Waterdown Village Chiropractic Group

5 Mill Street South
Waterdown, ON L0R 2H5
T 905·689·4440
F 905·689·4441
E info@wvchirogroup.ca

wvchirogroup.ca

Naturopathic - Adult

File No: _____

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:** _____

First: _____

Address: _____

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

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

Email: _____ _____
PLEASE INITIAL

Express 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?** _____

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

_____

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

Referred to this office by: _____

Why did you decide to choose our office? _____

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.

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Medical Information

Please list any current prescription or over-the-counter medications (please include contraceptives/birth control)

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 food or environmental allergies or sensitivities:

1. _____
2. _____
3. _____

File No. _____

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 +

Chief Health Concerns

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

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

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

****FOR WOMEN****

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

File No. _____

MENSTRUAL CYCLE

Date of last menstrual cycle: _____

How long is your menstrual cycle? _____ days

How many days of flow/bleeding? _____ days

Please circle any of the following that are applicable:

Cramping Clots Bloating

Breast tenderness Irritability Weepiness

Swelling Constipation Loose stools

Depression

PREGNANCY HISTORY

Number of pregnancies? _____

Number of live births?_____

Number of miscarriages? _____

Number of abortions? _____

Please circle any of the following in your history:

In vitro fertilization or medical fertility treatments

C-section Epidural Antibiotics during birth

Vacuum delivery Forceps delivery

Please list any pregnancy or birth-related complications

_____

_____

_____

_____

DAILY DIET SUMMARY

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Drinks:_____

Do you smoke cigarettes □ Yes □ No

Do you drink alcohol □Yes □ No

Please check □ 0-5 drinks/week
□ 5-10 drinks/week
□ 10+ drinks/week

Do you use recreational drugs?
(i.e. marijuana, cocaine, etc…)
□ Yes □ No

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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.
- Pain or bruising with acupuncture.

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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.

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 due when services are provided or supplements are purchased.

CANCELLATION POLICY

I acknowledge 24 hours' notice is required should I wish to cancel or reschedule my appointment. If less than 24 hours' notice is given, **a cancellation fee of $25.00** will be applied to my account. If I fail to cancel an appointment and do not show for my scheduled appointment, I will be charged in full for type of appointment booked.

Please initial to confirm you have read the cancellation policy and agree to pay any outstanding balances owing.

_____ **(please initial)**

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): _____