Waterdown Village Chiropractic & Wellness Group

255 Dundas Street East
Unit #14A
Waterdown, ON L8B 0E5
T 905·689·4440
F 905·689·4441
E info@wvchirogroup.ca

wvchirogroup.ca

Naturopathic - Adult

File #: _____

Date: _____

General Information

How do you wish to be addressed in our office?

☐ First name ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr

How do you wish to be contacted by our office? **Email** ☐ **Phone** ☐

Name:

Last: _____ **Date of birth(D/M/YY)**_____

First: _____

Address: _____

Town/City: _____ **Province:** _____ **Postal Code:** _____

Home Phone: ( ) _____ **Cell Phone: ( )** _____

Email: _____ _____ **Please Initial** I consent to receive email communication from the clinic

Occupation: _____

Children: Y N **Number and ages of children:** _____

Are you pregnant? Y N **How many weeks?** _____

Are you breastfeeding? Y N

Family Dr. Name: _____ **Phone: ( )** _____

Previous Naturopathic Care? **Y** **N** **If Yes, Doctor's name:** _____

How did you hear about us? _____

Reason for consulting the office:

- ☐ I have a specific problem and require help only with this problem.
- ☐ After my specific problem has been relieved, I am interested in strategies to insure the problem does not return.
- ☐ After my specific problem has been resolved and I understand methods to insure it does not return, I am interested in strategies to improve my general health.
- ☐ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

File #: _____

Medical Information

Please list any current prescription or over-the-counter medications, including contraceptives/birth control or fertility medications

1. _____
Reason **Duration of use**

2. _____
Reason **Duration of use**

3. _____
Reason **Duration of use**

4. _____
Reason **Duration of use**

Current Supplements (multivitamin, herbs, vitamins, minerals, etc.)

Supplement & Brand Name	Dose/Amount	Reason	Duration of use

Please list any current or past illnesses, surgeries, or conditions:

1. _____
Diagnosis Date

2. _____
Diagnosis Date

3. _____
Diagnosis Date

4. _____
Diagnosis Date

5. _____
Diagnosis Date

Please list any known or suspected food or environmental allergies/sensitivities:

1. _____

2. _____

3. _____

Number of antibiotic prescriptions in the past year (please check): □ 0 □ 1-4 □ 5-9 □ 10 +

Number of antibiotic prescriptions in the past 5 years (please check): □ 0 □ 1-4 □ 5-9 □ 10 +

File #: _____

Chief Health Concerns

Please list, **in order of importance to you,** the areas of your health you would like me to help you address:

1. _____

2. _____

3. _____

4. _____

Current Health

How would you describe your current state of health? (check one)
□ Excellent □ Very Good □ Average □ Fair □ Poor

How many times per week do you engage in physical activity?
_____

Do you eat regular meals and/or snacks? □ Yes □ No
Do you consume caffeine? □ Yes □ No
Please check any of the following that are sources of caffeine for you:
□ Coffee □ Tea □ Chocolate □ Cola

SLEEP
How many hours of sleep do you get nightly?
_____
Do you have trouble falling asleep? □ Yes □ No
Do you wake during the night? □ Yes □ No
Do you wake feeling refreshed? □ Yes □ No

BOWEL MOVEMENTS (BM)
How many BM do you have a day? _____
Do you experience difficulty passing a BM? □ Yes □ No
Do you take anything to assist your bowels? □ Yes □ No
Have you noticed blood in your stool? □ Yes □ No
Have you noticed mucus in your stool? □ Yes □ No
Have you noticed undigested food in your stool? □ Yes □ No

ENERGY
On a scale of 1-10 (10 being the MOST energetic), how would you rate your energy level?
_____
Does your energy fluctuate during the course of a day? □ Yes □ No

MOOD
How would you describe your general moods? _____
Have you ever been concerned about your moods? □ Yes □ No

STRESS (10= most stressful)
On a scale of 1-10 how would you rate your stress level at home? _____
On a scale of 1-10 how would you rate your stress level at work? _____
Do you feel you are able to manage your stress? □ Yes □ No

DAILY DIET SUMMARY

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Drinks:_____

File #: _____

Do you smoke cigarettes □ Yes □ No

Do you drink alcohol □ Yes □ No
If yes, how much □ 0-5 drinks: week month
□ 5-10 drinks: week month
□ 10+ drinks: week month

Do you use recreational drugs?
(i.e. marijuana, cocaine, etc…)
□ Yes □ No
If yes, how often? _____

****FOR WOMEN****

MENSTRUAL CYCLE
Date of last menstrual cycle: _____
How many days between each menstrual cycle? _____ days
How many days of **flow/bleeding**? _____ days

Please check any of the following that are applicable before/during your period:

□ Cramping □ Clots □ Bloating
□ Breast tenderness □ Irritability □ Weepiness
□ Swelling □ Constipation □ Diarrhea
□ Depression

PREGNANCY HISTORY
Number of pregnancies_____
Number of live births?_____
Number of miscarriages?_____
Number of abortions? _____
Please check any of the following in your history:

□ In vitro fertilization/medical fertility treatments

□ C-section □ Epidural □ Antibiotics during birth

□ Vacuum delivery □ Forceps delivery

Please list any pregnancy or birth-related complications:

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INFORMED CONSENT TO NATUROPATHIC CARE

A worsening or aggravation of symptoms with homeopathic Naturopathic Medicine is the treatment and prevention of diseases with natural medicines. Our Naturopathic Doctors (NDs) assess you as a *whole* person by taking into consideration your physical, mental, and emotional health. Gentle, non-invasive medicines are used in order to treat the underlying causes of your illness & disease, while promoting and supporting your healing process. Our Naturopathic Doctors use a variety of therapeutic approaches, either alone, or in combination.

These therapeutic approaches include nutritional and lifestyle counseling, nutritional supplementation, Traditional Chinese Medicine (TCM) and acupuncture, botanical medicine, homeopathy, hydrotherapy B12 injections, and physical medicine. Your Naturopathic Doctor will take a thorough health history, perform a screening physical examination if needed, and request laboratory testing when necessary.

It is very important you inform your Naturopathic Doctor of any diseases you are suffering from, any known allergies you have, and any prescriptions medications or over the counter drugs you are currently taking.

Please advise your Naturopathic Doctor if you are pregnant, suspect you are pregnant, or if you are breastfeeding, as your treatment plan may change in these stages of life. As a patient of Naturopathic Medicine, you will receive information about your diagnosis, your treatment, and alternative courses of action. You will also be advised of the expected benefits, risks, side effects, and consequences of not acting upon your diagnosis or treatment.

There are some slight health risks associated with treatment in naturopathic medicine. These include, but are not limited to:

An adverse reaction to a supplement and/or herb

An aggravation of symptoms with homeopathic medicine. The duration is usually short and self-limiting.

Discomfort or bruising with acupuncture.

I, _____ **(please print name)** understand that the form of medical care I will be receiving is based on Naturopathic principles and practices. I hereby acknowledge that I have been informed and understand the recommended diagnostic and therapeutic procedure(s)/plan and have discussed them with my Naturopathic Doctor to my satisfaction. I also recognize that even the gentlest forms of therapies have potential side effects, and I release my Naturopathic Doctor from any responsibility of side effects. I acknowledge and confirm I have been informed of the diagnostic/therapeutic procedures with respect to potential risks and side effects, expected benefits, financial costs, and the likely consequences of not having/following the provided recommendations and what alternative course(s) of action are available to me.

File #: _____

I also acknowledge that:
1.) Any treatment or advice provided to me as a patient of Naturopathic Medicine is not mutually exclusive of any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider;
2.) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider qualified to practice in Ontario;
3.) My Naturopathic Doctor. has not suggested or recommended to me to refrain from seeking or following the advice of another licensed health care provider;
4.) The treatment and therapies rendered or recommended by my Naturopathic Doctor may be different from those usually offered by a medical doctor or other licensed health care provider.

I acknowledge that full payment is required at the time services are provided or supplements are purchased.

CANCELLATION POLICY
While the clinic does provide regular appointment reminders, I acknowledge that I am responsible for my attendance and that 24 hours' notice is required should I wish to cancel or reschedule my appointment. If less than 24 hours' notice is given, or if I fail to show for my scheduled appointment, I understand that one of the following charges will be applied to my account:

- ☐ **A cancellation fee of $25.00** should I cancel an appointment with less than 24 hours' notice
- ☐ **A full appointment fee** should **I** not show for my scheduled appointment without notice

Please initial to confirm that you have read the cancellation policy and agree to pay any outstanding balances owing. _____ **(Initial Here)**

I declare that my Naturopathic Doctor has explained, to the best of her ability, the treatment or services that I may receive and hereby authorize and consent to treatment.

I intend this consent to apply to all my present and future naturopathic treatments.

Patient Name (print): _____ **Date:** _____

Signature: _____

Parent/Guardian Signature (if under 16 years old): _____