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 48 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