≈ Balance Point Health Centre ≈

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NEW PATIENT QUESTIONNAIRE

Date:_____

Name:_____ Sex: M F

Address:_____Postal Code:_____

Home Phone #:_____Work#:_____Cell #:_____

Email address:_____

Bithdate:_____Age:_____Occupation – present:_____

- past:_____

Marital Status: (please circle) married single divorced common law re-married

How did you hear about our office?_____

Name of Family Doctor:_____

_____

Primary reasons for coming to our clinic: Please state the first time you noticed the condition and describe any factors that you suspect may have played a role in its onset and progression; Please list in order of importance to you.

1._____
2._____
3._____
4._____
5._____

List any other health concerns:

_____
_____
_____

List any significant illnesses that you have had in the past including any hospitalizations:

_____
_____
_____
_____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____
_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) Y / N

Medications/Supplements: Please list all current and previous medications and supplements used (including antibiotics)

Medications/Supplements	Condition prescribed for	Dose	Duration of use	Side Effects/Reactions

Family History: Indicate where applicable if anyone in your family currently has or has had any of the following conditions:

Disease/Illness	Mother	Father	Sibling	Maternal Grandparents	Paternal Grandparents
Heart Disease (ie. Heart attack, Congestive Heart Failure)	❑	❑	❑	❑	❑
Cancer Type:	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
Hypercholesterolemia	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑
Tuberculosis	❑	❑	❑	❑	❑
Allergies Type:	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑
Psoriasis	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑
Osteoarthritis	❑	❑	❑	❑	❑
Alcoholism	❑	❑	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑	❑	❑
Cystic Fibrosis	❑	❑	❑	❑	❑
Eczema	❑	❑	❑	❑	❑
Age (at death)					
Cause of death					

Please indicate your frequency of use of the following:

Cigarettes/Cigars	___/d	___/wk	___/mo	Antacids	___/d	___/wk	___/mo
Coffee	___/d	___/wk	___/mo	Drugs	___/d	___/wk	___/mo
Tea	___/d	___/wk	___/mo	Pain Relievers	___/d	___/wk	___/mo
Pop (regular)	___/d	___/wk	___/mo	TV (hrs)	___/d	___/wk	___/mo
Pop (diet)	___/d	___/wk	___/mo	Computers (hrs)	___/d	___/wk	___/mo
Alcohol	___/d	___/wk	___/mo	Cell phone (hrs)	___/d	___/wk	___/mo
Microwave	___/d	___/wk	___/mo				

Did you ever smoke? Use alcohol excessively? Use recreational drugs to excess?
Give details and when you quit:_____
_____

Do you have any allergies? (food, environmental, drug)
_____
_____

Do you have any pets?_____

Where do you live? Apartment_____ House_____
How long have you lived there?_____
How old is your home?_____
Have you done any home renovations recently?_____
How would you describe the emotional climate of your home?_____
_____
_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?_____
_____
_____
_____

Review of Systems

For the following, place a ✓ in the space if you currently have the symptom, a P if it has been a problem in the past.

Vitality		**Musculo-skeletal**	
Low stamina		Weakness	
Low ambition		Stiffness	
Fatigue		Aches	
Energy drop during the day		Twitching	
When?		Cramps	
Poor Sleep		Prone to sprains	
Insomnia		Joint Pain	
Feel unrefreshed on waking		Joint swelling	
Unexplained weight gain/loss		Bursitis	
		Arthritis	

Respiration		Unsteady/lose balance	
Hayfever		Numbness/tingling	
Asthma		**Hair**	
Coughing		Thin	
Bronchitis		Excess loss	
Shortness of breath		Graying	
Frequent sore throats		Excess growth	
Frequent colds/ coughs		Prematurely gray	
Phlegm		Grows slowly	
		Thinning eyebrows, underarm, pubic hair	
Skin/Nails		**Mouth/Lips**	
Dryness/Cracking		Jaw clicks	
Itching		Coldsores	
Pimples/Acne		Lips cracking	
Boils		Canker sores	
Blotchy/White Patches		Peculiar taste in mouth	
Eczema		Bad breath	
Psoriasis		Impaired taste/ smell	
Dandruff			
Increased pigmentation		**Teeth**	
Easy bruising		Cavities	
Spots on nails		Loose Teeth	
Nails brittle/split		Dentures/ Bridges	
Bite nails		Root canal	
Fungal infection of nails		Sensitivity to hot/cold	
		Bleeding gums	
Eyes		Gum disease	
Watering		Grinding teeth	
Burning		Braces	
Redness			
Dryness		**Gastro – Intestinal**	
Discharge		Poor appetite	
Itching		Large appetite	
Double vision		Heartburn	
Blurring		Indigestion	
Sensitive to light		Belching	
Cataracts		Excessive flatulence	
Glaucoma		Bloating after eating	
Failing vision		Nausea/ Vomiting	
Frequent conjunctivitis/ styes		Ulcer	
Spots in front of eyes		Constipation	
Dark circles under the eyes		Diarrhea	
Urination		Hemorrhoids	
Dribbling		Cravings	
Difficulty		Strong thirst	
Increased frequency of urination		No thirst	
Blood in urine		Stomach pain, burning, aching 1-4 hrs after eating	
Painful urination		Digestive problems subside with rest/ relaxation	
Urination at night		Hungry shortly after eating	
Unable to hold urine		Anal itching	
Kidney stones		Pain under right side of rib cage	
		Fatty foods cause indigestion	

Ears		History of worms/ parasites	
Loss of hearing		# of bowel movements per day_____	
Ringing in the ears			
Wax build up		**Nose**	
Frequent earaches		Itching	
		Loss of smell	
Circulation/ Blood		Discharge	
Dizziness		Sneezing	
Cold hands/ feet		Sinusitis	
Varicose veins		Polyps	
Low/ high blood pressure		Prone to nose bleeds	
Anemia			
Fainting		**Neurological**	
		Headaches	
Cardiovascular		Migraines	
Heart disease		Forgetful	
Palpitations		Convulsions/ Seizures	
Angina			
Heart murmurs		**For Females**	
Chest pain/heaviness		Age at first period	
		Length of cycle	
For Males		Length of period	
Frequent/ urgent urination		Irregular periods	
Weak/ delayed urinary stream		Bleeding between periods	
Urge to urinate several times per night		Menstrual clots	
Dripping after urination		Breast tenderness	
Lack of sex drive		Irritability/ mood swings	
Impotence		Bloating during period	
Difficulty attaining/ maintaining erection		Vaginal discharge	
Painful testicles		Ovarian cysts	
Genital rash		Uterine fibroids	
Low sperm count		Venereal disease	
Low sperm mobility		Breast lumps	
		# of pregnancies	
		# of live births	
		Menopause	
		Type of birth control	

Context of Care

1. Why did you choose to come to this clinic? _____
_____

What do you know about our approach?_____
_____

2. What three expectations do you have from this visit to our clinic? _____
_____
_____
_____

What long term expectations do you have from working with our clinic?_____
_____
_____

What expectations do you have of me personally as your physician?_____
_____
_____

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

0 1 2 3 4 5 6 7 8 9 10

4. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)_____
_____
_____

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)_____
_____
_____

5. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?_____
_____
_____

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?_____

7. What do you LOVE to do?_____
_____

PATIENT CONSENT FORM
FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our Clinic, while providing you with quality Naturopathic Care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our Clinic is doing to ensure that:
• Only necessary information is collected about you
• We only share your information with your consent
• Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols
• Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopaths

This Clinic will collect, use and disclose information about you for the following purposes:

To asses your health concerns	To advise you of treatment options
To provide health care	To establish and maintain contact with you
To send you newsletters and other information mailings	To remind you of upcoming appointments
To communicate with other treating health-care providers	To allow us to efficiently follow-up for treatment, care and billing
To invoice for goods and services	To collect unpaid accounts
To comply generally with the law	To assist this clinic to comply with all regulatory requirements
To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the Drugless Practitioners Act	

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

It should be made clear that our Naturopathic Doctor is NOT a Medical Doctor. The Naturopath works within their scope of practice. Treatment and referral to other health practitioners is based upon assessment and laboratory testing. If conventional medical treatment is desired, it must be obtained from a licensed medical doctor. We encourage you NOT to abandon contact with your medical doctor.

PATIENT CONSENT

I have reviewed the above information that explains how the clinic will use my personal information, and the steps your clinic is taking to protect my information. I agree that the Naturopathic Doctors can collect, use and disclose personal information as set out above in the information about the clinic's privacy policies.

_____ _____ _____
Signature Print Name Date

INFORMED CONSENT

I, _____, consent to treatment from _____at the Balance Point Health Centre.

Signature:_____ Date:_____