**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: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ Province: _____ PostalCode: _____

Phone Numbers: Home: (  ) _____

Cell: (  ) _____

Work: (  ) _____

Email: _____

☐ I Agree to receive Limitless Health Clinic's News Letters containing news, updates and promotions regarding Limitless Health Clinic's Products. You can withdraw your consent at any time.

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 visit. **I further acknowledge and agree that I will be charged the full fee for all any missed appointments unless I have advised the office of my cancellation 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, called directly with the receptionist.
4. In order for our **Naturopathic Doctors to provide Accurate Assessment, If you have not seen the Doctor for More than 12 Months it will be consider a Return Visit.**
5. Please be advised that due to the health regulations, **No supplements can be returned after One month**.
6. 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