Y N How many cups per day? _____

How often do you exercise? 5-7 days/week 3-4 days/week 1-2 days/week How long do you spend? _____

What do you do for exercise/movement? _____

How many hours of sleep do you get each night? _____ Do you wake feeling rested? Y N Do you nap? Y N

Do you wake in the night? Y N For any particular reason? _____ At any particular time? _____

Have you ever been diagnosed with any of the following?

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mono
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Depression	<input type="checkbox"/> Gastric/Duodenal Ulcer	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Benign Prostatic Hypertrophy	<input type="checkbox"/> Eczema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> HIV	<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Intestinal Parasites	<input type="checkbox"/> STD
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Stroke
<input type="checkbox"/> Colitis	<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Other: _____			

Childhood History:

Were you breastfed? Y N If yes, for how long? _____

Were you immunized? Y N If yes, any reactions? _____

Which "childhood" illnesses did you have?

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Eczema	<input type="checkbox"/> German Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Red Measles	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Thrush/Candida	<input type="checkbox"/> Autism/Asperger's

Family History:

Has anyone in your family been diagnosed with any of the following conditions?

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> High Blood Cholesterol	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Depression	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Thyroid Disorder

Please list any other illnesses of your relatives, such as: parents, siblings, grandparents, aunts and uncles:

Is there anything else that you feel is important that hasn't been addressed on this form? _____

Review of Systems:

Weight: _____ Weight one year ago: _____ Height: _____

Do you consider yourself: Underweight Slightly Underweight Slightly Overweight Overweight Just Right

Please mark symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank

Systemic			Comments
Chills	C <input type="checkbox"/>	P <input type="checkbox"/>	
Chronic Generalized Pain	C <input type="checkbox"/>	P <input type="checkbox"/>	
Dizziness/Vertigo	C <input type="checkbox"/>	P <input type="checkbox"/>	
Dizziness upon rising	C <input type="checkbox"/>	P <input type="checkbox"/>	
Fainting	C <input type="checkbox"/>	P <input type="checkbox"/>	
Fatigue	C <input type="checkbox"/>	P <input type="checkbox"/>	
Frequent Colds	C <input type="checkbox"/>	P <input type="checkbox"/>	
Lightheadedness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Low Grade Fever	C <input type="checkbox"/>	P <input type="checkbox"/>	
Night Sweats	C <input type="checkbox"/>	P <input type="checkbox"/>	
Strong Body Odour	C <input type="checkbox"/>	P <input type="checkbox"/>	
Skin			Comments
Acne	C <input type="checkbox"/>	P <input type="checkbox"/>	
Boils	C <input type="checkbox"/>	P <input type="checkbox"/>	
Changes in Mole(s)	C <input type="checkbox"/>	P <input type="checkbox"/>	
Colour Change	C <input type="checkbox"/>	P <input type="checkbox"/>	
Dry Skin	C <input type="checkbox"/>	P <input type="checkbox"/>	
Eczema/Dermatitis	C <input type="checkbox"/>	P <input type="checkbox"/>	
Hives	C <input type="checkbox"/>	P <input type="checkbox"/>	
Itching	C <input type="checkbox"/>	P <input type="checkbox"/>	
Lumps	C <input type="checkbox"/>	P <input type="checkbox"/>	
Nail Changes	C <input type="checkbox"/>	P <input type="checkbox"/>	
Rashes	C <input type="checkbox"/>	P <input type="checkbox"/>	
Skin Cancer	C <input type="checkbox"/>	P <input type="checkbox"/>	
Eyes			Comments
Far Sighted	C <input type="checkbox"/>	P <input type="checkbox"/>	
Near Sighted	C <input type="checkbox"/>	P <input type="checkbox"/>	
Blind Spot(s)	C <input type="checkbox"/>	P <input type="checkbox"/>	
Sensitive to Sun	C <input type="checkbox"/>	P <input type="checkbox"/>	
Cataract(s)	C <input type="checkbox"/>	P <input type="checkbox"/>	
Stigmatism	C <input type="checkbox"/>	P <input type="checkbox"/>	
Blurred Vision	C <input type="checkbox"/>	P <input type="checkbox"/>	
Discharge	C <input type="checkbox"/>	P <input type="checkbox"/>	
Dry Eyes	C <input type="checkbox"/>	P <input type="checkbox"/>	
Eye Pain	C <input type="checkbox"/>	P <input type="checkbox"/>	
Glaucoma	C <input type="checkbox"/>	P <input type="checkbox"/>	
Itching	C <input type="checkbox"/>	P <input type="checkbox"/>	
Redness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Tearing	C <input type="checkbox"/>	P <input type="checkbox"/>	
Ears			Comments
Discharge	C <input type="checkbox"/>	P <input type="checkbox"/>	
Earache	C <input type="checkbox"/>	P <input type="checkbox"/>	
Feeling of Fullness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Frequent Infections	C <input type="checkbox"/>	P <input type="checkbox"/>	

Review of Systems:

Please mark symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank.

Ears (cont.)			Comments
Impaired Hearing	C <input type="checkbox"/>	P <input type="checkbox"/>	
Ringing	C <input type="checkbox"/>	P <input type="checkbox"/>	
Sensitive Hearing	C <input type="checkbox"/>	P <input type="checkbox"/>	
Wax Build-Up	C <input type="checkbox"/>	P <input type="checkbox"/>	
Nose and Sinuses			Comments
Allergies	C <input type="checkbox"/>	P <input type="checkbox"/>	
Frequent Nose Bleeds	C <input type="checkbox"/>	P <input type="checkbox"/>	
Nasal Discharge	C <input type="checkbox"/>	P <input type="checkbox"/>	
Sinusitis/Sinus Problems	C <input type="checkbox"/>	P <input type="checkbox"/>	
Stuffiness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Mouth & Throat			Comments
Bleeding of Gums/Tongue	C <input type="checkbox"/>	P <input type="checkbox"/>	
Canker Sores	C <input type="checkbox"/>	P <input type="checkbox"/>	
Cold Sores	C <input type="checkbox"/>	P <input type="checkbox"/>	
Dentures	C <input type="checkbox"/>	P <input type="checkbox"/>	
Gum Problems	C <input type="checkbox"/>	P <input type="checkbox"/>	
Frequent Sore Throat	C <input type="checkbox"/>	P <input type="checkbox"/>	
Hoarseness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Loss of Taste	C <input type="checkbox"/>	P <input type="checkbox"/>	
Metal Fillings	C <input type="checkbox"/>	P <input type="checkbox"/>	
Phlegm	C <input type="checkbox"/>	P <input type="checkbox"/>	
Root Canal(s)	C <input type="checkbox"/>	P <input type="checkbox"/>	
Sore Tooth/Teeth	C <input type="checkbox"/>	P <input type="checkbox"/>	
Tonsillitis	C <input type="checkbox"/>	P <input type="checkbox"/>	
Head & Neck			Comments
Dandruff	C <input type="checkbox"/>	P <input type="checkbox"/>	
Goiter (Enlarged Thyroid)	C <input type="checkbox"/>	P <input type="checkbox"/>	
Headaches	C <input type="checkbox"/>	P <input type="checkbox"/>	
Hair Loss, Excessive	C <input type="checkbox"/>	P <input type="checkbox"/>	
Hair Growth/Hirsutism	C <input type="checkbox"/>	P <input type="checkbox"/>	
Migraines	C <input type="checkbox"/>	P <input type="checkbox"/>	
Pain/Stiffness of Neck	C <input type="checkbox"/>	P <input type="checkbox"/>	
Swollen Glands	C <input type="checkbox"/>	P <input type="checkbox"/>	
Thinning Eyebrows	C <input type="checkbox"/>	P <input type="checkbox"/>	
Respiratory			Comments
Difficulty Breathing	C <input type="checkbox"/>	P <input type="checkbox"/>	
Hyperventilation	C <input type="checkbox"/>	P <input type="checkbox"/>	
Pain on Breathing	C <input type="checkbox"/>	P <input type="checkbox"/>	
Persistent Cough	C <input type="checkbox"/>	P <input type="checkbox"/>	
Persistent Respiratory Infection	C <input type="checkbox"/>	P <input type="checkbox"/>	
Shortness of Breath	C <input type="checkbox"/>	P <input type="checkbox"/>	
Shortness of Breath on Exertion	C <input type="checkbox"/>	P <input type="checkbox"/>	
Shortness of Breath While Lying Down	C <input type="checkbox"/>	P <input type="checkbox"/>	
Sitting Up Blood	C <input type="checkbox"/>	P <input type="checkbox"/>	
Sputum	C <input type="checkbox"/>	P <input type="checkbox"/>	
Wheezing	C <input type="checkbox"/>	P <input type="checkbox"/>	

Review of Systems:

Please mark symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank.

Cardiovascular			Comments
Angina	C <input type="checkbox"/>	P <input type="checkbox"/>	
Abnormal Heart Tests	C <input type="checkbox"/>	P <input type="checkbox"/>	
Chest Pain(s)	C <input type="checkbox"/>	P <input type="checkbox"/>	
Cholesterol, Elevated	C <input type="checkbox"/>	P <input type="checkbox"/>	
Heart Murmur(s)	C <input type="checkbox"/>	P <input type="checkbox"/>	
Heart Palpitations	C <input type="checkbox"/>	P <input type="checkbox"/>	
High Blood Pressure	C <input type="checkbox"/>	P <input type="checkbox"/>	
Low Blood Pressure	C <input type="checkbox"/>	P <input type="checkbox"/>	
Peripheral Vascular			Comments
Bruise Easily	C <input type="checkbox"/>	P <input type="checkbox"/>	
Bleed Easily	C <input type="checkbox"/>	P <input type="checkbox"/>	
Cold Hands/Feet	C <input type="checkbox"/>	P <input type="checkbox"/>	
Cyanosis (Skin Appears Blue)	C <input type="checkbox"/>	P <input type="checkbox"/>	
Deep Leg Pain	C <input type="checkbox"/>	P <input type="checkbox"/>	
Extremity Numbness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Extremity Swelling	C <input type="checkbox"/>	P <input type="checkbox"/>	
Extremity Ulcers	C <input type="checkbox"/>	P <input type="checkbox"/>	
Hemorrhoids	C <input type="checkbox"/>	P <input type="checkbox"/>	
Leg Cramps	C <input type="checkbox"/>	P <input type="checkbox"/>	
Leg Pain Worse with Exercise	C <input type="checkbox"/>	P <input type="checkbox"/>	
Lymph Node Swelling	C <input type="checkbox"/>	P <input type="checkbox"/>	
Numbness or Tingling	C <input type="checkbox"/>	P <input type="checkbox"/>	
Past Transfusions	C <input type="checkbox"/>	P <input type="checkbox"/>	
Raynode's Syndrome	C <input type="checkbox"/>	P <input type="checkbox"/>	
Varicose Veins	C <input type="checkbox"/>	P <input type="checkbox"/>	
Wounds Heal Slowly	C <input type="checkbox"/>	P <input type="checkbox"/>	
Urinary			Comments
Blood in Urine	C <input type="checkbox"/>	P <input type="checkbox"/>	
Cloudy Urine	C <input type="checkbox"/>	P <input type="checkbox"/>	
Dribbling of Urine	C <input type="checkbox"/>	P <input type="checkbox"/>	
Frequent Infections	C <input type="checkbox"/>	P <input type="checkbox"/>	
Increased Frequency	C <input type="checkbox"/>	P <input type="checkbox"/>	
Increased Urgency	C <input type="checkbox"/>	P <input type="checkbox"/>	
Inability to Hold Urine	C <input type="checkbox"/>	P <input type="checkbox"/>	
Hesitancy	C <input type="checkbox"/>	P <input type="checkbox"/>	
Kidney Stones	C <input type="checkbox"/>	P <input type="checkbox"/>	
Pain on Urination	C <input type="checkbox"/>	P <input type="checkbox"/>	
Strong Urine Odour	C <input type="checkbox"/>	P <input type="checkbox"/>	
Unusual Change in Colour of Urine	C <input type="checkbox"/>	P <input type="checkbox"/>	
Urination at Night	C <input type="checkbox"/>	P <input type="checkbox"/>	
Gastrointestinal			Comments
Abdominal Pain	C <input type="checkbox"/>	P <input type="checkbox"/>	
Anal Fissures	C <input type="checkbox"/>	P <input type="checkbox"/>	
Anal Prolapse	C <input type="checkbox"/>	P <input type="checkbox"/>	
Belching, Excessive	C <input type="checkbox"/>	P <input type="checkbox"/>	
Bloating	C <input type="checkbox"/>	P <input type="checkbox"/>	
Constipation	C <input type="checkbox"/>	P <input type="checkbox"/>	
Diarrhea	C <input type="checkbox"/>	P <input type="checkbox"/>	

Review of Systems:

Please mark symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank.

Gastrointestinal (cont.)			Comments
Fecal Incontinence	C <input type="checkbox"/>	P <input type="checkbox"/>	
Gallstones	C <input type="checkbox"/>	P <input type="checkbox"/>	
Heartburn	C <input type="checkbox"/>	P <input type="checkbox"/>	
Indigestion	C <input type="checkbox"/>	P <input type="checkbox"/>	
Nausea	C <input type="checkbox"/>	P <input type="checkbox"/>	
Painful Bowel Movement	C <input type="checkbox"/>	P <input type="checkbox"/>	
Pain on Swallowing	C <input type="checkbox"/>	P <input type="checkbox"/>	
Passing Gas, Excessive	C <input type="checkbox"/>	P <input type="checkbox"/>	
Rectal Bleeding	C <input type="checkbox"/>	P <input type="checkbox"/>	
Vomiting	C <input type="checkbox"/>	P <input type="checkbox"/>	
Worse with Fatty Foods	C <input type="checkbox"/>	P <input type="checkbox"/>	
Number of Bowel Movements Each Week: _____			
Stool			Comments
Blood in Stool	C <input type="checkbox"/>	P <input type="checkbox"/>	
Black/Tarry Stool	C <input type="checkbox"/>	P <input type="checkbox"/>	
Greenish Stool	C <input type="checkbox"/>	P <input type="checkbox"/>	
Hard Stool	C <input type="checkbox"/>	P <input type="checkbox"/>	
Loose Stool	C <input type="checkbox"/>	P <input type="checkbox"/>	
Mucus in Stool	C <input type="checkbox"/>	P <input type="checkbox"/>	
Stool Floats	C <input type="checkbox"/>	P <input type="checkbox"/>	
Undigested Food in Stool	C <input type="checkbox"/>	P <input type="checkbox"/>	
Yellow/Pale Stool	C <input type="checkbox"/>	P <input type="checkbox"/>	
Musculoskeletal			Comments
Backache	C <input type="checkbox"/>	P <input type="checkbox"/>	
Bone Pain	C <input type="checkbox"/>	P <input type="checkbox"/>	
Broken Bones	C <input type="checkbox"/>	P <input type="checkbox"/>	
Heel Spurs	C <input type="checkbox"/>	P <input type="checkbox"/>	
Joint Pain	C <input type="checkbox"/>	P <input type="checkbox"/>	
Joint Stiffness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Joint Swelling	C <input type="checkbox"/>	P <input type="checkbox"/>	
Limited Joint Motion	C <input type="checkbox"/>	P <input type="checkbox"/>	
Muscle Cramps	C <input type="checkbox"/>	P <input type="checkbox"/>	
Muscle Spasms	C <input type="checkbox"/>	P <input type="checkbox"/>	
Muscle Weakness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Muscle Wasting	C <input type="checkbox"/>	P <input type="checkbox"/>	
Sprain Joints Easily	C <input type="checkbox"/>	P <input type="checkbox"/>	
Endocrine			Comments
Change in Thirst	C <input type="checkbox"/>	P <input type="checkbox"/>	
Change in Appetite	C <input type="checkbox"/>	P <input type="checkbox"/>	
Cold Intolerance	C <input type="checkbox"/>	P <input type="checkbox"/>	
Excessive Sweating	C <input type="checkbox"/>	P <input type="checkbox"/>	
Heat Intolerance	C <input type="checkbox"/>	P <input type="checkbox"/>	
High Blood Sugar	C <input type="checkbox"/>	P <input type="checkbox"/>	
Low Blood Sugar	C <input type="checkbox"/>	P <input type="checkbox"/>	
Recent Weight Gain	C <input type="checkbox"/>	P <input type="checkbox"/>	
Recent Weight Loss	C <input type="checkbox"/>	P <input type="checkbox"/>	
Seasonal Depression	C <input type="checkbox"/>	P <input type="checkbox"/>	
Thyroid Problems	C <input type="checkbox"/>	P <input type="checkbox"/>	

Review of Systems:

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Neurological			Comments
Learning Challenges	C <input type="checkbox"/>	P <input type="checkbox"/>	
Loss of Balance	C <input type="checkbox"/>	P <input type="checkbox"/>	
Loss of Coordination	C <input type="checkbox"/>	P <input type="checkbox"/>	
Loss of Memory	C <input type="checkbox"/>	P <input type="checkbox"/>	
Paralysis	C <input type="checkbox"/>	P <input type="checkbox"/>	
Seizures/Convulsions	C <input type="checkbox"/>	P <input type="checkbox"/>	
Speech Difficulties	C <input type="checkbox"/>	P <input type="checkbox"/>	
Tremor(s)	C <input type="checkbox"/>	P <input type="checkbox"/>	
Unusual Sensations	C <input type="checkbox"/>	P <input type="checkbox"/>	
Emotional			Comments
Anger, Excessive	C <input type="checkbox"/>	P <input type="checkbox"/>	
Anxiety/Nervousness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Depression	C <input type="checkbox"/>	P <input type="checkbox"/>	
Irritability, Excessive	C <input type="checkbox"/>	P <input type="checkbox"/>	
Insomnia	C <input type="checkbox"/>	P <input type="checkbox"/>	
Mood Swings	C <input type="checkbox"/>	P <input type="checkbox"/>	
Panic Attacks	C <input type="checkbox"/>	P <input type="checkbox"/>	
Fears/Phobias	C <input type="checkbox"/>	P <input type="checkbox"/>	
Worry, Excessive	C <input type="checkbox"/>	P <input type="checkbox"/>	
Female Reproductive			Comments
Age menses began: _____			
Average number of days of menstruation at present: _____			
Average number of days between periods at present: _____			
Are you pre-menopausal, menopausal or post-menopausal? _____			
Are you sexually active? _____			
Could you be pregnant? _____			
Birth Control: What type(s), when and for how long? _____			
Number of pregnancies: _____			
Number of miscarriages: _____			
Number of abortions: _____			
Bleeding Between Periods	C <input type="checkbox"/>	P <input type="checkbox"/>	
Blood Clots	C <input type="checkbox"/>	P <input type="checkbox"/>	
Breast Lumps	C <input type="checkbox"/>	P <input type="checkbox"/>	
Breast Tenderness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Breast Discharge	C <input type="checkbox"/>	P <input type="checkbox"/>	
Cervical Dysplasia	C <input type="checkbox"/>	P <input type="checkbox"/>	
Cervical Cancer	C <input type="checkbox"/>	P <input type="checkbox"/>	
Decreased Sex Drive	C <input type="checkbox"/>	P <input type="checkbox"/>	
Difficulty Conceiving	C <input type="checkbox"/>	P <input type="checkbox"/>	
Endometriosis	C <input type="checkbox"/>	P <input type="checkbox"/>	
Excessive Flow	C <input type="checkbox"/>	P <input type="checkbox"/>	

Review of Systems:

Please mark symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank.

Female Reproductive (cont.)			Comments
Fibroids	C <input type="checkbox"/>	P <input type="checkbox"/>	
Hot Flashes	C <input type="checkbox"/>	P <input type="checkbox"/>	
Hysterectomy	C <input type="checkbox"/>	P <input type="checkbox"/>	
Increased Sex Drive	C <input type="checkbox"/>	P <input type="checkbox"/>	
Irregular Cycles	C <input type="checkbox"/>	P <input type="checkbox"/>	
Night Sweats	C <input type="checkbox"/>	P <input type="checkbox"/>	
Ovarian Cancer	C <input type="checkbox"/>	P <input type="checkbox"/>	
Ovarian Cysts	C <input type="checkbox"/>	P <input type="checkbox"/>	
Painful Menses	C <input type="checkbox"/>	P <input type="checkbox"/>	
Pain on Intercourse	C <input type="checkbox"/>	P <input type="checkbox"/>	
Scanty Flow	C <input type="checkbox"/>	P <input type="checkbox"/>	
Sexually Transmitted Disease: What kind and when: _____	C <input type="checkbox"/>	P <input type="checkbox"/>	
Sexual Difficulties	C <input type="checkbox"/>	P <input type="checkbox"/>	
Uterine Cancer	C <input type="checkbox"/>	P <input type="checkbox"/>	
Vaginal Discharge	C <input type="checkbox"/>	P <input type="checkbox"/>	
Vaginal Dryness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Vaginal Itching	C <input type="checkbox"/>	P <input type="checkbox"/>	
Yeast Infections	C <input type="checkbox"/>	P <input type="checkbox"/>	
Are there any other symptoms not described on the above list? _____			
Male Reproductive			Comments
Are you sexually active? _____			
Date of last prostrate exam: _____			
Discharge of Sores	C <input type="checkbox"/>	P <input type="checkbox"/>	
Decreased Sex Drive	C <input type="checkbox"/>	P <input type="checkbox"/>	
Itchiness	C <input type="checkbox"/>	P <input type="checkbox"/>	
Prostate Problems	C <input type="checkbox"/>	P <input type="checkbox"/>	
Prostate Cancer	C <input type="checkbox"/>	P <input type="checkbox"/>	
Rashes in Genital Area	C <input type="checkbox"/>	P <input type="checkbox"/>	
Sexually Transmitted Disease: What kind and when: _____	C <input type="checkbox"/>	P <input type="checkbox"/>	
Testicular Hernia	C <input type="checkbox"/>	P <input type="checkbox"/>	
Testicular Masses	C <input type="checkbox"/>	P <input type="checkbox"/>	
Testicular Pain	C <input type="checkbox"/>	P <input type="checkbox"/>	

Patient Agreement Form

Naturopathic Medicine



Your signature below acknowledges the following:

1. *I understand that Naturopathic medicine is not covered by the provincial government (OHIP), though may be covered by private and extended insurance plans. Naturopathic medicine may also be tax deductible.*
2. *The fees and services have been clarified in advance. Payment is due at the end of each visit as the Head to Toe Health Centre does not bill insurance companies directly. Cash, Cheque, Interac, Visa, and Mastercard are acceptable methods of payment.*
3. *Twenty-four hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 50% of the missed appointment fee.*
4. *Items purchased are non-refundable, whether or not they have been opened.*
5. *I understand that naturopathic care is a joint responsibility between me (the patient) and my practitioner. Improving my lifestyle can be as important as the remedies and treatments.*
6. *I recognize that Naturopathic medicine is not an isolated system and that Naturopathic Doctors welcome teamwork with MDs, DCs, RMTs, and other health practitioners.*

Informed Consent:

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional, spiritual and environmental factors, all of which play a role in an individual's health. Gentle, non-invasive modalities of treatment are employed to stimulate the body's inherent healing capacity. These modalities include, but are not limited to; diet and nutritional supplements, botanical medicine, homeopathy, Traditional Chinese Medicine and acupuncture, hydrotherapy, massage, physical medicine, as well as psychotherapeutic and lifestyle counselling.

As a patient of the Head to Toe Health Centre, I hereby acknowledge that I am willing to provide an ND with the information necessary for them to fully understand my medical history, presenting symptoms, and health goals I wish to achieve in our work together. I thereby consent to a thorough case history and relevant physical examination.

I understand that the Head to Toe Health Centre will keep a record of my personal health information and of the services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless required by law. I understand that the Head to Toe Health Centre will act as the Health Information Custodian for my personal and health information. If I am seeing more than one practitioner at the Head to Toe Health Centre, I imply consent for them to share and discuss my file as deemed necessary by the practitioners, to ensure that I receive care most appropriate for my condition.

I understand that naturopathic medicine can be employed in conjunction with other forms of therapy and need not be considered exclusively beneficial. I acknowledge that one method of treatment need not be chosen over others and that various methods often work best in conjunction with one another.

I recognize that even the gentlest forms of treatment potentially have their risks and complications. The risks associated with Naturopathic medicine include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, interactions with prescription medications, or pain, bruising, fainting or injury from acupuncture.

As with all forms of therapy, I understand that naturopathic treatment also has its limitations and thus I understand that the results are not guaranteed. Nor do I expect the naturopathic doctor at the Head to Toe Health Centre to be able to anticipate and explain all risks and complications prior to treatment.

With this knowledge, I voluntarily consent to Naturopathic care and I intend for this consent form to cover my entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient name (Please print): _____

Signature of Patient or Guardian: _____ Date: _____