health flow
naturopathic solutions

Healing Touch Health Centre
Suite 305, 908 17th Avenue SW, Calgary, AB, T2T 0A3
t.403.244.8925 f.403.541.1034 dr.cook@healthflow.ca

# Consent to naturopathic diagnoses and treatment

Patient Name_________________________________________ File #: ________________________

Attending N.D.__________________________ License #: _______ Assistant__________________________

I, the undersigned, do hereby acknowledge that I have the right to be informed of any recommended diagnostic and/or treatment procedure(s) and have the right to discuss this, to my satisfaction and understanding. I have the right to request related information with the naturopathic doctor named above and/or with his office or clinical assistant(s). I further acknowledge and confirm that, prior to any diagnostic and/or treatment procedures, I have the right to be informed of, and understand the diagnostic and treatment procedure(s) with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.

As a result, I do hereby voluntarily give my informed consent for Naturopathic diagnostic and treatment procedure(s). I also understand that I may change the status of my voluntary informed consent at any time.

________________________________________ ________________________________________
Patient or Lawful Representative Signature — Date Signed

________________________________________ ________________________________________
Witness Signature* — Witness Relation to Patient

Address ________________________________________

________________________________________
Phone no

Town/City ________________________________________

Province ________________________________________

________________________________________
Attending N.D. / Assistant

Postal Code ________________________________________

*Witness signature is advised but not necessary

License #____________________________

I, ____________________________________________, also agree to pay the full cost of any scheduled appointment that I miss, unless I give 24 hours notice.

________________________________________ ________________________________________
Patient or Lawful Representative Signature — Date Signed

CHANGE STATUS OF INFORMED CONSENT (fill only if withdrawing your consent to treat)

I do hereby voluntarily withhold and/or withdraw my informed consent for the Naturopathic diagnostic and treatment procedure(s) as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

________________________________________ ________________________________________
Patient or Lawful Representative Signature — Date Signed

________________________________________ ________________________________________
Witness Signature* — Witness Relation to Patient

Address ________________________________________

________________________________________
Phone no

Town/City ________________________________________

Province ________________________________________

________________________________________
Attending N.D. / Assistant

Postal Code ________________________________________

*Witness signature is advised but not necessary

License #____________________________

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# General Information

The information that you provide is very important in the assessment of your case. It is vital that you fill it out as accurately as possible. Thank you in advance.

Name: ______________________________ Date (mm/dd/yr): ______________

Address: ______________________________

City: ______________________ Province: ________ Postal Code: ________

Phone – Home ( ) ______________ Phone – Work: ( ) ______________

E-mail: ______________________________

Sex: ______ Age: ______ Date of birth: ________ Birthplace: ______________

Emergency contact name and number: ______________________(____)________

Relationship: ______________ Number of weeks of vacation do you take per year? ________

Occupation: ______________________ Hours of work per week: ________

Do you like your job? Yes / No Retired? Yes / No If yes, when? ____________

Past occupations: ______________________________

Marital status: __________ Religion or personal philosophy: ______________

Names of children and age: ______________________________

______________________________

Contact information of Family Medical Doctor: Name ______________________

Address: ______________________________

Phone: ( ______ ) ______________________ Fax: ( _____ ) ______________________

How did you hear about us? ______________________________

What are your main health concerns? (*current symptom scale 1-10, 10 being the worse its ever been)

| Importance | First noticed | Health concern | *Scale 1-10 |
|---|---|---|---|
| (Most) 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| (Least) 7 | | | |

Please list two to three expectations you have today from your Naturopathic Doctor:

______________________________

______________________________

Please outline your long term expectations that you have of your Naturopathic Doctor:

______________________________

______________________________

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## Medical History – General:

Date of last physical exam: ________________________Weight: ______________ Height: _______________

Maximum Weight: ____________ When?_____________ Energy Level (1-10 with 10 the highest) _______

Blood type:__________ Date of last blood test: _______________ Why it was taken? _________________

Do you usually wake up feeling refreshed? Yes / No Problems falling asleep? Yes / No

Hours of sleep/night: ____________ Do you wake up during the night? Yes / No

If yes, when and why do you get up?______________________________________________________

Do you sleep on a water bed or use an electric blanket? Yes / No If yes, how long: ________________

Amount of time you spend outside a week? _______hrs. Amount of time reading a week? _________hrs

What do you read? ________________ ________________________________________________________

Time watching T.V. or on computer?_______/week Number times you go out to eat?________/week

Do you eat breakfast? Yes / No If yes, how often ______/week

Number of meals per day?_________ Number of snacks? ______ Vegetarian? Yes / No

If yes, what type: ____________ Any food allergies/sensitivities?___________________________________

Do you eat: Tuna? Yes / No How often?_________ Swordfish? Yes / No How often? ___________

Do you use an antiperspirant? Yes / No Use deodorant? Yes / No Brand: _____________________

Do you smoke now? Yes / No How many cigarettes or packs per day? _________________________

Have you ever smoked? Yes / No How many cigarettes or packs per day? ______________________

Have you ever used recreational drugs? Yes / No If yes, what ?___________________________________

How long? ________________ Do you drink alcohol? Yes / No How many per week? __________

Do you drink: coffee? Yes / No Cups/day: _______ Black tea? Yes / No Cups/day: _________

Have you had any dental work done before problems started? Yes / No If Yes, When?_____________

Describe problem:_______________________________________________________________________

Do you have any known allergies? Yes / No Which? _________________________________________

Current medications, dosage & how long taken (use other side of page if more space is needed): _______

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Current vitamins and other supplements (use other side of page if more space is needed):_____________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

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What other treatments have you tried with other health care providers:______________________________

_____________________________________________________________________________

_____________________________________________________________________________

Are you currently pregnant? Yes / No Are you currently breastfeeding? Yes/ No

## Childhood (please circle all that apply):

Have you ever had any of the following? Measles / Rubella / Rheumatic Fever / Mumps / Whooping Cough / German Measles / Diphtheria / Chickenpox / Scarlet Fever / Polio / Meningitis / Mononucleosis / Smallpox Other: ___________________________________________________

Were you born premature? Yes / No Were you born vaginally or C-section? ________________

Other birth complications? ____________________________________ Are you a twin? Yes / No

Were you breast fed as a new born? Yes / No At what age did you begin eating solids?__________

## Vaccinations (please circle all that apply):

Pertussis / Rheumatic fever / Polio / Measles / Mumps / Rubella / Tetanus / Smallpox

Other: ____________________ Did you have any reactions to the vaccination (e.g. fever)? Yes / No

If yes, what type of reaction? _____________________________________________________

## X-Rays (please circle all that apply):

Teeth / Stomach / Gall bladder / Back / Chest / Colon / Extremities / Other: ________________

Your last EKG/ECG (heart) test: ___________________ Last EEG (brain) test was: ____________

Have you ever had a blood or plasma transfusions? Yes / No If yes, when? ________________

# Habits/Lifestyle

Do you participate in physical activities that give you relaxation at least 3 hours weekly? Yes / No

If yes, what type of activities?

1. __________________________________________________ Number of hours per week?_____
2. __________________________________________________ Number of hours per week?_____
3. __________________________________________________ Number of hours per week?_____

What type of water do you drink (circle all that apply): Tap / Spring / Distilled / Reverse osmosis

How much water do you drink per day? _______________ ml / oz. / glasses (circle most appropriate)

Do you have any implants or transplants (screws, pins, pacemakers, etc.)? Yes / No

What type and when placed? ________________________________________________________

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# Review of Body Systems

Please circle "N" if you never had, "Y" if you have now and "P" if you had the condition.

**General:**
N / Y / P Cancer
N / Y / P Sensitivity to cold
N / Y / P Excessive hair loss
N / Y / P Sudden tiredness / weakness
Time of day: ______________________
N / Y / P Fever / Chills
N / Y / P Rapid weight gain / loss
N / Y / P Sweat easily / excessively

Other: ________________________________

**Skin:**
N / Y / P Rashes
N / Y / P Psoriasis
N / Y / P Boils
N / Y / P Scabies
N / Y / P New Moles / Changes in old moles
N / Y / P Hives
N / Y / P Acne
N / Y / P Dry Skin
N / Y / P Lice
N / Y / P Night Sweats

How often? ______________________

Other: ________________________________

**Head:**
N / Y / P Headache
N / Y / P Jaw / TMJ problems
N / Y / P Injuries
N / Y / P Discharge
N / Y / P Itching
N / Y / P Excess wax
N / Y / P Infections
N / Y / P Ringing in ear
N / Y / P Earache
N / Y / P Hearing Loss
N / Y / P Loss of balance / vertigo / dizzy

Other:___________________________

**Eyes:**
Glasses / contacts? Yes / No

If yes, since when? _____________________

Prescription? __________________________

Has it changed? Yes / No When?________

Are you Near sighted or Far sighted? ______
N / Y / P Impaired vision
N / Y / P Spots / Stars in vision
N / Y / P Eye pain
N / Y / P Double vision
N / Y / P Cataracts
N / Y / P Redness
N / Y / P Light sensitivity
N / Y / P Discharge
N / Y / P Loss of sight
N / Y / P Tearing or dryness
N / Y / P Glaucoma
N / Y / P Itching
N / Y / P Blurring
N / Y / P Blind spot(s)
N / Y / P Color blind

Other: ________________________________

**Nose and Sinuses:**
N / Y / P Nose bleeds
N / Y / P Injury
N / Y / P Stuffiness
N / Y / P Allergies
N / Y / P Sinus problems
N / Y / P Loss of smell
N / Y / P Obstructions

Other: ________________________________

**Mouth and Throat:**
N / Y / P Hoarseness
N / Y / P Grinding teeth / Teeth problems
N / Y / P Gum problems
N / Y / P Excessive saliva
N / Y / P Metallic taste in mouth
N / Y / P Jaw clicks
N / Y / P Sores on lips / tongue / mouth
N / Y / P Many sore throats
N / Y / P Dental cavities
Silver fillings? Yes / No
Gold crowns Yes / No
Other: ________________________________

Other metal appliances: ________________

______________________________________

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**Neck:**
N / Y / P Lump
N / Y / P Pain
N / Y / P Swollen glands
N / Y / P Goiter
N / Y / P Stiffness

Other: ______________________________

**Respiratory:**
N / Y / P Chronic or frequent cough
N / Y / P Frequent colds
N / Y / P Chronic mucous in throat
N / Y / P Excessive phlegm
N / Y / P Pain on breathing
N / Y / P Bronchitis
N / Y / P Chest pain
N / Y / P Coughing blood
N / Y / P Difficulty breathing
N / Y / P Wheezing
N / Y / P Asthma
N / Y / P Hayfever
N / Y / P Shortness of breath
N / Y / P Emphysema
N / Y / P Pneumonia
N / Y / P Pleurisy

Other: ______________________________

Last chest x-ray: ______________________

Last T.B. test: ________________________

**Breasts:**
N / Y / P Fibrous tissue
N / Y / P Pain
N / Y / P Lumps
N / Y / P Tenderness
Do you self examine? Yes / No

Other: ______________________________

**Urinary:**
N / Y / P Pain on urination
N / Y / P Increased frequency
N / Y / P Frequency at night
N / Y / P Inability to urinate
N / Y / P Inability to hold urine
N / Y / P Abnormal thirst
N / Y / P Swelling of hands / feet / ankles
N / Y / P Bladder / kidney disease/infections
N / Y / P Kidney stones
N / Y / P Blood / sugar / pus in urine
N / Y / P Frequent infections
N / Y / P Decrease in flow

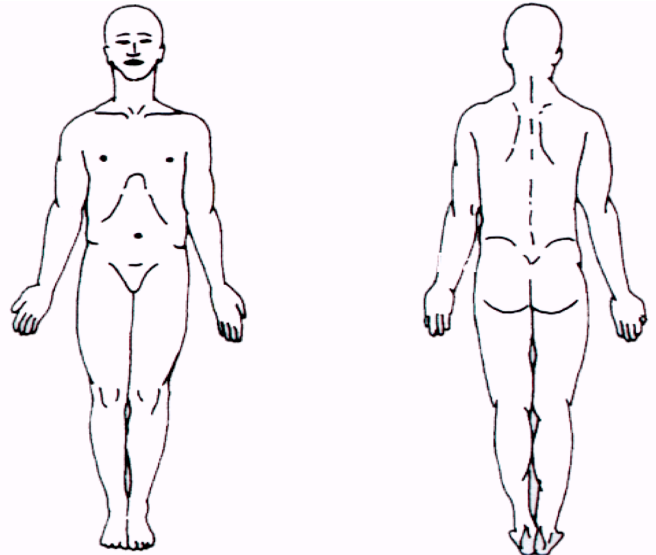
Other: ______________________________

Colour of urine: Pale / Yellow / Dark / Frothy

**Musculoskeletal:**
N / Y / P Joint pain or stiffness
N / Y / P Arthritis/rheumatism
N / Y / P Broken bones
N / Y / P Sciatica
N / Y / P Numbness/tingling
N / Y / P Muscle spasm/cramps
N / Y / P Muscle weakness
N / Y / P Back pain
N / Y / P Shoulder pain

Other: ______________________________

**Body map**:
Mark pain locations with **"X"** and mark numbness or tingling with **"O".**
Use **arrows** to indicate direction of radiation, if present.



**Peripheral Vascular:**
N / Y / P Cold hands / feet
N / Y / P Easy bleeding or bruising
N / Y / P Deep leg pain
N / Y / P Varicose veins
N / Y / P Thrombophlebitis

Other: ______________________________

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**Cardiovascular:**
N / Y / P Heart disease
N / Y / P Stroke
N / Y / P Ankle swelling
N / Y / P Palpitations / Irregular heart beat
N / Y / P Rheumatic fever
N / Y / P Chest pain / angina
N / Y / P Phlebitis
N / Y / P High blood pressure
N / Y / P Murmurs

Other: ___________________________

**Gastrointestinal:**
N / Y / P Difficulty swallowing
N / Y / P Food allergies
N / Y / P Colitis
N / Y / P Spitting up blood
N / Y / P Jaundice
N / Y / P Gall bladder problems
N / Y / P Nausea / vomiting
N / Y / P Indigestion / bloating
N / Y / P Belching / gas
N / Y / P Regurgitation
N / Y / P Abdominal pain
N / Y / P Appendicitis
N / Y / P Heartburn
N / Y / P Change in thirst
N / Y / P Change in appetite
N / Y / P Hernias
N / Y / P Hepatitis
N / Y / P Diarrhea
N / Y / P Constipation
N / Y / P Black stool
N / Y / P Mucous in stool
N / Y / P Rectal bleeding / bloody stool
N / Y / P Hemorrhoids
N / Y / P Change in bowel movement
Number of bowel movements per day _____

Other: ___________________________

Symptoms relieved by eating ? Yes / No
Symptoms worse by eating ? Yes / No

Food desires/cravings: _______________

___________________________________

___________________________________

Foods that disagree: _________________

___________________________________

___________________________________

Foods aversions: ____________________

___________________________________

___________________________________

**Reproductive:**
N / Y / P Sexual difficulties
N / Y / P Herpes
N / Y / P Gonorrhea
N / Y / P Non-specific venereal disease
N / Y / P Chlamydia
N / Y / P Syphilis
N / Y / P Genital infection
N / Y / P Warts on genitals
Are you HIV+? Yes / No
Are you sexually active now? Yes / No
Sexual preference (circle):
Heterosexual / Bisexual / Homosexual
Pain during intercourse: Yes / No
Increased sex drive: Yes / No
Decreased sex drive: Yes / No

Other: ___________________________

**Reproductive – Males:**
N / Y / P Prostate disease
N / Y / P Testicular pain
N / Y / P Testicular masses
N / Y / P Discharge or sores
N / Y / P Hernias
N / Y / P Impotence
N / Y / P Premature ejaculation

Birth control (if yes, type?): ____________

Since when: ________________________

Other: ___________________________

**Reproductive – Females:**
Menopausal? Yes / No

If yes – Age: ________________________

Symptoms: _________________________

Birth control (if yes, type?): ____________

Since when: ________________________

Regular menstrual cycle ? Yes / No
Bleed between menstrual? cycles Yes / No

Length of cycle (days): ______________

Duration of flow (days): ______________

Flow is: Heavy / Medium / Light

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**Reproductive – Females:** (continued)

Blood clots during menstruation: Yes / No
Pains or cramps: Yes / No
If yes, Pain or cramps occurs: before / during / after (in relation to beginning of flow)
Age at first menstrual cycle : ____________

First day of last menstrual cycle :__________

Number of pregnancies: ________________

Number of miscarriages: ________________

Number of abortions: ___________________

Pregnancy complications: Yes / No

Date of last PAP: ______________________

N / Y / P Vaginal discharge
N / Y / P Frequent yeast / other infections
N / Y / P Endometriosis
N / Y / P Ovarian cysts
N / Y / P Difficulty conceiving
N / Y / P Cervical dysplasia
N / Y / P Breast pain / tenderness
N / Y / P Regular self breast exams
N / Y / P Nipple Discharge
N / Y / P Do self breast exams

**Pre Menstrual Syndrome Symptoms:**
N / Y / P Depression
N / Y / P Bloating
N / Y / P Increased Appetite
N / Y / P Weight gain
N / Y / P Breast tenderness

Other: ________________________________

**Neurological:**
N / Y / P Fainting
N / Y / P Numbness / tingling / paralysis
N / Y / P Involuntary movements
N / Y / P Muscle weakness
N / Y / P Loss of coordination
N / Y / P Concussion / head injury
N / Y / P Loss of memory / poor memory
N / Y / P Seizures / Convulsions
N / Y / P Loss of balance
N / Y / P Speech problems
N / Y / P Hallucinations / Mental confusion
N / Y / P Poor concentration

Other: ________________________________

**Endocrine:**
N / Y / P Thyroid problems
N / Y / P Diabetes
N / Y / P Hormone therapy
N / Y / P Excessive thirst
N / Y / P Excessive hunger
N / Y / P Excessive tiredness
N / Y / P Seasonal Depression
N / Y / P Excessive hair loss
N / Y / P Brittle nails

Other: ________________________________

**Blood/Lymphatics:**
N / Y / P Anemia
N / Y / P Easy bleeding/bruising
N / Y / P Lymph node swelling
N / Y / P Blood transfusions

Other: ________________________________

**Psycho/Social:**
N / Y / P Depression
N / Y / P Attempted suicide
N / Y / P Mood swings
N / Y / P Anxiety / Nervousness
N / Y / P Tension
N / Y / P Easily angered / Easy to cry
N / Y / P Phobias
N / Y / P Sleep problems
N / Y / P Alcoholism / drug abuse
Do you consider yourself (circle one):
Underweight / Overweight / Just right
Have you ever had psychiatric-psychological counselling? Yes / No

Other: ________________________________
What would you like to change in your life?

________________________________

________________________________

________________________________

Express your emotions easily? Yes / No

How much stress are you under? (1-10, with 10 the highest level): ________________

What are the major stresses in your life? ___

________________________________

________________________________

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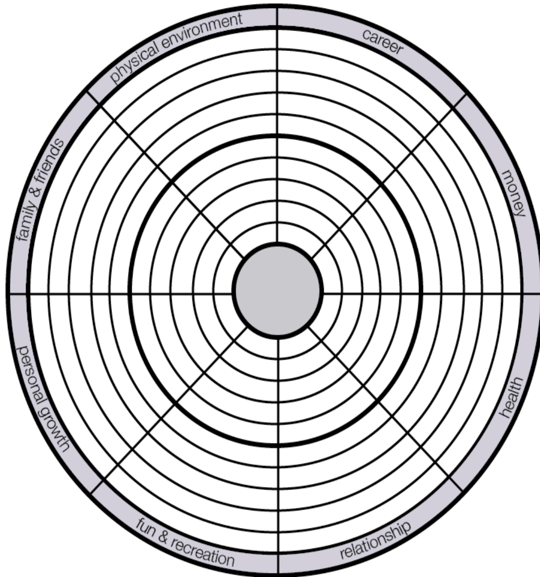
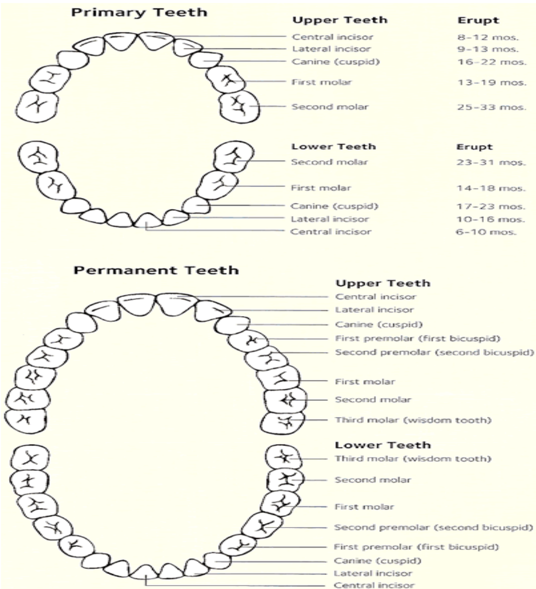
Wheel of Balance: Shade your level of satisfaction in each pie area as it relates to you. Start from the centre and work your way outward. The dark circle border in the middle represents 50% satisfaction.




Map of your Teeth: Primary teeth map is for children while the Permanent teeth map is for adults. Use a **"/"** over the teeth that have had dental work (filling, bridges, crowns etc.) Use an **"X"** over root canalled teeth.

| Preference | Favorite | Least Liked |
|---|---|---|
| Colour | | |
| Taste | | |
| Smell | | |
| Season | | |
| Time of day | | |

Please list in order of appearance from your birth, all hospitalizations, surgeries, diseases, major accidents, traumas and scars (emotional and physical). The outcome? (write on reverse side if needed)

| Age | Event | Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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

______________________________

______________________________

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# Family Medical History

Please place an **"X"** in the box that corresponds to the blood relative whom has been affected by the indicated condition.

| Condition | Mom | Dad | Sister | Brother | Grandma | Grandpa | Aunt | Uncle | Others |
|---|---|---|---|---|---|---|---|---|---|
| Heart attack / disease Type: | | | | | | | | | |
| High blood pressure Severity: | | | | | | | | | |
| Arteriosclerosis / Stroke Type: | | | | | | | | | |
| Asthma Severity: | | | | | | | | | |
| Lung disease / T.B. Type: | | | | | | | | | |
| Liver disease / Cirrhosis Type: | | | | | | | | | |
| Gall bladder disease Type: | | | | | | | | | |
| Hypoglycemia / Diabetes Type: | | | | | | | | | |
| Kidney disease Type: | | | | | | | | | |
| Thyroid disorders / Obesity Type: | | | | | | | | | |
| Digestive Problems Type: | | | | | | | | | |
| Food Allergies Type: | | | | | | | | | |
| Arthritis / Gout Type: | | | | | | | | | |
| Eczema / Psoriasis Type: | | | | | | | | | |
| Skin Allergies / Hives Type: | | | | | | | | | |
| Cancer Type: | | | | | | | | | |
| Epilepsy / Nervous breakdown Type: | | | | | | | | | |
| Syphillis / Gonorrhea Type: | | | | | | | | | |
| Miscarriages Number: | | | | | | | | | |
| Other Type: | | | | | | | | | |

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