

Healing Path Centre for Natural Medicine

Name: _____	Date: _____
Date of Birth: _____ (M/D/Y)	
Address: _____	

Home Phone: _____	Work Phone : _____
Email Address: _____	

May we use your email address to contact you about upcoming events or seminars? Y / N

May we leave telephone messages relating to your visits? Y / N

Emergency Contact Name: _____

Phone number: _____ Relation: _____

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

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

Please list all current medications (prescription, over-the-counter, vitamins, herbs, etc.)

Medical History

Please circle **Y** (Yes = present concern) **N** (Never a concern) **P** (Previous concern) or **F** (Family history – parents and siblings)

Y N P F	Allergies/hay fever
Y N P F	Anxiety
Y N P F	Arthritis
Y N P F	Asthma
Y N P F	Alcoholism
Y N P F	Alzheimer's disease
Y N P F	Blood pressure, high
Y N P	Bronchitis
Y N P F	Cancer
Y N P F	Chronic fatigue
Y N P F	Cholesterol, high
Y N P	Chronic cough
Y N P	Circulatory problems
Y N P	Cold hands &/or feet
Y N P	Congestion, nasal
Y N P	Constipation
Y N P	Cysts
Y N P	Decreased sex drive
Y N P F	Depression
Y N P F	Diabetes
Y N P	Digestive concerns
Y N P	Dizziness
Y N P F	Drug addiction
Y N P F	Eating disorder
Y N P	Ear infections
Y N P	Epilepsy
Y N P	Emphysema
Y N P	Environmental sensitivities
Y N P	Fertility difficulties
Y N P	Fibromyalgia
Y N P F	Food intolerance
Y N P	Frequent colds & flues
Y N P	Gall Stones
Y N P	GERD (reflux, heartburn)
Y N P	Glaucoma
Y N P	Gout
Y N P F	Headaches
Y N P	Hearing loss
Y N P F	Heart disease
Y N P	Infection, chronic

Y N P	Itching in ears
Y N P F	Kidney or bladder disease
Y N P	Learning disability
Y N P F	Liver disease
Y N P	Loose stools
Y N P F	Mental Illness
Y N P F	Migraines
Y N P F	Multiple sclerosis
Y N P F	Obesity
Y N P F	Osteoporosis / osteopenia
Y N P F	Panic attacks
Y N P	Pneumonia
Y N P F	Respiratory difficulties
Y N P	Seasonal affective disorder
Y N P	Sexually transmitted disease
Y N P	Sinus problems
Y N P F	Skin problems
Y N P	Sleep difficulties
Y N P	Stroke
Y N P F	Thyroid disorder
Y N P	Tuberculosis
Y N P	Ulcer(s)
Y N P	Urinary tract infection
Y N P	Urination, difficulties
Y N P	Varicose veins
Y N P	Vision problems
Y N P	Yeast infections
Females:	
Y N P	Endometriosis
Y N P	Fibroids, ovarian cysts
Y N P	Menstrual irregularities
Y N P	Pelvic Inflammatory disease
Y N P	PMS
Males:	
Y N P	Enlarged prostate (BPH)
Y N P F	Prostate cancer
Y N P	Erectile dysfunction

Would you like to:	
<input type="checkbox"/>	Have more energy
<input type="checkbox"/>	Be stronger
<input type="checkbox"/>	Have more endurance
<input type="checkbox"/>	Increase your sex drive
<input type="checkbox"/>	Be thinner
<input type="checkbox"/>	Be more muscular
<input type="checkbox"/>	Improve your complexion
<input type="checkbox"/>	Have stronger nails
<input type="checkbox"/>	Have healthier hair
<input type="checkbox"/>	Be less moody
<input type="checkbox"/>	Be less depressed
<input type="checkbox"/>	Be less indecisive
<input type="checkbox"/>	Feel more motivated
<input type="checkbox"/>	Be more organized
<input type="checkbox"/>	Think more clearly and be more focused
<input type="checkbox"/>	Improve memory
<input type="checkbox"/>	Do better on tests in school
<input type="checkbox"/>	Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
<input type="checkbox"/>	Stop using laxatives or stool softeners
<input type="checkbox"/>	Be free of pain
<input type="checkbox"/>	Sleep better
<input type="checkbox"/>	Have agreeable breath
<input type="checkbox"/>	Have agreeable body odour
<input type="checkbox"/>	Have stronger teeth
<input type="checkbox"/>	Get less colds and flues
<input type="checkbox"/>	Get rid of your allergies
<input type="checkbox"/>	Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)
<input type="checkbox"/>	Other: _____

Weight:	
Current weight:	_____
Maximum weight:	_____
Minimum weight:	_____

Do you have regular physical exams done by another doctor? Y / N

If yes, how often?

Do you get regular screening tests done by another doctor (Pap, blood tests, etc.)? Y / N

If yes, how often?

Have you had your routine childhood vaccinations? Y / N

Have you ever had an adverse reaction to a vaccination? Y / N

If yes, which one(s)?

DIET

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

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (and total quantity): _____

CONTEXT OF CARE OVERVIEW

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from your first visit to our clinic?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?: (please list)

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?

INFORMED CONSENT

As a patient of this clinic I have read all of the information given to me and I understand that the form of medical care is based on naturopathic and other supportive principles and practices. As such, I understand that my practitioner is not a medical doctor and does not prescribe prescription medications.

In the course of my care at Healing Path, 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. Hence the information I have provided is complete and inclusive of all health concerns including risk of pregnancy, use of all medications, including over the counter drugs and supplements. I agree to inform Healing Path, in a timely manner and prior to any treatment received through Healing Path, all information relating to changes in my medications and/or treatments received through other healthcare providers, as I realize that important and dangerous interactions may occur between the concomitant use of natural and medical or other therapies.

There are some slight health risks associated with treatment by naturopathic medicine. These include, but are not limited to:

- homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your practitioner of any allergies you may have.
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from use of moxa
- Muscle strains and sprains, disc injuries from spinal manipulation
- The N.D.'s are trained to handle emergencies should the need arise.

I understand that treatment results for each individual are variable and that Healing Path does not and cannot predict or guarantee individual treatment results at any time. I also understand that the treatment times or length of treatment plans suggested to me by my practitioner are general guidelines only, based on my practitioner's experience and clinical judgment, but do not guarantee any type of treatment results.

Patient Name (please print name): _____

Patient (or Guardian) Signature: _____

Date: _____

PRIVACY POLICY AND AGREEMENT

This document is your Consent Form for Collection, Use, and Disclosure of Personal Information.

Privacy of your personal information is an important part of our clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing this information responsibly. We will be as open and transparent as possible with you about the way we handle your personal information.

Our Privacy Policy:

- only necessary information is collected about you;
- only with your consent do we share information with others outside the clinic;
- storage, retention, and destruction of your information complies with existing law;
- our policy conforms to privacy legislation and standards of our regulatory body – the Board of Directors of Drugless Therapy – Naturopathy

We collect personal information in order to:

- assess your health
- provide health care
- advise you of treatment options
- establish and maintain contact with you for appointments, invoicing, follow-up care
- send you information mailings
- facilitate your insurance claims
- allow potential purchasers, practice brokers or advisors to conduct audits in preparation for sale of the practice.
- Comply with regulatory requirements and laws under the Drugless Practitioners Act

By signing below, you will have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information as outlined above.

PATIENT CONSENT

I, _____ (print name) agree that Michael Torreiter, N.D. or Rachel Vanden Berg, N.D., can collect, use, and disclose information about me as detailed above.

Signature: _____ Date: _____

Witness: _____