



**NATURAL TERRAIN**

**NATUROPATHIC CLINIC**

## CONTACT INFORMATION

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

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

Street

City

Province

Postal code

Telephone: (home) [\_\_\_\_\_] \_\_\_\_\_ (work) [\_\_\_\_\_] \_\_\_\_\_ Best place to call H or W

E-mail: \_\_\_\_\_ Cell : [\_\_\_\_\_] \_\_\_\_\_ Fax:[\_\_\_\_\_] \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Occupation: \_\_\_\_\_

Sex: Male\_\_\_ Female\_\_\_ Marital Status: S M D W Sep Number of Children: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Tel: [\_\_\_\_\_] \_\_\_\_\_

Are you currently under his/her care? Y or N If 'yes' for what? \_\_\_\_\_

Date of last visit to Medical Doctor: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

How or by whom were you referred to this clinic? \_\_\_\_\_

Have you been treated by a Naturopathic Doctor before? Y or N

If 'yes', by whom? \_\_\_\_\_ When? \_\_\_\_\_

For what reason(s)? \_\_\_\_\_

In Case of Emergency:

Contact: \_\_\_\_\_ [\_\_\_\_\_] \_\_\_\_\_

Full name

Relation

Telephone

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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# CONSENT FORM

We would like to take this opportunity to welcome you to the Natural Terrain Naturopathic Clinic. This clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body, mind and spirit in its own inherent healing power. We seek to improve your quality of life and health through natural means.

Naturopathic Doctors assess the whole person, taking into consideration the physical, mental, emotional and spiritual aspects of an individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. At the Natural Terrain Naturopathic Clinic a thorough case history will be taken and a complaint oriented physical exam will be performed. We would also like to obtain recent blood tests (taken within the last 2 months). More specific examinations such as breast, rectal, prostate or genital exams may also be required.

It is very important that you inform us immediately of any health concerns that you have, if you are taking any medication (either prescription or over the counter drugs, supplements, herbs and/or homeopathic remedies). If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise us immediately.

There are some slight health risks to naturopathic medical treatment. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements, herbs and/or homeopathic remedies
- Pain, bruising or injury from intra-muscular injections or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa

\_\_\_\_\_  
Initials You understand that a record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others unless so directed by yourself or unless law requires it. You understand that you may look at your medical record at anytime and can request a copy of it by paying the document fee of \$25. You understand that information from your medical record may be analyzed for research purposes and that your identity will be protected and kept confidential.

\_\_\_\_\_  
Initials You understand that your naturopath will answer any questions that you have to the best of their ability. You understand that treatment results are not guaranteed. You do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, you voluntarily consent to diagnostic and therapeutic procedures, except for (please list any exceptions): \_\_\_\_\_.

\_\_\_\_\_  
Initials You intend this consent form to cover the entire course of treatment for your chief health concerns. You also confirm that you have the ability to accept or reject this care of your own free will and choice. You also acknowledge that you are not representing an agency (private, governmental or otherwise) attempting to gather information without so stating.

\_\_\_\_\_  
Initials You understand that charges are to be paid at the time of the visit unless specific arrangements have been made prior to my schedules appointment. Payment for all dispensary items is due at the time of the visit.

\_\_\_\_\_  
Initials You understand that a missed appointment fee of \$35 will be charged for any appointment that is missed or late cancellations (less than 24 hours).

Patient Name: (Please Print) \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

# **CONFIDENTIAL HEALTH QUESTIONNAIRE**

Dear Patient: Please complete this questionnaire with care. Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. This is a confidential record of your medical history. It will not be released without your prior authorization.

**Please Print Clearly and Fill out Both Sides of the Pages**

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

**List your health concerns and how long they have been occurring, in order of importance:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Have you had similar problems before? \_\_\_\_\_ Explain: \_\_\_\_\_

Do you have any relatives with similar problems? \_\_\_\_\_

What do you feel is causing any health problems you may have? \_\_\_\_\_

When did you last feel well? \_\_\_\_\_

What long-term expectations do you have from working with this 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 health concerns that relate to your lifestyle? Rate on a scale from 1 to 10, with 10 indicating 100% commitment.

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? Please list.

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What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive to your health? Please list.

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

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

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## Health History

Do you have any known contagious diseases at this time? Y N  
If yes, what? \_\_\_\_\_

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How would you describe your current state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that you have had. Include approximate dates.

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List any X-rays, CT scans, or other studies that you have had.

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## Medications

Check (✓) any of the following that you currently take or use.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Laxatives     | <input type="checkbox"/> Pain relievers        | <input type="checkbox"/> Antacids            |
| <input type="checkbox"/> Cortisone     | <input type="checkbox"/> Appetite suppressants | <input type="checkbox"/> Antibiotics         |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Thyroid medication    | <input type="checkbox"/> Sleeping pills      |
| <input type="checkbox"/> Aspirin       | <input type="checkbox"/> Diet pills            | <input type="checkbox"/> Birth control pills |

List any over the counter medications or those prescribed by your doctor that you are presently taking

Medication	Date started [m/y]	Dose	Effectiveness

List any vitamins, minerals and supplements that you are presently taking

Supplement / Vitamin	Brand Name	Date started [m/y]	Dose	Effectiveness

How many times have you been treated with antibiotics? \_\_\_\_\_

### Allergies

Are you sensitive or allergic to...

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental? \_\_\_\_\_

Any chemicals? \_\_\_\_\_

Any supplements? \_\_\_\_\_

### Immunizations

What immunizations have you had?

- |   |                                       |                                   |
|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Hepatitis A  | <input type="checkbox"/> Flu shot |
| <input type="checkbox"/> Haemophilus influenza B              | <input type="checkbox"/> Hepatitis B  | <input type="checkbox"/> Polio    |
| <input type="checkbox"/> MMR (measles, mumps, rubella)        | <input type="checkbox"/> Hepatitis C  | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Chicken pox                          | <input type="checkbox"/> Other: _____ |                                   |

Please indicate any adverse reactions you have experienced from an immunization.

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### Illnesses

Which of the following conditions have you had?

<input type="checkbox"/> Abscesses	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Rubella	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Herpes genitalia	<input type="checkbox"/> Parasites	<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Amnesia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pelvic inflammatory disease	<input type="checkbox"/> Shingles	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gall stones	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Peritonitis	<input type="checkbox"/> Skin disease	<input type="checkbox"/> Venereal warts
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Strep throat	<input type="checkbox"/> Warts
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Malaria	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Gout	<input type="checkbox"/> Measles	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Sunstroke	<input type="checkbox"/> Worms
<input type="checkbox"/> Cold sores	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Stroke	<input type="checkbox"/> Yellow fever

## Family History

	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)						
Health (G=Good; P=Poor)						
Age at death (if deceased)						

Check (✓) those applicable

Allergies/Hay fever						
Arthritis						
Asthma						
Cancer						
Depression						
Diabetes						
Drug abuse/alcoholism						
Epilepsy						
Gonorrhea						
Gout						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Paralysis						
Pneumonia						
Skin Disease						
Syphilis						
Tuberculosis						
Other						
Cause of Death						

## Diet

Describe a typical day's diet.

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Supper \_\_\_\_\_

Snacks \_\_\_\_\_

How many cups/bottles/glasses do you drink on average per day?

Beverage	Amount	Beverage	Amount	Beverage	Amount
Water		Fruit juice		Coffee	
Tea		Vegetable juice		Beer	
Soft drinks regular		Herbal Tea		Wine	
Soft drinks diet		Milk		Liquor	

Do you have any dietary restrictions (religious, vegetarian, vegan, etc.)? \_\_\_\_\_

\_\_\_\_\_

## Lifestyle

Do you meditate or use any relaxation exercises? \_\_\_\_\_

What level of personal stress are you experiencing right now? *Minimal Average Considerable Unbearable*

Circle those that apply. Main stressor: *Financial; Job related; Interpersonal; Marriage; Health;*

*Family members; Spiritual; Unfulfilled expectations* or other: \_\_\_\_\_

Are / were you a smoker? *Y or N* How long? \_\_\_\_\_ If you quit, when? \_\_\_\_\_

Does anyone else smoke in your household? \_\_\_\_\_ Does anyone smoke in your work place? \_\_\_\_\_

Do you have regular sleeping habits? *Y or N* How many hours? \_\_\_\_\_

Circle if any apply to you: *Early riser; Difficulty falling asleep; Wake in middle of night; Nightmares.*

Do you exercise regularly? *Y or N* How often? \_\_\_\_\_

Do you or have you ever eaten large or regular amounts of chocolate? \_\_\_\_\_

Do you have amalgam dental fillings? *Y or N* How many? \_\_\_\_\_ Have you had any removed? *Y or N*

Root canals? *Y or N* When? \_\_\_\_\_

Do you color your hair? *Y or N* If your hair has turned grey, at what age were you? \_\_\_\_\_

How old is your home? \_\_\_\_\_ Has there been any kind of renovations / construction in your

home recently [dry wall, paint, new carpets]? \_\_\_\_\_

Do you use a microwave oven? *Y or N* Electric blanket? *Y or N* Waterbed? *Y or N*

What are your main interests and hobbies? \_\_\_\_\_

For the following, **circle “Y” for yes, “N” for no, or “P” for in the past**

Average 6-8hrs sleep per night?	Y N	Do you have a religious or spiritual practice? ↳ If yes, what?	Y N
Do you awake rested?	Y N		
Have a supportive relationship?	Y N	Do you watch television? ↳ How many hours/day?	Y N
Have a history of abuse?	Y N		
Do you use recreational drugs?	Y N P	Do you read? ↳ How many hours/day?	Y N
Treated for drug dependence?	Y N P		
Do you eat three meals a day?	Y N	Do you drink alcohol? ↳ What type? ↳ How many drinks/day?	Y N P
Do you eat out often?	Y N		
Do you drink coffee?	Y N P	Treated for alcoholism?	Y N P
Do you drink black tea?	Y N P		
Do you drink cola/other sodas?	Y N P	Do you smoke tobacco? ↳ How many packs/day? ↳ How many years?	Y N P
Do you eat refined sugar?	Y N P		
Do you add salt to your food?	Y N P	Exposed to significant tobacco smoke (i.e., 2 <sup>nd</sup> hand smoke)?	Y N P
Do you enjoy your work?	Y N		
Do you take vacations?	Y N		
Do you spend time outdoors?	Y N		

## Review of Systems

**General** \_\_\_\_\_

Weight? \_\_\_\_\_ lbs      Weight 1 year ago? \_\_\_\_\_ lbs

Maximum weight? \_\_\_\_\_ lbs      Time of day when your energy is:

↳ When? \_\_\_\_\_      ↳ Best? \_\_\_\_\_ ↳ Worst? \_\_\_\_\_

Blood type? \_\_\_\_\_

**Comments?**

### Skin

Rashes?	Y N P	Lumps?	Y N P
Eczema, hives?	Y N P	Hair loss?	Y N P
Acne, boils?	Y N P	Dryness?	Y N P
Itching?	Y N P	Night sweats?	Y N P
Colour change?	Y N P	Change in a mole?	Y N P
Temperature change?	Y N P	Skin cancer?	Y N P
Nail changes?	Y N P		

### Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems?	Y N P

### Eyes

Impaired vision?	Y N P	Double vision?	Y N P
Glasses/contacts?	Y N P	Spots in vision?	Y N P
Eye pain?	Y N P	Blurred vision?	Y N P
Tearing or dryness?	Y N P	Colour blindness?	Y N P
Glaucoma?	Y N P	Cataracts?	Y N P
Sensitive to the sun?	Y N P	Discharge?	Y N P
Itching/redness?	Y N P	Blind spot?	Y N P

### Ears

Impaired hearing?	Y N P	Ringings?	Y N P
Earaches?	Y N P	Dizziness?	Y N P
Discharge?	Y N P	Infections?	Y N P

### Nose and Sinuses

Frequent colds?	Y N P	Nose bleeds?	Y N P
Stiffness?	Y N P	Hay fever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

### Mouth and Throat

Frequent sore throat?	Y N P	Loss of taste?	Y N P
Teeth grinding?	Y N P	Sore tongue/mouth?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

### Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

**Respiratory**

Comments?

Cough?	Y N P	Difficulty breathing?	Y N P
Spitting up blood?	Y N P	Pain on breathing?	Y N P
Asthma?	Y N P	Sputum?	Y N P
Pneumonia?	Y N P	Wheezing?	Y N P
Emphysema?	Y N P	Bronchitis?	Y N P
Shortness of breath?	Y N P	Pleurisy?	Y N P
Shortness of breath lying down?	Y N P	Tuberculosis?	Y N P
Shortness of breath at night?	Y N P	Last chest x-ray?	

**Cardiovascular**

Heart disease?	Y N P	Angina?	Y N P
High/low blood pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/fluttering?	Y N P
Rheumatic fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P	Past ECG (Echocardiogram)?	Y N P

**Gastrointestinal**

Trouble swallowing?	Y N P	Change in thirst?	Y N P
Nausea?	Y N P	Change in appetite?	Y N P
Vomiting?	Y N P	Indigestion?	Y N P
Vomiting blood?	Y N P	Heartburn?	Y N P
Blood in stool?	Y N P	Constipation?	Y N P
Abdominal pain or cramps?	Y N P	Diarrhea?	Y N P
Belching or passing gas?	Y N P	Gall bladder disease/gall stones?	Y N P
Black, tarry stools?	Y N P	Ulcer?	Y N P
Jaundice (i.e., yellow skin)?	Y N P	Hemorrhoids/fissures?	Y N P
Liver disease?	Y N P	Hernia?	Y N P
Bowel movements – how often?		Change in bowel movements?	Y N P

**Urinary**

Pain on urination?	Y N P	Frequent infections?	Y N P
Increased frequency?	Y N P	Inability to hold urine?	Y N P
Frequency at night?	Y N P	Kidney stones?	Y N P
Urgency or hesitancy?	Y N P	Blood in urine?	Y N P

**Male Reproduction**

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate enlargement or disease?	Y N P
Venereal disease?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N P	Chlamydia?	Y N P
Impotence?	Y N P	Gonorrhea?	Y N P
Premature ejaculation?	Y N P	Condyloma (i.e., genital warts)?	Y N P
Do you use birth control?	Y N P	Herpes?	Y N P
↳ What type?		Syphilis?	Y N P
Sexual preference: <i>Heterosexual</i> <i>Bisexual</i> <i>Homosexual</i>			

**Musculoskeletal**

Comments?

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P
Joint swelling?	Y N P	Backache?	Y N P

**Blood/Peripheral Vascular**

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P
Extremity numbness?	Y N P	Extremity swelling?	Y N P
Extremity coldness?	Y N P	Extremity ulcers?	Y N P
Past transfusion?	Y N P	Lymph node swelling?	Y N P

**Neurologic**

Seizures/convulsions?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Speech problems?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P
Fainting?	Y N P	Involuntary movement?	Y N P

**Endocrine**

Hypothyroid?	Y N P	Diabetes?	Y N P
Hyperthyroid?	Y N P	Heat or cold intolerance?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P
Excessive thirst?	Y N P	Hypoglycemia?	Y N P
Excessive hunger?	Y N P	Excessive sweating?	Y N P
Excessive urination?	Y N P	Hormone therapy?	Y N P

**Immune**

Chronic fatigue syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

**Mental/Emotional**

Treated for emotional problems?	Y N P	Memory problems?	Y N P
Mood swings?	Y N P	Anxiety or nervousness?	Y N P
Poor concentration?	Y N P	Depression?	Y N P
Tension and/or stress?	Y N P	Considered/attempted suicide?	Y N P
Phobias?	Y N P	Insomnia?	Y N P

Is there anything else that you would like to add or comment on? \_\_\_\_\_

**Thank-you for your time and effort.**

**I look forward to working with you on your journey to health and well-being.**

*“Those who do not find time every day for health  
must sacrifice a lot of time one day for illness.”*

**-Father Sebastian Kneipp**

**For Women** – Please circle all that apply

Age of first menses? \_\_\_\_\_ Are your menses regular? *Y or N* Average number of days? \_\_\_\_\_

Length of cycle? \_\_\_\_\_ Last menstrual period? \_\_\_\_\_ Age of cessation of menses? \_\_\_\_\_

The blood flow during the menses is: *Not at all; Spotting; Moderate; Heavy; Heavy and clots*

Do you have bleeding between periods? *Y N P* Any pain during intercourse? \_\_\_\_\_

Pain with the menses? *Not at all; Slight; Moderate; Severe; Incapacitating*

***PMS Questionnaire***

Rate each of the following symptoms of your last menstrual cycle only

0 if not experienced

1 if mild [present but does not interfere with activities]

2 if moderate [present and interferes with activities but not disabling]

3 if severe [disabling; unable to function]

<b>SYMPTOMS</b>	<b>0, 1, 2, 3</b>	<b>SYMPTOMS</b>	<b>0, 1, 2, 3</b>	<b>SYMPTOMS</b>	<b>0, 1, 2, 3</b>
Abdominal bloating		Anxiety		Breast lumps	
Breast tenderness		Confusion		Craving for sweets	
Crying		Depression		Dizziness or faintness	
Fatigue		Forgetfulness		Headache	
Heart palpitations		Increased appetite		Insomnia	
Irritability		Mood swings		Nervous tension	
Nipple discharge		Swelling of extremities		Weight gain	

Are you now on or have you ever taken birth control pills? *Y N P* How long? \_\_\_\_\_ What type? \_\_\_\_\_

Are you now or have you ever used any hormone-modulating medications in the form of pills, patches, or creams [estrogen, progesterone, or birth control pills]? *Y N P* If yes, please list the type, dosage and frequency: \_\_\_\_\_

Have you experienced fibrocystic disease of the breast? *Y N P* Endometriosis? *Y N P*

Have you had uterine fibroids? *Y N P* Do you have cervical dysplasia? *Y or N* Ovarian cysts? *Y or N*

Have you ever had a venereal disease? *Y N P* What type? \_\_\_\_\_

Do you have recurring vaginal infections? *Never; Rarely; Frequently; More than 3x/yr*

Do you have vaginal discharge? *Y N P* Do you have vaginal itching? *Y N P* Yeast infections? *Y N P*

Do you self-exam your breasts for lumps regularly? *Y or N* Last Pap Smear? \_\_\_\_\_

Are you sexually active? *Y or N* Any sexual difficulties? \_\_\_\_\_ Difficulty conceiving? *Y or N*

Sexual preference? *Heterosexual; Bisexual; Homosexual*

Number of pregnancies? \_\_\_\_\_ Deliveries? \_\_\_\_\_ Miscarriages? \_\_\_\_\_ Abortions? \_\_\_\_\_

Were there any complications associated with the above? \_\_\_\_\_

Menopausal symptoms? \_\_\_\_\_