Ilana Block ND

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	Syphillis
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 (Diptheria, Pertussis, Tetanus)	Hepatits 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 _____
Alcoholism _____
Allergies _____
Alzheimer's _____
Arthritis _____
Asthma _____
Bronchitis _____
Cancer _____
Depression _____
Diabetes _____
Easy Bleeding _____
Eczema _____
Emphysema _____

Epilepsy _____
Gallstones _____
Glaucoma _____
Gout _____
Hay Fever _____
Heart Disease _____
High Blood Pressure _____
High Cholesterol _____
Hepatitis _____
Kidney Disease _____
Liver Disease _____
Mental Illness _____
Multiple Sclerosis _____

Osteoporosis _____
Pneumonia _____
Psoriasis _____
Rheumatic Fever _____
Sickle Cell Anemia _____
Strep Throat _____
Stroke _____
Thyroid Disease _____
Tuberculosis _____
Venereal Disease _____

Other _____

☐ I do not know my family history

DIET

How many meals on average do you have a day? _____ Who prepares your food? _____

How much coffee do you drink on average? None 1/week 2/week 3+/week 1/day 2/day 3+/day

How do you feel after drinking coffee? No effect Hands shaking Heart racing Light-headed feeling Other _____

How much alcohol do you drink on average? None 1-2/month 1-2/week 3-4/week 5+/week
1-2/day 3-4/day 5+/day

What type of alcohol do you drink? _____

Do you tend to be thirsty? Y N How much water do you drink each day? _____

Do you have any food allergies or sensitivities? (Please list)

_____

_____

What foods do you crave? Do you have any reactions to these foods?

_____

_____

PSYCHOSOCIAL

How often do you exercise? Never 1-2/month 3-4/month 1/week 2/week 3/week 4/week 5+/week
Has your frequency of exercise changed recently? Y N How? _____
What type/s of exercise do you do? _____
Do you enjoy exercising? If not, why not? _____

How would you describe the emotional climate of your home?

_____

_____

How stressful is your work or other aspects of your life? How do you handle this stress?

_____

_____

List the three most significant, stressful experiences in your life from the most recent to the most distant.

_____

_____

_____

What are your interests or hobbies? _____

What long-term goals and expectations do you have with regards to working with me?

_____

Is there anything else you would like me to know at this time?

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 _____

Name _____

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	

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