ORTHOMED CLINIC AND SUPPLY

7200 Airport Rd, Mississauga, ON, L4T 2H3
Phone: 905.671.0200 | Fax: 905.671.0270
E-mail: info@orthomedical.ca
Web: www.orthomedical.ca

NATUROPATHIC CLIENT INFORMATION PACKAGE

SECTION #1: GENERAL INFORMATION

Name: _____

Age: _____ Date of Birth (mm/dd/yy): _____ □ Male □ Female

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone (home): _____ Telephone (cell/work): _____

Email address: _____ Occupation: _____

Have you ever seen a naturopathic doctor before? □ NO □ YES
If so, Name of previous ND: _____Date of last visit: _____

SECTION #2: CURRENT MEDICAL INFORMATION

Your Health Concerns:

Please list the health concerns that you wish to address with the naturopathic doctor:

Health Concern:	How long have you had this condition?

If you have any *severe* allergies or medical conditions (eg. Anaphylaxis, Epilepsy) please list here:

Emergency Contact: _____

Relationship: _____ Telephone: _____

Current Medications: Please list all prescribed medications that you are currently taking.

Name/Brand:	Dose:	For what Condition?	Since When?

Current Natural Health Products: Please list all natural products that you are currently taking.

Name/Brand:	Dose:	For what Condition?	Since When?

Do you:

□ NO □ YES Have any known contagious diseases/infections at this time? If yes, what? _____
□ NO □ YES Smoke? If yes, # per day & how long? _____
□ NO □ YES Exercise? If yes, please describe: _____

SECTION #3: PAST MEDICAL INFORMATION: Please describe any major illnesses, medical diagnoses, hospitalizations, surgeries, imaging, etc. (Including the date of occurrence).

_____
_____

SECTION #4: FAMILY MEDICAL INFORMATION:

Please indicate whether anyone in your family (grandparents, parents, siblings) has had any of the following conditions?

□ Heart disease □ Hypertension □Diabetes □Asthma
□Allergies □Kidney problems □Digestive problems □Arthritis
□Nervous System problems □Hormonal problems □ Mental/Emotional problems □ Cancer
□ Other _____

SECTION #5: REVIEW OF SYSTEMS

The following section is a detailed review of every system in your body. For each system, please indicate any symptoms that you are either experiencing currently **(C)**, or have experienced in the past **(P)**, by circling the appropriate letter.

SKIN					
Rashes/ eczema/ hives/rosacea			Colour change/ texture change		
Excess dryness			Excessive sweat/night sweats		
Acne/boils			Mole changes/ new moles		
Lumps/ulcers			Dandruff/ Psoriasis		
HAIR/NAILS					
Hair changes (colour, luster, loss)			Nail changes (shape, strength)		
HEAD					
Headache/migraine			TMJ (jaw) problems		
Head injury/concussion			Facial pain / paralysis		
Dizziness/Vertigo			Other		
EYES					
Impaired Vision/glasses/contacts			Excess tearing/dryness/redness		
Double vision/blurring			Glaucoma/cataracts		
Floaters/blind spots			Light sensitivity		
Eye pain/ itching/ discharge			Night blindness/Colour blindness		
EARS					
Impaired hearing/hearing aid			Ear infections/ Ear aches		
Ringing/tinnitus			Ear tubes		
Loss of balance			Ruptured ear drum		
NOSE					
Frequent colds/stuffiness			Impaired sense of smell		
Sinus problems/Post nasal drip			Change in ability to taste		
Allergies/hay fever			Problems breathing thru nose		
MOUTH, THROAT, AND NECK					
Lips, Mouth, Tongue sores/pain/ulcers			Thyroid problems/ goiter		
Tooth or Gum pain/problems			Problems swallowing food/liquids		
Recurrent sore throat			Lumps/ swollen glands in neck		
Laryngitis/ loss of voice			Neck pain/stiffness		
REPIRATORY					
Asthma/ wheezing			Pneumonia		
Difficulty breathing/ Shortness of Breath/ Painful breathing			Bronchitis		
Recurrent cough			Tuberculosis		
Coughing mucous/sputum			Apnea		

CARDIOVASCULAR					
High or low blood pressure			Murmur/ palpitations/ fluttering		
High blood cholesterol			Swelling in ankles		
Heart disease			Cyanosis		
Angina/ chest pain			Past ECG/stress test/ imaging		
GASTROINTESTINAL					
Indigestion/ Abdominal pain/ cramps/ bloating			Blood or mucous in stool/ black or tarry s		
Excess gas/flatus/belching			Rectal pain/bleeding, hemorrhoids		
Nausea/ vomiting			Ulcer/ Hernia		
Constipation/ laxative use			Excessive halitosis (bad breath)/ bad tast mouth		
Diarrhea			Heat burn/ acid reflux		
Do you have any food regular cravings? Please list:					
How much water to you drink per day? (NOT including coffee, tea, or juice)					
URINARY					
Frequent urinary infections			Pain/ pressure/ blood with urination		
Change in Urgency or Frequency			Incontinence/ inability to hold urine		
MUSCULOSKELETAL					
Joint pain/ stiffness/ swelling/ Arthritis			Bone fractures		
Back pain/ sciatica			Sprains/ strains		
Muscle pain/ weakness/ cramps			Change in Bone density		
PERIPHERAL VASCULAR					
Varicose veins/ vein pain			Extremity numbness/swelling/ pain		
Deep leg pain/ leg cramps			Cold hands or feet		
NEUROLOGIC					
Areas of numbness/ tingling/ loss of sensation			Seizures/ convulsions/ involuntary mover		
Fainting/ loss of balance			Loss of memory		
Paralysis			Speech problems		
ENDOCRINE					
Diabetes			Thyroid problems		
Hypoglycemia			Excessive hunger/ thirst		
Heat or cold intolerance			Hormone problems/ therapy		
BLOOD/ LYMPHATIC					
Anemia			Clotting problems/ hemophilia		
Easy bleeding/ bruising			Lymph node swelling		
MALE REPRODUCTIVE					
Prostate problems			Trouble conceiving/ sperm problems		
Testicular pain/ masses			Other?		
FEMALE REPRODUCTIVE					
Average number of days of flow/bleeding?			Number of pregnancies?		
Average length of menstrual cycle?			Number of live births?		
Have you ever had an abnormal PAP result?			Date of last PAP?		
Irregular cycles			Use of hormonal birth control		
Excess flow/ bleeding between periods			Difficulties conceiving		
Endometriosis			Yeast/ candida infections		
PMS			Vaginal itching/ redness/ dryness		
Hot flashes/ menopausal symptoms			Hormonal therapy for menopause		
MALE AND FEMALE SEXUAL					
Sexual difficulties/ impotence/ erectile dysfunction			Genital sores/ discharge		
Pain during intercourse			Sexually transmitted infection		
BREASTS: (male and female)					
Lumps/ skin puckering			Nipple discharge		
Pain/ tenderness			Surgery/ implants/ reduction		
MENTAL/ EMOTIONAL					
Depression			Hallucinations/ Paranoia		
Thoughts or attempts of suicide			Stress		
Anxiety			Substance abuse		
Phobias			Mania/ mood swings		

Privacy Policy: For the Collection, Use, and Disclosure of the Above Information

The collection of the above information is designed to provide the Naturopathic Doctor with all relevant information necessary to establish a baseline assessment of your health status. It will be used to: assess your health care needs, advise you of naturopathic treatment options, deliver safe and effective patient care, and establish appropriate follow-up measures. In the event of an emergency, we may notify, or assist in notifying the specified emergency contact person. The ND may contact you using the provided phone number(s) and /or email address to confirm appointment bookings or to maintain communication with you for follow-up purposes. Personal health information will not be left with any other person or on a voicemail / answering machine. The ND will keep your medical information confidential; however the multi disciplinary nature of the clinic files may not guarantee absolute confidentiality from other clinic practitioners. This record will not be released to others. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential. Please note that, according to regulation, original documents will be kept by the ND for the length of your active care with her and for ten years after your last appointment. I understand that a record will be kept of the health services provided to me.

Naturopathic Consent to Treatment

Naturopathic medicine is the treatment and prevention of diseases by natural means. ND's assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. A number of different approaches are used. Diet and nutritional supplements, botanical medicine, homeopathy, Asian medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counseling are the mainstays of naturopathic medicine.

I understand that I must notify ORTHOMED Clinic and Supply concerning the presence or development of any of the following:

- Abnormal blood coagulation; use of blood thinning medication
- Presence of heart disease/pacemaker
- High blood pressure
- Diabetes, Epilepsy
- Severe migraines (3+ migraines/week)
- Former cosmetic/plastic surgery (including use of Botox, Hyaform, Restylane, Arecoll, or fat transfer)
- Known Pregnancy
- If I am currently experiencing a cold sore (herpes), allergic reaction, common cold/flu

Any medical treatment has the possibility of health risks. In Naturopathic Medicine these may include, but are not limited to: aggravation of a pre-existing condition; adverse reaction to supplements or herbs; pain, bruising, or injury from acupuncture or injections. No results are guaranteed, and not all risks/complications can be anticipated.

I understand that the practitioner will answer any questions that I have to the bet of his/her ability. I understand that the results are not guaranteed. I do not expect ND to be able to anticipate and explain all risks and complications. I will rely ND to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to Naturopathic assessment and treatment. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that it is my full responsibility to be aware of the details of my coverage regarding any Extended Healthcare Plan. I do not hold ORTHOMED Clinic and Supply liable for any misinterpretation regarding reimbursement of paid services between myself and my healthcare insurance company.

I release ORTHOMED CLINIC AND SUPPLY and a treating naturopath from liability associated with treatment procedures**.** I certify that I am a competent adult of at least 18 years of age. This Consent Form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. Note: All prices are subject to change without prior notice. I confirm that all acupuncture needles are sterile and disposable and that they were taken out of the package by the practitioner in front of my eyes. This is to confirm that I do NOT consent to reveal/release my file and all confidential information pertaining to my treatments and any related services to any third party.

CLIENT NAME: _____CLIENT SIGNATURE _____Date_____