Borealis Naturopathic Health Centre
615 Davis Drive, Suite 302,
Newmarket, ON L3Y 2R2
Tel. 905-830-1236
Fax 905-830-1226

Date _____

Name _____

Address _____

City _____Province:_____ Postal Code: _____

Tel. Home: _____ Tel. Office: _____

Where should we leave messages? Home_____ Work_____ Cell_____

E-Mail Address:_____

Date of Birth D/M/Y_____ Present Age: _____Blood Group: _____

Occupation _____

Marital Status _____ Name of Spouse/Partner: _____

# of children and details (ages, sex) _____

_____

Health Care Practitioner _____

How did you hear about us?

Yellow Pages _____ Word of mouth _____

Ad _____ Drive by _____

Other _____ Referral Name_____

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Dear Patient,

Welcome to the Borealis Naturopathic Health Centre. Our ability to draw effective conclusions about your present state of health and the best way to improve it depends to a certain extent on your ability to complete this questionnaire honestly and accurately. The doctor is the only person who will review this survey and your confidentiality is strictly maintained. If you have questions or concerns about this questionnaire, please call the office and we will help you to decide how best to solve the issue.

Please be sensitive to the fact that some people are not able to tolerate the odour of cigarettes, perfume, and cologne or after-shave lotions. Please come to our office smoke and fragrance free. We appreciate your attention to this. Thank you.

FEE SCHEDULE

Consultation.....$185.00 per hour
(e.g. 1 hour 30 min appointment costs $260.00)
Subsequent Visit.....varies with amount of time spent
Telephone Appointments.....varies with amount of time spent
Hair Analysis (optional).....$100.00
NSF cheques.....$10.00
Medical - Legal reports.....varies with amount of time spent
Failure to keep a scheduled appointment.....cost of scheduled visit

A 10% discount is offered to:

- Seniors
- Full-time under-graduate students

All fees must be paid at the time of the visit including services, remedies and supplements and costs of laboratory tests. Form of payment is cash, Debit, Visa or MC.

ACKNOWLEDGMENT

Naturopathic medicine uses non-invasive methods for the assessment of bodily dysfunction, and natural therapeutics for their correction. There is a great deal of commonality in what Naturopathic Doctors and Medical Doctors do. However, each person seeking care at the Centre should realize that the doctor is a Naturopathic Doctor and not a Medical Doctor. If a straight medical diagnosis and/or treatment is required, it is best to see an M.D. about your condition.

In order to avoid any confusion or misunderstanding, we request that all patients read and acknowledge the following:

_____ initial

•That you understand that the Doctor at the Borealis Naturopathic Health Clinic works within the Naturopathic scope of practice, is not a Medical Doctor, and employs some methods which are not orthodox medical practice at this time e.g. Applied Kinesiology.

_____ initial

•That you understand that the treatment here and/or referral to other health professionals is based upon the assessment of conditions revealed through personal history and interview, physical assessment, laboratory testing, and methods that evaluate the electro-magnetic field of the body e.g. Electro-acupuncture-testing.

_____ initial

•That you understand Naturopathic care is not covered under O.H.I.P. at the present time and, therefore, you are responsible for any fees incurred while under treatment at the Centre. Naturopathic care is covered under certain private insurance plans and we, at the Centre, will do our utmost to provide the appropriate documentation to your insurer upon request.

_____ initial

•That you are here as a patient and are not attending the Centre for any other reason without making your intention known to the Doctor and/or to the staff.

Please be informed that you are required to give at least 2 business days notice in case you need to cancel or reschedule any appointment, including the initial one. We regret that otherwise we will need to charge you for the missed appointment.

We greatly appreciate your consideration in this matter.

_____ _____

Date Patient's/Guardian Signature

Confidential Patient Information

What is your weight? _____Height?_____

What are your health concerns in order of importance to you?

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

Who diagnosed your illness? _____

When was this diagnosis made? _____

What health specialists have you seen and when? _____

_____

How has this illness been treated until now, and what results have been obtained to date?

_____
_____
_____
_____
_____

Do you have a pacemaker or other electronic device? _____

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

a. _____
b. _____
c. _____
d. _____
e. _____

Is there any other information regarding your health which you would like to add?_____

_____

_____

Are you regularly exposed to toxins or other hazards at your work, home or when engaged in hobbies? _____

_____

- Electromagnetic Field _____
- Loud noise_____

What other health care are you presently receiving?_____

_____

When was you last physical exam?_____ Name of doctor?_____

Please list any surgeries or hospitalizations and date:_____

_____

_____

Please describe with dated all serious accidents, severe injuries, head injuries and broken bones: _____

Please list all prescription, over the counter medications, nutritional and herbal supplements you are currently taking:_____

_____

_____

FAMILY HEALTH HISTORY

INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER AILMENTS HAVE AFFECTED YOUR RELATIVES:

Alcoholism	Asthma	Epilepsy	Heart Disease	Paralysis	Syphilis
Allergies	Cancer	Gonorrhea	Hypertension	Pneumonia	Thyroid Disorder
Alzheimer's	Depression	Gout	Kidney Disease	Skin Disorder	Tuberculosis
Arthritis	Diabetes	Hay Fever	Mental Illness	Digestive Disorders	

RELATIVE	AGE IF ALIVE	AGE AT DEATH	AILMENTS
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

REVIEW OF SYMPTOMS:
Please circle "Y" if you have the condition now and "P" if you had it in the past.

SKIN:

Rashes	Y	P
Hives	Y	P
Acne	Y	P
Boils	Y	P
Eczema	Y	P
Psoriasis	Y	P
Dry skin	Y	P
Itching	Y	P
Lumps	Y	P
Night sweats	Y	P

How often _____
Other _____
_____

MOUTH &THROAT:

Hoarseness	Y	P
Gum problems	Y	P
Dental cavities	Y	P
Sores	Y	P
Mouth dryness	Y	P
Sore throats	Y	P
Lost taste	Y	P

Other _____
_____

RESPIRATORY:

Wheezing	Y	P
CoughingY	P	
Breath short	Y	P
Difficult breath	Y	P
Chest pain	Y	P
Bloody sputum	Y	P
Emphysema	Y	P
Asthma	Y	P
Breath painful	Y	P
Bronchitis	Y	P
Pneumonia	Y	P
Pleurisy	Y	P

Last chest X-Ray _____
Last TB test _____
Other _____

GASTROINTESTINAL:

Heartburn	Y	P
Difficult swallow	Y	P
Thirst changes	Y	P
Appetite changes	Y	P
Nausea	Y	P
Indigestion	Y	P
Gas/belching	Y	P
Constipation	Y	P
Rectal bleeding	Y	P
Hemorrhoids	Y	P
Jaundice	Y	P
Hernias	Y	P
Diarrhea	Y	P

# of BM/day _____

HEAD:

Headache	Y	P
Migraine	Y	P
Dizziness	Y	P
Injuries	Y	P

Amalgam fillings _____
_____

NECK:

Pain	Y	P
Swollen glands	Y	P
Lumps	Y	P
Goiter	Y	P
Stiffness	Y	P

Other _____

NOSE & SINUSES:

Bleeding	Y	P
Stuffiness	Y	P
Hay fever	Y	P
Injury	Y	P
Colds	Y	P
Allergies	Y	P
Obstruction	Y	P
Sinus problems	Y	P

Other _____
_____

CARDIOVASCULAR:

Heart disease	Y	P
Angina	Y	P
High blood pres	Y	P
Murmurs	Y	P
Chest pain	Y	P
Palpitations	Y	P
Ankle swelling	Y	P
Rheumatic fever	Y	P

Last ECG test _____
Other _____
_____

URINARY:

Pain urinating	Y	P
More frequent	Y	P
Reduced flow	Y	P
Kidney stones	Y	P
Blood in urine	Y	P
Infections	Y	P
Incontinence	Y	P

Other_____

EYES:

Impaired vision	Y	P
Pain	Y	P
Redness	Y	P
Double vision	Y	P
Cataracts	Y	P
Light sensitive	Y	P
Discharge	Y	P
Tearing	Y	P
Dryness	Y	P
Itching	Y	P
Blurring	Y	P
Glaucoma	Y	P
Blind spot(s)	Y	P
Contact lens	Y	P

Other _____
_____

EARS:

Discharge	Y	P
Itching	Y	P
Excess wax	Y	P
Infection	Y	P
Ringing	Y	P
Earache	Y	P
Hearing loss	Y	P

Other _____
_____

BREASTS:

Lumps	Y	P
Tenderness	Y	P
Self examine?	Y	P

Other _____
_____

PERIPHERAL VASCULAR:

Cold hands/feet	Y	P
Deep leg pain	Y	P
Varicose veins	Y	P
ThrombophlebitisY		P

Other _____
_____

MUSCULOSKELETAL:

Joint pain	Y	P
Arthritis	Y	P
Broken bones	Y	P
Numbness	Y	P
Tingling	Y	P
Muscle spasms	Y	P
Weakness	Y	P
Backache	Y	P

Other _____

FEMALES:

Age of first menses____
Menopause symptoms Y P
Age_____
Type of birth control___
How long?_____
Last pap_____
Vaginal discharge Y P
Vaginal itching Y P
Other_____

MENSES:

Cycle regular Y N
Length of cycle_____
Bleeding between periods Y P
Painful menses Y P
Excessive flow Y P
No. of pregnancies_____
Age_____
No. of miscarriages_____
No. of abortions_____

PMS SYMPTOMS:

Depression Y P
Bloating Y P
Increased appetite Y P
Weight gain Y P
Breast tenderness Y P
Other_____

REPRODUCTIVE:

Sexual difficulties Y P
Venereal disease Y P

MALE:

Prostate Symptoms Y P
Impotence Y P
Testicular masses Y P
Hernia Y P
Urgency of urination Y P
Incomplete urination/ dribbling Y P
Decreased sexual desire Y P

BLOOD/LYMPHATICS:

Anemia Y P
Swollen lymph's Y P
Easy bleeding Y P
Bruising Y P
Transfusions Y P
Clotting Y P

ENDOCRINE:

Thyroid problems Y P
Diabetes Y P
Hypoglycemia Y P
Hormone therapy Y P
Other_____

NEUROLOGICAL:

Fainting Y P
Seizures Y P
Convulsions Y P
Paralysis Y P
Muscle weakness Y P
Memory loss Y P
Involuntary movements Y P
Loss of balance Y P
Speech problems Y P
Other_____

PSYCHO/SOCIAL:

Depression Y P
Tension Y P
Mood swings Y P
Phobias Y P
Sleep problems Y P
Anxiety Y P
Nervousness Y P
Low back pain Y P
Knee pain Y P
Ringing in the ears Y P

ADRENAL:

Fatigue, apathy Y P
Allergies Y P
Delayed wound healing Y P
Low blood pressure Y P
Dizziness when standing up Y P
Frequent urination Y P
Urination at night Y P
Muscular weakness Y P
Nervousness Y P
Low back pain Y P
Knee pain Y P
Ringing in the ears Y P

THYROID:

Loss of hair Y P
Weight gain Y P
Dry skin Y P
Loss of outer part of eyebrows Y P
Menstrual disorders Y P
Stubborn constipation Y P
Goiter Y P
Low or high blood cholesterol Y P
Feeling very cold Y P

LIVER:

Anemia Y P
Hypertension Y P
Elevated blood cholesterol Y P
Low energy before eating Y P
Decreased drug or alcohol tolerance Y P
Premenstrual tension Y P
Endometriosis Y P
Heavy menses Y P
Frequent headaches Y P
Skin problems Y P
Constipation Y P
Gall bladder problems Y P
Chronic muscle tension Y P
Eye problems Y P
Difficulty digesting fatty foods Y P

PANCREAS:

Food allergies Y P
Blood sugar abnormalities Y P
Maldigestion Y P
Undigested food in stool Y P
Bowel gas Y P
Stool floats Y P

PARATHYROID:

Osteoporosis Y P
Joint pain Y P
Gum/tooth disease Y P
Kidney stones Y P
Ridged fingernails Y P

INFORMED CONSENT FOR ACUPUNCTURE

Patient Name:

Attending Practitioner: _____

Recommended Procedure(s) and point(s) to be treated: _____

_____

_____

_____

I, the undersigned, do herby acknowledge that I have been informed of and understand the nature and purpose of the recommended acupuncture treatment procedure and have discussed this to my satisfaction with the practitioner named above. I further acknowledge that I understand the expected benefits, potential risks and side effects, the likely consequences of not following the after-care instructions, and what alternate course(s) of action are available to me (including having no treatment).

As a result, I do hereby voluntarily consent to the recommended acupuncture treatment as specified above.

_____ _____

Signature of Patient or Lawful Guardian *Date Signed*

_____ _____

*Signature of Witness** *Signature of attending Practitioner*

*Witness signature is advised but not required