Balance Point Health Centre
Holistic Nutrition Intake Questionnaire

Date: ______________________

Name:

Address: City:

Postal Code: Email Address:

Home Phone: (   )   -   Cell Phone: (   )   -

Referred By: Blood Type: *(Please Circle)*: A B AB O

Date of Birth: *month/day/year* Age: Weight: Height:

Occupation:

Past experience with other practitioners *(ie: Chiropractor, Naturopath, Therapist, Homeopath, Massage, Etc):*

List up to five health goals you would like to attain for yourself, in order of priority: *(How long have they been a concern?)*

1.
2.
3.
4.
5.

"I haven't felt well since…"

What do you believe or suspect is the reason for your condition?

Recent diagnosis:

Surgeries: Date:

List any vaccinations that you have had, including flu shots: Date: *(Use back of sheet if necessary)*

What physical trauma / accidents have you experienced?

Family Health History:

Mother:

Father:

Siblings:

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Please list any medications you are taking now or have taken in the past:

Medication	Reason	How Long

Please list any supplements you are currently taking:

Supplements	Amount	How Long

What is your daily consumption of:

Black Tea	Green Tea	Coffee	Herbal Tea	Alcohol	
Water	Fruit Juice	Pop	Sugar	Artificial Sweetener	Milk
Cream	Margarine	Butter	Cheese		

Do you smoke?

Now? In the past? For how long? When did you quit?

Allergies that you know of:

What foods do you crave?

Exercise:

What kind?

Frequency:

How is your concentration/focus?

Is your weight stable, or up and down? Do you constantly diet?

Menstrual Cycle:

Regular Cramping PMS Yeast/Bladder Infections Date of Last Period

Birth Control Pills? Hormone Replacement?

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Bowel Movements: # per day?

Type: strained, loose, soft, hard, very thin, diarrhea, explosive, constipated, undigested food, blood or mucus in stool

What time do you go to bed? What time do you get up? Do you fall asleep easily?

Restless sleeper? Wake up during the night? Do you feel rested?

Do you snore? Do you have sleep apnea? What position do you sleep in?

Frequent urination? Prostate enlargement?

Teeth:

Amalgam/Silver Fillings: How many? Any removed? How many and when?

Root Canals? Teeth Removed?

Crowns or other metals (braces, retainers, partials)?

Previous occupations:

Do you have a high stress job or stressful relationship/situation?

What emotional trauma/events have you experienced?

What do you do to manage/relieve stress?

What are your hobbies now and previous?

Do you use:

cell phone cordless phone computer microwave

aluminum cookware electric blanket water bed antiperspirant perfume/hairspray

pesticides on lawn/flowers/vegetable garden

Where have you lived?

How old is your home? Remodelling/construction/new carpets/paint?

Are there hydro lines or transformers near your home or work?

What could get in the way of your plan of action?

Please complete a 3-4 day Daily Food Record on the chart provided.

This information is provided for a nutritional assessment. I understand the information I am seeking is of a nutritional nature and not a medical diagnosis.

Signature: Date:

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PRIVACY INFORMATION CONSENT FORM

FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

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 all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

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

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality service
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services
- To communicate with other treating health care providers, including specialists and referring doctors
- To allow us to maintain communication and contact with you to distribute healthcare information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- To invoice for goods and services
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirements
- To comply with the general law

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 for the purposes listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

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Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defence of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I agree that Balance Point Health Care Inc. can collect, use and disclose personal information about

_______________________________________ as set out above in the information.
(Patient's Name)

Print Name:____________________________________ Signature: _______________________________________