

Naturopathic Treatment Form

Please complete this form as thoroughly as possible. The information provided is kept confidential according to The Pacific Wellness Institute Privacy Policy. This completed form is required before your naturopathic appointment.

Date: _____ Height: _____ Weight: _____

Mr. Mrs. Ms. Dr.

Family Name: _____ Given Name: _____

Address:

 _____ Apt. # _____ Postal Code _____

Telephone: (_____) _____ (H) (_____) _____ (B)

E-mail: _____

Date of Birth (mm/dd/yr): _____ Occupation: _____

How did you hear about us? Please specify: _____

If you are referred, please indicate the name of the person who referred you:

Did the person who referred you suggest that you see any particular practitioner at Pacific Wellness?
 If so, whom? _____

If you found us through a website, please indicate the site you found first:

- www.pacificwellness.ca www.acupuncture-treatment.com
 www.twotreesnaturopathy.ca Other: URL _____

Are you claiming all__ or part __ of our fee under insurance? Yes No

Does your insurance company allow direct billing from us? Yes No Don't know

If you are involved in an unsettled car accident case please indicate here _____

Have you ever seen a naturopathic doctor before? No _____ Yes _____

If so, Name of previous naturopath: _____

When was your last visit? _____ Briefly describe your experience: _____

Please list your health concerns that you want us to address:

Health concerns

How long have you had this condition?

YOUR HEALTHCARE TEAM		
Please list all healthcare practitioners who help treat you:		
Name	Type of practitioner (eg. family doctor, counselor, acupuncturist, RMT)	Phone and fax number
		Phone: Fax
		Phone: Fax:
		Phone: Fax:

MEDICATION YOU ARE CURRENTLY TAKING			
Name/ brand/ type	Dose	For what condition	Since when

PAST MEDICATION			
Name/ brand/ type	Dose	For what condition	For how long?

NATURAL HEALTH PRODUCTS YOU ARE CURRENTLY TAKING			
Product/ brand	Dose	Reason	Since when

MEDICAL HISTORY		
Have you ever been hospitalized/ had surgery?		
Date:	Reason	Problems experienced since

For each item, please circle or check (✓) symptoms that you are experiencing or have experienced. Also include when you last had that symptom and any additional information.

SKIN		
Rashes/ eczema/ hives/ itching		Hair changes (colour, shine, loss)
Acne/ boils/ bumps/ lumps		Nail changes (shape, strength, thickness)
Excess dryness/ moistness		Temperature/ night sweats
Colour change/ mole changes		Skin ulcers/ skin cancer
Have you ever had a complete skin exam?		Date:
HEAD		
Headache		Problems with jaw joint? (TMJ)
Head injury		Dizziness
Have you ever had an MRI, CT Scan etc?		Date: Result:
EYES		
Impaired vision/ double vision/ blurring		Floaters/ blind spot
Glasses/ contact lenses		Sensitive to sunlight
Eye pain/ itching/ discharge		Excess tearing/ dryness/ redness
Glaucoma/ cataracts		
When did you last visit your eye doctor?		Do you use eye drops, artificial tears or other eye products?
EARS		
Ringing		Ruptured ear drum
Impaired hearing/ hearing aid/ ear tubes		Excess ear wax / discharge
Earache/ infection		Do you use Q-tips?
NOSE AND SINUSES		
Frequent colds/ stuffiness		Sinus problems
Nose bleeds		Sensitive to smells
Allergies/ hay fever		Change in ability to taste
MOUTH, THROAT AND NECK		
Frequent sore throat/ hoarseness		Lumps/ swollen glands in neck
Sore or dry tongue/ mouth		Thyroid problems/ goiter
Gum problems/ bleeding		Pain/ stiffness in neck
How often do you brush?		Dental cavities
How often do you floss?		How many?
		What type of filling?
When was your last visit to the dentist?		
RESPIRATORY		
Cough/ wheezing		Shortness of breath at night/ apnea
Sputum/ mucous		Bronchitis/ pneumonia
Spitting up blood		Pleurisy (inflammation of lungs)
Asthma		Emphysema
Pain/ difficulty on breathing/ shortness of breath		Tuberculosis
Do you / have you smoke(d)?		How long? How many?
Tuberculin test		Date: Test result:
Date of last chest x-ray		
CARDIOVASCULAR		
Heart disease		High blood cholesterol
Angina/ chest pain		Rheumatic fever
High blood pressure		Swelling in ankles
Murmur/ irregular heart beat/ palpitations/ fluttering		Cyanosis (blueness)
Past ECG/ Stress test/ other imaging		Date: Result:

BREASTS			
Lumps/ skin puckering		Nipple discharge/ changes	
Pain or tenderness		Implants/ reduction/ surgery	
Have you ever breast fed? Any problems breast feeding?		Do you do self exams? How often?	
Is there is history of breast cancer in your family?			
GASTROINTESTINAL			
Heartburn/ acid reflux		Belching/ passing gas	
Trouble swallowing		Offensive breath/ bad taste in mouth	
Changes in appetite/ thirst		Bloating/ abdominal pain	
Nausea/ vomiting		Yellow skin	
Vomiting blood		Hernia	
How often are your bowel movements?		Is this a change?	
Blood/ mucous/ undigested food in stool		Indigestion	
Liver disease/ hepatitis		Diarrhea/ constipation	
Gall bladder disease/ stones/ removal		Rectal bleeding/ hemorrhoids	
Ulcer		Black tarry stool	
Food allergies/ sensitivities		Please list offending foods:	
How is your appetite?			
a) I'm hungry all the time and can't seem to satisfy my hunger (regular meals aren't enough)			
b) It seems normal to me (eat regular meals)			
c) I'm often not hungry and I sometimes have to force myself to eat (can easily skip meals)			
How is your thirst?			
a) I've noticed an increased thirst that I can't satisfy (drink a lot of fluids throughout the day)			
b) It seems normal to me (drink fluids throughout the day)			
c) I'm not usually thirsty (I forget to drink fluids)			
What food restrictions do you have?			
Do you have any food cravings?			
Please list the foods that you crave most:		What affects your food cravings?	
How much water do you drink? (do not include caffeinated drinks or alcohol)			
Do you drink tea, coffee, or pop?		How much?	
Do you drink alcohol?		What kind?	How much?
Please circle what additives/ condiments you use and check frequency of use:			
	Often (daily)	Sometimes (not everyday)	
Salt	<input type="checkbox"/>	<input type="checkbox"/>	
Butter/ margarine	<input type="checkbox"/>	<input type="checkbox"/>	
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	
Artificial sweetener	<input type="checkbox"/>	<input type="checkbox"/>	
Mayonnaise	<input type="checkbox"/>	<input type="checkbox"/>	
Soy sauce	<input type="checkbox"/>	<input type="checkbox"/>	
Spice mixes	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any gastrointestinal surgeries/ tests?		Do you take antacids/ special digestive aids?	
Is there a history of colorectal cancer in your family?			

URINARY		
Pain/ pressure/ blood with urination		Inability to hold urine/ incontinence
Urgency/ hesitancy		Frequent urinary infections
Increased frequency, day or night		Kidney problems (stones, infections)
MALE REPRODUCTIVE		
Testicular masses/ pain		Prostate problems
When was last prostate exam?		Do you do testicular self-exams?
Any sexual difficulties/ erectile dysfunction		Discharge/ sores
Problems with sperm/ conceiving		
FEMALE REPRODUCTIVE		
Age of first period		Average number of days of bleeding
Length of cycle (# of days from first day of period to day before next period)		
Bleeding between periods/ irregular cycles/ excess flow		Endometriosis
Ovarian cysts		Hormonal birth control
Sexual difficulties/ pain during intercourse		
Number of pregnancies		Number of miscarriages/ abortions
Number of live births		Difficulties conceiving
Menopause at what age?		Yeast/ candida infections
Hot flashes/ dryness/ other problems with menopause		Cervical cancer/ abnormal PAP results
Hormonal therapy for menopause		Vaginal itching/ redness
PMS (circle those that apply) a) cramps/ muscle aches b) cravings c) mood changes d) water retention/ bloating e) tender breasts f) other:		Vaginal discharge (circle those that apply) a) clear fluid b) white c) thick or sticky d) greenish/ yellow e) grey f) strong odour (fishy)
Date of last PAP		Result
MALE AND FEMALE SEXUAL		
Are you sexually active?		
Age of first sexual encounter		
Do you use barrier contraception?		What type?
Sexually transmitted disease		
Sexual preference		
MUSCULOSKELETAL		
Joint pain or stiffness/ swelling/Arthritis		Muscle weakness/ spasms/ cramps
Bone fractures		Back pain
Sciatica		Have you ever had a bone density test?
History of injury/ accidents		

PERIPHERAL VASCULAR		
Cold hands/ feet		Vein pain (thrombophlebitis)
Varicose veins		Extremity numbness/ swelling/ pain/ ulcers
Deep leg pain/ leg cramps		
NEUROLOGIC		
Fainting / loss of balance		Numbness or tingling
Seizures/ convulsions/ involuntary movement		Speech problems/ slurring
Paralysis		Loss of memory

ENDOCRINE			
Sensitive to heat or cold		Diabetes	
Thyroid problems		Hypoglycemia (low blood sugar)	
Excessive thirst/ hunger		Hormone/ steroid therapy	
Excessive urination/ sweating			

BLOOD/ LYMPHATIC			
Anemia		Lymph node swelling	
Easy bleeding/ bruising		Hemophilia/ clotting problems	
Blood transfusions		What is your blood type?	

ALLERGIES			
Any reactions to vaccines?		Drug sensitivities	
Please list all allergies			

MENTAL EMOTIONAL			
Mood swings		Depression	
Sleeping difficulties/ insomnia		Phobia	
Anxiety		Excess stress	

Have you experienced past trauma/ significant grief?			
Are you still affected by it today?			
Substance abuse		Have you been treated for substance abuse?	
Thoughts of suicide/ attempts			
Have you ever sought help or used medication to deal with personal problems?			

SLEEP			
How many hours do you usually sleep?		How many hours of sleep do you <i>need</i> ?	
If you have trouble sleeping, please circle all that apply			
a) I have problems falling asleep			
b) I have problems staying asleep. If so, what time(s) do you usually wake up? _____			
c) I take medication or other substances to help me sleep			
Do you awake well rested?		Do you take naps during the day?	
Do you fall asleep during the day?		Do you talk/ walk in your sleep?	
Grind teeth while sleeping		Have vivid dreams	
Sleep apnea		Shift work	

ENERGY			
How is your energy? (please choose one)			
a) I have plenty of energy for work and for all my daily activities			
b) I have enough energy during work, but feel tired for the rest of the day			
c) I don't have enough energy for work or any other activities			
What affects your energy level?			

EXERCISE	
How would you describe your daily activity level? a) very active b) moderately active c) sedentary	
Do you exercise regularly?	How frequently?
What kind?	How long?

FAMILY MEDICAL HISTORY			
Has anyone in your family (siblings, parents, grandparents) had the following conditions?		Which member was affected by this condition	Age
Heart disease			
High blood pressure			
Diabetes/ blood sugar problems			
Asthma			
Allergies			
Cancer (breast, colon, lung, liver, skin, prostate, etc.)			
Psychiatric (depression, anxiety, addiction, etc.)			
Kidney problems			
Hormonal problems (thyroid, pituitary, estrogen, testosterone, adrenal (cortisol, etc.)			
Congenital (birth)/ developmental problem			
Neurologic problems (eg. MS, parkinson's, Alzheimer's)			
Arthritis			
Digestive (Celiac's disease, Crohn's, Ulcerative colitis, Irritable Bowel Syndrome, Diverticulitis, Lactose intolerance, Gall stones, etc.)			
Other			

If you have any life threatening allergies (e.g., anaphylaxis, medication), please list here:

In case of emergency call:

Name: _____ Relationship: _____

Phone: _____

Please utilize the space below if you need to make any additional statements.