



Hello and Welcome!

Before your scheduled appointment, please carefully read and fill out this form. Please note that the diet diary on the last page will take *5 days* to complete. I know your time is valuable and bringing your completed information forms with you will maximize the amount of time we can spend discussing your case.

Naturopathy is a holistic and preventive approach. This means that I assess the whole person, taking into consideration the physical, mental, emotional, and spiritual aspects of the individual with the ultimate goal of identifying and eliminating the underlying causes of illness. Gentle, non-invasive techniques are used in order to stimulate the body's inherent healing capacity. These include a number of different modalities such as the following:

- ***Nutritional Support*** and dietary recommendations are integral to ensuring that the body has the needed building blocks to sustain and aid healing.
- ***Lifestyle Counseling*** addresses the link between concerns and concerns of well-being, lifestyle, events, thoughts and emotions and provides recommendations such as breathing and relaxation techniques or coping strategies.
- ***Botanical Medicine*** using herbal teas, tinctures or capsules for addressing specific concerns and aiding the body in recovering from injury or disease.
- ***Nutritional Supplementation*** to address deficiencies, assist the body in eliminating toxins, etc.
- ***Homeopathy*** is an energy-based system that stimulates the healing process in the body on all levels.
- ***Hydrotherapy*** is the use of water as an accessible and effective form of stimulating healing.

Most private health insurance companies cover naturopathy; please check with your provider to determine the amount that is covered under your policy. If you have coverage, you are responsible for billing your own insurance company - I will provide you with all the information necessary to send your claim for reimbursement.

Note that my office is ***scent free*** to respect those patients with allergies or sensitivities.

If you are unable to keep your scheduled appointment time please give me a 24hour notice so that we may reschedule your visit. If not, a \$50 cancellation fee will be charged.

Remember to bring copies of any recent lab work or medical records as well as any supplements or medications you are currently taking.

I look forward to supporting you on your journey to greater wellbeing

Name _____ **Date of appointment** _____
First name Last name dd / mm / yyyy

Date of birth _____ **Age** _____ **Sex** M F
dd / mm / yyyy

Address _____
Street Apt#

City Province Postal Code

Phone _____
Home Work Cell phone

_____ Email

Emergency contact _____
First name Last name Relation

_____ Day Phone Evening Phone

How did you hear about the centre? _____

Occupation _____ Full time Part time

Marital Status Single Married Common Law Divorced Widowed Other _____

Please list your health concerns in order of importance, including how long they have been present

- 1- _____
- 2- _____
- 3- _____
- 4- _____
- 5- _____

How would you describe your general state of health? Excellent Good Fair Poor Very poor

PERSONAL HISTORY

Please list any hospitalizations, surgeries, X-Rays, or imaging scans you have received in the past.

Please list any injuries or traumas you have received in the past.

Please list all current prescription medications, over the counter medications, vitamins or other supplements you are taking.

Please list all past prescription medications.

How many times have you received antibiotic treatments in your lifetime? Never 1-5 6-10 11-15 16-20 21+
When was the last time you received an antibiotic treatment? _____

Which of the following conditions have you had? (Circle all that apply)

- | | | | |
|----------------------|---------------------|------------------------|--------------------|
| Abscesses | Eczema | Leukemia | Scarlet Fever |
| Acne | Emphysema | Liver Disease | Schizophrenia |
| ADHD | Epilepsy | Malaria | Strep Throat |
| Alcoholism | Gall stones | Measles | Sinusitis |
| Allergies _____ | Gonorrhoea | Mononucleosis | Stroke |
| Anemia | Gout | Mood Disorder | Syphilis |
| Anxiety | Hay Fever | Mumps | Thalassemia |
| Arthritis | Heart Disease | Parasites | Thyroid Disease |
| Asthma | Heart Murmur | Pelvic Inflammatory Dz | Tonsilitis |
| Bronchitis | Hemochromatosis | Peritonitis | Tuberculosis |
| Cancer _____ | Hepatitis | Pleurisy | Typhoid |
| Chicken Pox | Herpes Genitalia | PMS | Ulcerative Colitis |
| Coagulation Disorder | High Blood Pressure | Pneumonia | Ulcers |
| Crohn's Disease | High Cholesterol | Prostatitis | Venereal Warts |
| Cold Sores | Hypoglycemia | Psoriasis | Whooping Cough |
| Depression | Irritable Bowel | Rheumatic Fever | Worms |
| Diabetes | Kidney Disease | Rubella | Yellow Fever |

Other _____

Please indicate what vaccinations you have received (Circle all that apply):

- | | | |
|--------------------------------------|-------------------------------|-----------------|
| Chicken Pox | Hepatitis A | Small Pox |
| DPT (Diphtheria, Pertussis, Tetanus) | Hepatitis B | Tetanus booster |
| Flu | MMR (Measles, Mumps, Rubella) | |
| Haemophilus influenza | Polio | |

Other _____

What is the date of your last physical exam? _____

What is your overall energy? Low - 1 2 3 4 5 6 7 8 9 10 - High

Is this a change from this time last year? Y N

Height? _____ Weight? _____

Has your weight changed in the last year? Lost Gained No Change How many pounds? _____

Do you have any mercury fillings? Y N How many? _____

Do you smoke? Y N Previously _____ How many? _____
 Are you sexually active? Y N Type of protection used: _____
 Do you have children? Y N How many? _____
 Have you ever had problems with fertility? _____

Women only:

Age of first menstrual period _____ Date of last menstrual period _____
 Length of cycle (i.e. 28 days) _____ Days you menstruate (i.e. 5 days) _____
 Bleeding between periods? Y N Is your cycle regular? Y N
 Please circle if applicable: Cramps Abnormal vaginal discharge Pain during sexual activity Excessive flow
 Have you had a yeast infection? Y N Have you had a Sexually Transmitted Infection? Y N
 Are you currently pregnant? Y N Number of pregnancies _____
 Number of miscarriages _____ Number of abortions _____
 Date of last PAP smear _____ Date of last mammogram _____
 Do you perform regular self-breast exams? Y N Please circle if applicable: Lumps Tenderness Discharge
 Have you ever used the birth control pill? Y N For How long? _____ Any side effects? _____

Men only:

Date of last prostate exam _____
 Do you have a history of (circle if applicable):
 Hernia Testicular Mass Sexual Difficulty Enlarged Prostate
 Penile Discharge Genital Sores Urinary Difficulties Sexually Transmitted Infections

FAMILY HEALTH HISTORY

Which of the following have affected your family members? Which family member?
 Include parents (M or F), siblings (S or B), grandparents (MGF, MGM, PGF, PGM), aunts (A), and uncles (U)

Acne _____	Epilepsy _____	Osteoporosis _____
Alcoholism _____	Gallstones _____	Pneumonia _____
Allergies _____	Glaucoma _____	Psoriasis _____
Alzheimer's _____	Gout _____	Rheumatic Fever _____
Arthritis _____	Hay Fever _____	Sickle Cell Anemia _____
Asthma _____	Heart Disease _____	Strep Throat _____
Bronchitis _____	High Blood Pressure _____	Stroke _____
Cancer _____	High Cholesterol _____	Thyroid Disease _____
Depression _____	Hepatitis _____	Tuberculosis _____
Diabetes _____	Kidney Disease _____	Venereal Disease _____
Easy Bleeding _____	Liver Disease _____	
Eczema _____	Mental Illness _____	
Emphysema _____	Multiple Sclerosis _____	

Other _____ I do not know my family history

REVIEW OF SYSTEMS

Please check off any symptoms you currently experience (C) or have had in the past (P)

GENERAL

Fatigue _____
Night Sweats _____
Diminished libido _____

SKIN

Rashes _____
Inflammation _____
Infection _____
Growths _____
Changes in hair/nails _____

HEAD

Headache _____
Head Injury _____

EYES

Impaired Vision _____
Eye Pain _____
Tearing or dryness _____
Double Vision _____

EARS

Impaired Hearing _____
Ringing _____
Dizziness _____

NOSE and SINUSES

Frequent Colds _____
Nose Bleeds _____
Stuffiness _____
Sinus Problems _____
Post Nasal Drip _____

MOUTH and THROAT

Frequent Sore Throat _____
Sore Tongue _____
Sores in mouth/on lips _____
Gum Problems _____
Hoarseness _____
Dental Problems _____

NECK

Swollen Glands _____
Pain or Stiffness _____

BLOOD

Anemia _____
Easy bleeding/bruising _____

HEART

Heart Disease _____
High Blood Pressure _____
Rheumatic Fever _____
Chest Pain _____

Swelling Ankles _____
Palpitations/fluttering _____

RESPIRATORY

Cough _____
Spitting up Blood _____
Wheezing _____
Difficulty Breathing _____
Pain on Breathing _____
Shortness of Breath _____
Positive TB test ever Y N

DIGESTION

Trouble Swallowing _____
Heartburn _____
Stomach Pain _____
Nausea / Vomiting _____
Bowels Move: Daily More Less
Blood in Stools _____
Belching or Gas _____
Abdominal bloating _____
Hemorrhoids _____

URINARY

Pain on Urination _____
Increase Frequency _____
Inability to Hold Urine _____
Bladder Infections _____

CIRCULATION

Deep Leg Pain _____
Cold Hands/Feet _____
Varicose Veins _____

NEUROLOGIC

Fainting _____
Seizures _____
Paralysis _____
Muscle Weakness _____
Loss of Memory _____

EMOTIONAL ISSUES

Apathy _____
Depression _____
Sadness _____
Mood Swings _____
Anxiety or Nervousness _____
Tension _____
Fears or Phobias _____
Anger or Rage _____
Irritability _____

Other _____

DIET DIARY

The purpose of this daily record is to help you keep close watch over what you are eating, and help you to discover which, if any, foods or beverages may be causing or contributing to your symptoms. Use this as a tool for yourself to become more in tune with your dietary habits. It is very important that the information you record in this diary be as accurate and as correct as possible. The more honest you are, the more you will learn about yourself and the easier it will be to identify issues.

- 1- The following is to be done for 5 days in a row.
- 2- Write down everything you eat or drink, including water, snacks, alcoholic beverages, soft drinks, coffee and so on.
- 3- List the contents found inside mixed dishes and foods. It is not enough to write down "a turkey sandwich". You should also write down the kind of bread, spread, dressing (i.e. turkey sandwich – whole wheat bread, butter, mustard).
- 4- Whenever you make an entry in your diary, ask yourself: "Have I given myself and my licensed Naturopath enough information about what is in this food?"

Day 1	
Breakfast	
Lunch	
Dinner	
Snack	
Digestive, urinary, skin complaints, other (i.e. Pain)	
Overall mood and energy	

Day 2	
Breakfast	
Lunch	
Dinner	
Snack	
Digestive, urinary, skin complaints, other (i.e. Pain)	
Overall mood and energy	

Day 3	
Breakfast	
Lunch	
Dinner	
Snack	
Digestive, urinary, skin complaints, other (i.e. Pain)	
Overall mood and energy	

Day 4	
Breakfast	
Lunch	
Dinner	
Snack	
Digestive, urinary, skin complaints, other (i.e. Pain)	
Overall mood and energy	

Day 5	
Breakfast	
Lunch	
Dinner	
Snack	
Digestive, urinary, skin complaints, other (i.e. Pain)	
Overall mood and energy	

Ilana Block ND

INFORMED CONSENT

Statement of Acknowledgement

Printed name _____

As a patient of this clinic I understand that the form of medical care is based on Naturopathic principles and practices. I recognize that even the gentlest therapies potentially have their complications and hence the information provided is complete and inclusive of all medical history including all prescription medications, over the counter drugs and supplements. The slight health risks of some Naturopathic protocols include, but are not limited to aggravation of pre-existing symptoms, and allergic reaction to supplements or herbs.

I also confirm that I have the ability to accept or reject this care of my own free will and choice. I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

Please wait for your appointment to sign this form.

SIGNATURE

DATE

WITNESS