

## Naturopathic Clinic

350 Hwy 7 East, #211

Richmond Hill, Ontario L4B 3N2

### NEW PATIENT QUESTIONNAIRE

Please note: The ability to draw accurate conclusions about your present state of health and to discern the effective ways to optimize your health depends on the information that you provide.

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Numbers: Home: ( ) \_\_\_\_\_

Cell: ( ) \_\_\_\_\_

Work: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

Email: \_\_\_\_\_

Please **circle** which number or way is the best to reach you for appointment reminders.

Date of Birth: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_ Age: \_\_\_\_\_

Emergency Contact Info: \_\_\_\_\_

Profession: \_\_\_\_\_

How did you hear about our office: \_\_\_\_\_

Please **state your primary reason** for attending this office and any additional concerns.

If possible, please indicate when you first noticed the condition of concern.

**Past Medical History** (include date)

**Surgeries (major and minor):**

**Significant Illnesses:**     Cancer     Diabetes     Hepatitis     Heart Disease  
 Seizures     High Blood Pressure     Thyroid Disease  
 Other (please specify) \_\_\_\_\_

**Significant Trauma/Stress:**     Auto Accident     Own Birth     Falls  
 Divorce/Loss     Giving Birth     Job Loss  
 Other (please specify) \_\_\_\_\_

**Allergies (drugs, chemicals, food):**

**Medicines or Supplements currently taking:**

**Medicines or Supplements taken for a prolonged period in the past:**

**Occupational or Environmental Stresses (chemicals, new house, new boss, traffic):**

**Treatments, therapies or alternative/complementary services:**

**Average Daily Diet:**

Morning

Afternoon

Evening

**Habits:** \_\_\_\_\_ Coffee \_\_\_\_\_ Cigarettes \_\_\_\_\_ Tea \_\_\_\_\_ Cola \_\_\_\_\_ Alcohol

\_\_\_\_\_ Drugs \_\_\_\_\_ Salt \_\_\_\_\_ Sugar/ Sweets

\_\_\_\_\_ Other \_\_\_\_\_

**Family History:** \_\_\_\_\_ Diabetes \_\_\_\_\_ Cancer \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Stroke

\_\_\_\_\_ Asthma \_\_\_\_\_ Allergies \_\_\_\_\_ Alcoholism

\_\_\_\_\_ Other \_\_\_\_\_

**General:** \_\_\_\_\_ Poor Appetite \_\_\_\_\_ Heavy Appetite \_\_\_\_\_ Poor Sleep \_\_\_\_\_ Heavy Sleep

\_\_\_\_\_ Tremors \_\_\_\_\_ Fatigue \_\_\_\_\_ Insomnia \_\_\_\_\_ Vertigo

\_\_\_\_\_ Cold Hands \_\_\_\_\_ Cold Feet \_\_\_\_\_ Cold Back \_\_\_\_\_ Fevers

\_\_\_\_\_ Chills \_\_\_\_\_ Night Sweats \_\_\_\_\_ Cravings \_\_\_\_\_ Localized Weakness

\_\_\_\_\_ Poor Coordination \_\_\_\_\_ Appetite Changes \_\_\_\_\_ Sudden Drop of Energy at \_\_\_\_\_ (time)

\_\_\_\_\_ Strong Thirst (Hot/Cold Drinks)

**Skin and Hair:** \_\_\_\_\_ Rashes \_\_\_\_\_ Ulcerations \_\_\_\_\_ Hives \_\_\_\_\_ Itching

\_\_\_\_\_ Eczema \_\_\_\_\_ Pimples \_\_\_\_\_ Purpura \_\_\_\_\_ Dandruff \_\_\_\_\_ Loss of Hair

\_\_\_\_\_ changes in hair and skin \_\_\_\_\_ Other \_\_\_\_\_

**Head, Eyes, Ears, Nose, Throat:** \_\_\_\_\_ Dizziness \_\_\_\_\_ Concussions \_\_\_\_\_ Migraines

\_\_\_\_\_ Glasses \_\_\_\_\_ Eye Strain \_\_\_\_\_ Eye Pain \_\_\_\_\_ Poor Vision

\_\_\_\_\_ Night Blindness \_\_\_\_\_ Colour Blindness \_\_\_\_\_ Cataracts \_\_\_\_\_ Earaches

\_\_\_\_\_ Blurry Vision \_\_\_\_\_ Ringing in ears \_\_\_\_\_ Poor Hearing \_\_\_\_\_ Nose Bleeds

\_\_\_\_\_ Sinus Problems \_\_\_\_\_ Mucus \_\_\_\_\_ Dry Throat \_\_\_\_\_ Dry Mouth

\_\_\_\_\_ Copious Saliva \_\_\_\_\_ Eye Spots \_\_\_\_\_ Facial Pain \_\_\_\_\_ Grinding Teeth

\_\_\_\_\_ Sores on lips/tongue \_\_\_\_\_ Jaw Clicks \_\_\_\_\_ Headaches

\_\_\_\_\_ Other head or neck problem \_\_\_\_\_

**Cardiovascular:** \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Low Blood Pressure \_\_\_\_\_ Chest Pain

\_\_\_\_\_ Dizziness \_\_\_\_\_ Irregular Heartbeat \_\_\_\_\_ Fainting \_\_\_\_\_ Cold Hands and Feet

\_\_\_\_\_ Phlebitis \_\_\_\_\_ Swelling of hands/feet \_\_\_\_\_ Blood Clots \_\_\_\_\_ Difficulty Breathing

\_\_\_\_\_ Other \_\_\_\_\_

**Respiratory:**    \_\_\_ Cough                    \_\_\_ Coughing Blood                    \_\_\_ Asthma

\_\_\_ Bronchitis    \_\_\_ Pneumonia                    \_\_\_ Tight Chest

\_\_\_ Difficulty in breathing when lying down

\_\_\_ Production of phlegm    \_\_\_ Colour    \_\_\_

**Gastrointestinal:**    \_\_\_ Nausea                    \_\_\_ Vomiting                    \_\_\_ Diarrhea

\_\_\_ Gas            \_\_\_ Belching                    \_\_\_ Black Stools                    \_\_\_ Bad Breath

\_\_\_ Rectal Pain    \_\_\_ Hemorrhoids                    \_\_\_ Constipation                    \_\_\_ Bloody Stools

\_\_\_ Sensitive Abdomen                    \_\_\_ Pain or Cramps

\_\_\_ Laxative Use:    \_\_\_ times per week/type    \_\_\_

\_\_\_ Bowel Movement:    \_\_\_ Frequency    \_\_\_ Colour    \_\_\_ Odour    \_\_\_ Texture and form

**Genito-Urinary:**    \_\_\_ Pain on Urination    \_\_\_ Frequent Urination

\_\_\_ Blood In Urine    \_\_\_ Urgency to Urinate    \_\_\_ Unable to Hold Urine    \_\_\_ Kidney Stones

\_\_\_ Venereal Disease    \_\_\_ Impotency

\_\_\_ Wake up to Urinate, how often    \_\_\_/night; time    \_\_\_

**Pregnancy and Gynaecology:**    \_\_\_ Number of pregnancies    \_\_\_ Number of births

\_\_\_ Premature births    \_\_\_ Miscarriages    \_\_\_ Age at first menses

\_\_\_ Period (days)    \_\_\_ Duration    \_\_\_ Irregular Period

\_\_\_ Flow (describe)    \_\_\_ Clots    \_\_\_ Last PAP    \_\_\_

\_\_\_ Last menses    \_\_\_ Vaginal Discharge    \_\_\_ Vaginal Sores

\_\_\_ Menopause    \_\_\_ Birth Control    Type and Duration:    \_\_\_

\_\_\_ Changes in body/psyche prior to menstruation

**Musculoskeletal:**    \_\_\_ Neck Pain    \_\_\_ Muscle Pain/Cramps    \_\_\_ Back Pain

\_\_\_ Joint Pain    \_\_\_ Other    \_\_\_

**Neuropsychological:**    \_\_\_ Seizures    \_\_\_ Areas of Numbness    \_\_\_ Poor Memory

\_\_\_ Concussion    \_\_\_ Depression    \_\_\_ Anxiety    \_\_\_ Bad Temper

\_\_\_ Easily Stressed    \_\_\_ Considered/Attempted Suicide    \_\_\_ Treated for emotional problems

\_\_\_ Other neurological/psychological problems    \_\_\_

**Acknowledgement and Informed Consent**

I, \_\_\_\_\_  
Patient's Name. Please Print.

Hereby acknowledge and confirm that prior to signing this document and prior to undergoing any treatment by a Naturopathic Doctor

1. I have been informed and understand that any treatment or advice provided to me as a patient of this office is not being provided in place of, or to the exclusion of any other treatment or advice that I am currently receiving or may in the future receive from a physician, surgeon, or any other licensed health care provider.
2. I have been informed that the Naturopathic Treatment and products provided by this office are not covered under the Ontario Health Insurance Plan and accordingly, I hereby agree to pay any account to the office at the conclusion of each and very visit. I further acknowledge and agree that I will be charged the full fee for all and any missed appointments unless I have advised the office of my cancellations no less than 24 hours in advance of the scheduled appointment.
3. I understand that bookings and cancellations will not be accepted via email but must be made directly with the receptionist.
4. Any potential side effects that may be associated with Naturopathic Treatment Plans and products have been clearly indicated.

I hereby authorize and consent to such treatment(s) as the Naturopathic Practitioner considers necessary.

\_\_\_\_\_  
Patient's or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date