saskatoon
NATUROPATHIC MEDICINE
call. 306-664-2150 | fax. 306-664-2151
14-118 Cope Cres., Saskatoon S7T 0X3
www.saskatoonnaturopathic.com

Please take time to fill out the following information. It provides a basis for further questioning during your visit and helps with the health assessment. All information is for office use only and is strictly confidential.

Date of First Visit:____________________ Circle primary doctor: Dr. Velichka, ND / Dr. Reid, ND / Dr. Leung, ND
Dr. Sieben, ND / Dr. Loran, ND / Dr. Pearce, ND

Patient Information

Full Name: __________________________ Date of Birth (D/M/Y): __________ Age:___ Gender (M/F): ________

Address: _____________________________________ City: __________________ Postal Code:________________

Home Phone: __________________ Work Phone: ___________________ Cell Phone: ________________________

Email: ____

Health Card Number: ____

Occupation: ______________________________ Full or Part-time? _____________ Shift work? yes no

Marital Status: single married separated divorced other: ___________________

Children: yes no If yes, please list ages: _________ Parent's Name (if a minor): __________________________

How did you find out about the naturopathic services at this clinic? If referred please indicate from whom.

____

In Case of Emergency Contact

Full Name: ______________________________ Phone: (H)______________ (W)____________(C)____________

Address:___________________________________ Relationship to Patient:_______________________________

Please List Other Health Care Providers (include speciality if appropriate):

1.________________________ 2.________________________ 3________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Current Health Concerns

What are your health concerns? (list in order of importance to you and include the date when you first noticed symptoms)

____

____

____

____

How do you rate your general state of health? poor fair good very good excellent

Comments: ____

____

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Medical History

Current/past illnesses, accidents, conditions and hospitalizations (inc. year of occurrence): ____________

____

____

____

____

____

____

Allergies or sensitivities (foods, drugs, environmental, pets etc.): ______________________________

____

____

____

Are you also working with a medical doctor (MD)?

Yes No

State diagnosis (if applicable): ________________________

____

List any medications or supplements you are currently taking including dosage: ______________________________

____

____

____

____

____

List past prescription medications:________________________

____

____

____

How many times have you been treated with antibiotics: ____

Date of last antibiotic use: ______________________________

Date of last screening physical exam: ______________________

Do you have any dental mercury amalgam fillings?____#?_____

Females: Are you currently pregnant? Yes No

If so, when was that date of last menses ___________

Lifestyle History

Please list a typical day's diet:

Breakfast: ____

Snack: ____

Lunch: ____

Snack: ____

Dinner: ____

Snack: ____

Do you exercise? Yes No

If yes, how often? ________ times per week

... how long? ________ minutes per workout

....what type? ______________________________

How much water do you drink? ________ glasses per day

Do you avoid any foods and why? ________________________

Describe your appetite: ____

What are your sleep patterns? (Include usual time of sleep and wake, daytime naps and any difficulties in falling asleep or staying asleep): ____

____

____

What is your height? ________ Current weight? __________ Max. weight? ___________ Min. weight? ____________

Have you lost any weight lately? Yes No If yes, how many pounds? ________________________

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Lifestyle History Cont'd

Indicate whether you use or are exposed to the following (and if so, how much/how often)

Tobacco smoke: yes no ____________________

Coffee: yes no ____________________

Tea: yes no ____________________

Pop: yes no ____________________

Alcohol: yes no ____________________

Recreational drugs: yes no ____________________

Excess stress: yes no ____________________

Chemicals: yes no ____________________

Family History- *Please indicate any health conditions that have affected members of your family:*

Relative	Age if Alive	Age at Death	Health Conditions
Mother			
Father			
Siblings			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Social History

Describe your family/ work relationships: ____________________

List important events/ experiences in your life: ____________________

What is a typical day like for you? ____________________

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?____________________

When you are feeling stressed, what helps you relax and feel better?____________________

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Review of Systems: *Check the box if you have had in the past- Circle it if it is something you have now.*

- ❑ Abortion
- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Anxiety
- ❑ Arm/Shoulder pain
- ❑ Arthritis
- ❑ Asthma
- ❑ Black stools
- ❑ Bladder problems
- ❑ Bleeding gums
- ❑ Bloating/gas
- ❑ Blood/mucous in stool
- ❑ Blood in urine
- ❑ Breast lumps
- ❑ Breast tenderness
- ❑ Broken bones
- ❑ Brittle nails
- ❑ Cancer
- ❑ Cataracts
- ❑ Chest pain
- ❑ Chicken pox
- ❑ Chronic cough
- ❑ Chronic fatigue
- ❑ Cold hands/ feet
- ❑ Cold sores
- ❑ Constipation
- ❑ Dental cavities
- ❑ Depression
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Digestion problems
- ❑ Discharge from penis
- ❑ Dizziness/vertigo
- ❑ Dry skin
- ❑ Earache/infections
- ❑ Ear ringing
- ❑ Easy bruising
- ❑ Eczema
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Excess hunger
- ❑ Excess sweating
- ❑ Excess thirst
- ❑ Exposure to toxins/chemicals
- ❑ Eye floaters
- ❑ Eye redness/discharge
- ❑ Eye pain
- ❑ Fainting
- ❑ Fibrocystic breasts
- ❑ Frequent colds
- ❑ Gallstones
- ❑ Genital herpes
- ❑ Genital warts
- ❑ Glaucoma
- ❑ Gonorrhoea
- ❑ Gout
- ❑ Headaches
- ❑ Heartburn
- ❑ Heart disease
- ❑ Heavy menses
- ❑ Hemorrhoids
- ❑ Hernias
- ❑ Herniated disc
- ❑ High blood pressure
- ❑ HIV
- ❑ Hoarse voice
- ❑ Impaired hearing
- ❑ Inability to hold urine
- ❑ Indigestion
- ❑ Infertility
- ❑ Insomnia
- ❑ Irregular menstrual cycle
- ❑ Joint pain/stiffness
- ❑ Kidney problems
- ❑ Leg pain/cramps
- ❑ Lines on nails
- ❑ Loss of balance
- ❑ Loss of taste
- ❑ Low back pain
- ❑ Malaria
- ❑ Measles
- ❑ Memory loss
- ❑ Migraine
- ❑ Mono
- ❑ Mumps
- ❑ Muscle weakness
- ❑ Nausea/vomiting
- ❑ Neck pain
- ❑ Nosebleeds
- ❑ Numbness/tingling
- ❑ Osteoporosis/penia
- ❑ Pacemaker
- ❑ Pain on urination
- ❑ Painful intercourse
- ❑ Painful menses
- ❑ Palpitations
- ❑ Paralysis
- ❑ Parasites
- ❑ PMS
- ❑ Pneumonia
- ❑ Poor circulation
- ❑ Prostate problems
- ❑ Psoriasis
- ❑ Rashes
- ❑ Rubella
- ❑ Scarlet fever
- ❑ Sciatica
- ❑ Seizures
- ❑ Shingles
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Sore throats
- ❑ Speech problems
- ❑ Spitting up blood
- ❑ Stomach pain
- ❑ Strep throat
- ❑ Stroke
- ❑ Substance abuse
- ❑ Swollen neck glands
- ❑ Syphilis
- ❑ Testicular mass/pain
- ❑ Thyroid problems
- ❑ TMJ problems
- ❑ Tuberculosis
- ❑ Urinary tract infections
- ❑ Urinary urgency
- ❑ Urination at night
- ❑ Vaginal discharge
- ❑ Vaginal itching
- ❑ Wheezing

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Clarification of Goals

What expectations or goals do you have around your care? ____

____

For your care to be a true win for you, what do you see happening over the next 3 months? ______________________

____

What resources do you currently allocate to your health and well being? I.e. how much time, money and energy do you currently invest in your health? ____

____

How much time, money and energy are you willing to invest in your health? _______________________________

____

What is your present level of commitment to learn and implement healthy changes which will improve your health and well-being? (*Rate from 1-10*) _____

If below 8, what will it take to increase your level of commitment? _________________________________

____

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INFORMED CONSENT FORM

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's healing capacity.

Naturopathic Doctors are required to obtain informed consent and to make sure you are aware of possible side effects/risks due to treatment. The doctors of Saskatoon Naturopathic Medicine Incorporated (SNMI) use the following in their practices: diet and nutritional counseling, traditional Chinese medicine and acupuncture, botanical medicine, hydrotherapy, massage, homeopathy, and lifestyle counseling. It is important to know that any treatment or advice provided is not mutually exclusive from any treatment or advice that you may now be receiving or may in the future receive from another licensed health care provider. You are at liberty to continue medical care from a medical doctor or any other health care provider licensed to practice in Saskatchewan.

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, improved gastrointestinal function, enhanced immunity, and general well-being.

Botanical medicine is plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine based on the Law of Similars; that is, the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses, of plant, animal, or mineral origin, are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, the doctors of SNMI will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take urine samples for further testing, or blood samples for lab investigation.

Even the gentlest of therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases including but not limited to diabetes and heart/liver/kidney disease. It is very important therefore that you inform the doctors of SNMI immediately if any of the above applies to you.

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There are some risks to treatment by Naturopathic Medicine. These include but are not limited to aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain/bruising/injury from acupuncture and massage, fainting or puncturing of an organ with acupuncture needles.

_____ Initials	I understand that my case may be discussed for educational purposes and information from my medical record may be analyzed for research purposes in which my identity will be kept confidential. I acknowledge that I have discussed, or have had the opportunity to discuss, with the doctors of SNMI the nature and purpose of naturopathic treatment in general and my treatment in particular as well as the contents of this consent.
_____ Initials	I understand that a record will be kept of the health services provided to me. This record will be kept confidential among the naturopathic doctors at SNMI. This record will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.
_____ Initials	I understand that the doctors of SNMI will answer any questions that I have to the best of their ability. Because each individual responds differently to treatment, I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions): ____
_____ Initials	I understand that fees and supplements are to be paid for at the time of the consultation.
_____ Initials	I understand that I will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 48 hours notice. The credit card on file will be charged if no other method of payment is given for the Missed Appointment Fee.

As the patient, you are responsible for the total charges incurred for each visit. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company. The doctors of SNMI may prescribe supplements that can be purchased from our in-house dispensary, or elsewhere. Most insurance companies do not cover the supplements that we prescribe and dispense.

I have read and understand the above-stated policies and information. I hereby authorize and consent to naturopathic treatment and examination by the doctors of SNMI. I intend this consent to apply to all my present and future naturopathic care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print): ____

Signature of Patient or Guardian: ____

Date: ____________________________________

Welcome to naturopathic medicine!
The doctors of SNMI look forward to working with you on your journey to better health.