

Healing Path Centre for Natural Medicine

Name: _____	Date: _____
Date of Birth: _____ (M/D/Y)	
Address: _____	
Home Phone: _____	Alternate Phone : _____
Email Address: _____	

What's the best way to remind you of your visit? phone / email

Would you like to be on our email newsletter list? (approx 1-2 emails per month) Y / N

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

Emergency Contact Name: _____

Phone number: _____ Relation: _____

Medical Doctor _____

Phone number: _____ Fax number: _____

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	Easy bruising
Y N P	Ear infections
Y N P	Epilepsy
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	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	Night Sweats
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 F	Enlarged prostate (BPH)
Y N P F	Prostate cancer
Y N P	Erectile dysfunction

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

How did you hear about this clinic?

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

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

What challenges do you foresee in carrying out your naturopathic treatment plan (diet changes, exercise, supplements, etc.)?

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

What do you LOVE to do?

INFORMED CONSENT

The principles of naturopathic medicine assist the body's own ability to heal and improve quality of life and health through natural means.

In order to provide optimal care, your practitioner will conduct a thorough case history. Physical exam as well as specific blood and or urinary laboratory tests may be used as part of the treatment work-up.

The form of medical care in this clinic is based on Naturopathic and other supportive practices. It is important to recognize that even the gentlest of therapies come with some health risks. These risks include but are not limited to:

- Aggravations in response to herbs, homeopathic remedies or physical therapies
- Allergic reactions to herbs or supplements
- Pain, bruising or injury from acupuncture

Also understand that although generally safe, some treatments have complications in certain physiological conditions. Thus, it is essential to advise the care provider of:

- all current medications (including prescription and over the counter herbs and supplements) and any changes in these medications
- any chance of pregnancy
- breastfeeding

PRIVACY POLICY

At Healing Path Centre for Natural Medicine, we understand the importance of protecting your personal information. We are committed to collecting and disclosing this information responsibly. Our privacy policy will be reviewed with you in detail at your initial visit.

By signing below you indicate that you have read and understand the above consent form and have read and reviewed the privacy policy provided.

Patient name (please print): _____

Patient signature: _____

Parent (Guardian) Signature: _____

Naturopathic Doctor's signature: _____

Date: _____