Valley Naturopathic Clinic
139 Union St., Berwick, N.S.
B0P 1E0 (902) 538-8733

Date: _____

Email: _____

Thank You for taking the time to fill out this form. The information is very important in the assessment of your care.

Name: _____

Address: _____

Postal Code: _____ Phone: (H) _____ (W) _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Occupation: _____ Past Occupation: _____

Marital Status: _____ Number of Children: _____

Religion or Personal Philosophy: _____

Family Physician: _____ Phone: _____

Referred by: _____

What are your main health concerns: _____

_____

MEDICAL HISTORY:

GENERAL:

Date of last physical exam: _____ Weight: _____ Height: _____

Maximum Weight: _____ Energy Level (Scale 1 to 10, 10 highest) _____

Blood Type _____

Do you usually wake up refreshed? _____

Have you ever smoked? **Y** (yes, presently) **P** (yes in the past) Cigarettes per day _____

For how long? _____ Have you ever used recreational drugs **Yes** **No**

If so, what drugs? _____ For how long? _____

Do you drink alcohol? **Yes** **No** Number of drinks per week? _____

Do you exercise? **Yes** **No** Type of exercise? _____

How many hours per week? _____

Do you have any known allergies? **Yes** **No** Which? _____

Current medications: _____ Dosage? _____

For what? _____

Past Medications: _____ Taken for how long? _____

Current Vitamins and other supplements : _____

Other treatments tried in the past: _____ + _____

REVIEW OF THE BODY SYSTEMS:

Please circle **Y** if you have the condition now
or **P** if you had the condition in the past

Skin:

Rashes	. .	**Y**	**P**	Hives	. .	**Y**	**P**	Acne	. .	**Y**	**P**
Boils	. .	**Y**	**P**	Itching	. .	**Y**	**P**	Eczema	. .	**Y**	**P**
Lumps	. .	**Y**	**P**	Dry Skin	. .	**Y**	**P**				

Night Sweats? **Yes** **No** How often? _____

Other: _____

Head:

Headache	. .	**Y**	**P**	Injuries	. .	**Y**	**P**	Migraine	. .	**Y**	**P**
Dizziness	. .	**Y**	**P**	Other: _____							

Ears:

Discharge . . Y P
Itching . . Y P
Excessive Wax . . Y P
Infections . . Y P
Ringing . . Y P
Earache . . Y P
Decreased hearing . . Y P
Other: _____

Eyes:

Glasses? Contacts: _____ Since when? _____
Prescription changes _____
Impaired vision . . Y P
Eye Pain . . Y P
Glaucoma . . Y P
Cataracts . . Y P
Redness . . Y P
Light Sensitivity . . Y P
Discharge . . Y P
(Near sighted/ Far sighted?) _____
Tearing or dryness . . Y P
Double vision . . Y P
Itching . . Y P
Blurring . . Y P
Blind Spot (s) . . Y P
Night Vision . . Y P

Nose and Sinuses:

Nose bleeds . . Y P
Hay Fever . . Y P
Injury . . Y P
Frequent Colds . . Y P
Obstructions . . Y P
Stuffiness . . Y P
Allergies . . Y P
Sinus Problems . . Y P
How many per year: _____
Other: _____

Mouth and Throat:

Hoarseness . . Y P
Gum Problems . . Y P
Dental Cavities . . Y P
Many sore throats . . Y P
Sores . . Y P
Dryness of mouth . . Y P
Loss of taste . . Y P
How many per year: _____
Other: _____

Neck:

Lumps . . Y P
Pain . . Y P
Swollen glands . . Y P
Goitre . . Y P
Stiffness . . Y P
Other: _____

Respiratory:

Wheezing . . Y P
Frequent cough . . Y P
Difficulty breathing . . Y P
Chest Pain . . Y P
Bloody sputum . . Y P
Emphysema . . Y P
Last tuberculin test: _____
Asthma . . Y P
Sputum . . Y P
Bronchitis . . Y P
Pneumonia . . Y P
Pleurisy . . Y P
Last chest X-ray: _____
Other: _____

Breasts:

Lumps . . Y P Pain . . Y P Tenderness . . Y P
Do you self-examine? _____
Other: _____

Cardiovascular:

Heart disease . . Y P
Angina . . Y P
High blood pressure . . Y P
Murmurs . . Y P
Last ECG test: _____
Chest pain . . Y P
Ankle swelling . . Y P
Palpitations . . Y P
Rheumatic Fever . . Y P
Other: _____

Gastrointestinal:

Difficulty swallowing	Y	P		Diarrhea	Y	P	
Heartburn	Y	P		Rectal Bleeding	Y	P	
Change in thirst	Y	P		Hemorrhoids	Y	P	
Change in appetite	Y	P		Jaundice	Y	P	
Nausea/Vomiting	Y	P		Hernias	Y	P	
Indigestion	Y	P		Constipation	Y	P	
Belching/gas	Y	P		Bowel movements per day: _____			

Urinary:

Pain on urination	Y	P		Kidney stones	Y	P	
Increased frequency	Y	P		Blood in urine	Y	P	
Inability to urinate	Y	P		Frequent infections urine	Y	P	

Other: _____

Musculoskeletal:

Joint Pain or stiffness	Y	P		Muscle spasm/cramps	Y	P	
Arthritis	Y	P		Weakness	Y	P	
Broken bones	Y	P		Backache	Y	P	
Numbness/ tingling	Y	P		Other: _____			

Peripheral Vascular:

Cold hand/feet	Y	P		Varicose veins	Y	P	
Deep leg pain	Y	P		Thrombophlebitis	Y	P	

Other: _____

Reproductive:

Sexual difficulties	Y	P		Venereal disease	Y	P	
Are you sexually active?	Yes		No				
Type of birth control: _____				Since when: _____			

Males

Prostate disease	Y	P		Premature Ejaculation	Y	P	
Impotence	Y	P		Other: _____			

Females

Menopause: Yes No Age:_____ Symptoms:_____

Menses: Regular cycle? Yes No Number of days between cycles?_____

Age of first menstruation?_____

Number of pregnancies? _____ Of Miscarriages? _____ Of Abortions? _____

Premenstrual syndrome symptoms:

Depression/ Irritability	Y	P		Cravings	Y	P	
Bloating	Y	P		Weight Gain	Y	P	
Increased appetite	Y	P		Breast Tenderness	Y	P	
				Other: _____			

Neurological:

Fainting	Y	P		Loss of memory	Y	P	
Seizures/ Convulsions	Y	P		Involuntary movements	Y	P	
Paralysis	Y	P		Loss of balance	Y	P	
Muscle weakness	Y	P		Speech problems	Y	P	

Other: _____

Endocrine:

Thyroid problems	Y	P		Hormone Therapy	Y	P	
Diabetes	Y	P		Hypoglycemia	Y	P	

Other: _____

Blood / Lymphatic:

Anemia . . **Y** **P** Lymph Node Swelling . . **Y** **P**

Easy bleeding/bruising . . **Y** **P** Blood transfusions . . **Y** **P**

Other: _____

Psycho/Social:

Depression . . **Y** **P** Emotional/physical abuse . . **Y** **P**

Mood swings . . **Y** **P** Phobias . . **Y** **P**

Anxiety/Nervousness . . **Y** **P** Sleep Problems . . **Y** **P**

Have you ever had psychiatric/psychological counseling? _____

How content are you with your life? (1 - 10, 10 very content) _____

What would you like to change in your life? _____

Do you express your emotions easily? _____

Alcohol or drug abuse? **Yes** **No**

Other: _____

FAMILY HISTORY (please check)

	Mother	Father	Brother/Sister	Grandparents
Cancer				
T.B.				
Heat Disease				
Arthritis				
Diabetes				
High blood pressure				
Asthma				
Kidney Disease				
Anemia				
Other				

CHILDHOOD DISEASES (please circle):

Measles Rheumatic Fever Mumps Whooping Cough

German Measles Diphtheria Chicken Pox

Other: _____

VACCINATIONS (please circle):

Tetanus Pertussis Diphtheria Polio Measles Mumps Rubella

Did you have a reaction to any of these vaccinations (e.g. Fever) **Yes** **No**

If yes, what type of reaction? _____

PLEASE LIST in order of appearance from your birth all hospitalizations, surgeries, diseases, major accidents, traumas (emotional and physical). Use extra sheets of paper if necessary

Age _____ _____

Age _____ _____

Age _____ _____

Age _____ _____

Age _____ _____

Age _____ _____

Age _____ _____

Is there anything else that you feel I should know about you? _____

_____

_____

_____

_____

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Statement of Acknowledgement

Each person seeking care in this clinic should understand that the practitioner is a naturopath, ***not*** a medical doctor. If medical diagnosis or treatment is required, it must be obtained from a licensed medical doctor.

Naturopathy uses non-invasive methods for the assessment of bodily dysfunctions and natural therapeutics for correction. The methods used in this clinic for assessment and therapeutics include nutrition, homeopathy, botanical medicine, hydrotherapy, detoxification techniques, and lifestyle modification techniques.

Each person must sign this document before any treatment will be rendered.

My signature acknowledges that:

(1) I am in agreement with the commitments of this office and I agree to abide by the office and the financial policies outlined.
(2) I understand that the practitioner in this clinic works within the Naturopathic scope of practice, is not a medical doctor and employs some methods which are not considered orthodox medical practice.
(3) I understand that treatment here and/or referral to other health practitioners is based upon the assessment of the conditions revealed through personal history and interview, physical examination and laboratory testing.
(4) I understand that failure to follow the recommended nutritional, exercise and treatment programs will undermine the expected results.
(5) I am ***not*** an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating my intentions.
(6) I am accepting or rejecting this care of my own free will and choice.
(7) I accept full responsibilities for any fees incurred during care and treatment and I agree to fully discharge this responsibility at the time of my visit, unless prior arrangements have been made.

I, _____, have **read, understood, and acknowledge the above statements.** (To be signed in my office and witnessed by my office staff).

_____ (Signature)

_____ (Office Staff)

Date: _____