**Agreements**

**Welcome to our office.** By coming in today, you have made a commitment to your health. I hope you enjoy your experience with naturopathic medicine as we work together to help you attain your full health potential.

**Services Offered:**

Clinical Nutrition

Botanical Medicine

Homeopathic Medicine

Lifestyle Counselling

Body Work (Cranialsacral Therapy)

Acupuncture

Laboratory Testing

**Fees:** Payment is required upon receipt of service. Payment methods include cash, Visa, Mastercard, cheque and debit.

Initial Visit 75-90 minutes $180.00

Follow-Up Visit 30-45 minutes $85.00

Acupuncture (in series) 30-45 minutes $75.00

Acute Visit 15 minutes $40.00

**Fees for Children, Seniors, and Full-Time Students:**

Initial Visit 75-90 minutes $145.00

Follow-Up Visit 30-45 minutes $75.00

**All fees exclude costs of any naturopathic medicines and laboratory testing that may be recommended.** None of our fees are covered by OHIP. However, naturopathic services are covered by most private health insurance plans; please check your individual policies. Non-insured portions are eligible medical expenses for federal income tax purposes.

**NSF:** NSF cheques are subject to a $25.00 charge.

**Cancellation Policy:** If you cannot make your appointment, please call the office at least 24 hours prior to your scheduled visit and leave a message at (519)822-7075. Any visit not cancelled with at least 24 hours’ notice is subject to the FULL visit charge. **Initial appointments require a credit card form (which can be found at wyernaturopathic.ca) to be filled out and received by us prior to your appointment in order to secure your spot. Initial appointments require 48 hours notice for cancellations.**

**Your visit:** The time we spend in the office is dedicated to *you* and *your* health. You will be asked a number of detailed questions that help provide me with a comprehensive understanding of your health concerns. Take your time in answering these questions. Everything that goes on in this office is strictly confidential. If at any time during the course of your care you feel your needs have not been heard, attended to appropriately, or handled with consideration and efficiency, I welcome and encourage your constructive feedback. Your questions are always welcome. I look forward to working with you toward optimal health and well-being.

**ADULT DECLARATION AND CONSENT TO TREATMENT**

Each person seeking care in this clinic should understand that the practitioner is a licensed naturopathic doctor and practices primary care differently than a medical doctor does. If medical diagnosis is required, it must be obtained from a licensed medical doctor.

Naturopathic medicine uses non-invasive methods for the assessment of bodily dysfunction and natural therapeutics for its correction. The assessment and therapeutic methods used in this clinic include clinical nutrition, homeopathic medicine, botanical medicine, hydrotherapy, detoxification techniques, acupuncture, soft tissue and joint manipulation, parenteral therapies, and lifestyle modification techniques.

Each person must provide consent to treatment by signing this document before any treatment will be rendered.

**My signature acknowledges that:**

1. I have been informed of and I understand that:
   1. The treatments that I receive in this office are different from those usually offered by a medical doctor or other licensed health care provider.
   2. I am at liberty to seek or continue to seek medical care from a physician, surgeon or other health care provider qualified to practice in Ontario.
   3. I confirm that none of the above listed naturopathic doctors, nor anyone else under their control has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.
2. I declare that I have received a full and complete explanation of the treatment or services that I may receive at this office and hereby authorize and consent to treatment.
3. I agree to pay my full amount at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests and other fees. I am aware that these fees are not covered by OHIP.

**I,** (*print name*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, **have read, understood, and acknowledge the above statements.**

**Signature:** (*please sign in my* *office*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIVACY FORM**

**PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION**

Privacy of your personal information is an important part of our clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collection, using and disclosing your personal information responsibly and in compliance with policy requirements governing the naturopathic profession. We will try to be as open and transparent as possible about the way we handle your personal information.

In this clinic, Sarah S. Wyer, ND acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of its sensitive nature. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic is doing to ensure that:

* Only necessary information is collected about you;
* We only share information with your consent;
* Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
* Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy (BDDT-N).

How our clinic collects, uses and discloses patients’ personal information:

The clinic will collect, use and disclose information about you for the following purposes:

* To assess your health concerns;
* To provide health care;
* To advise you of treatment options;
* To establish and maintain contact with you;
* To send you any pertinent information and mailings;
* To remind you of upcoming appointments;
* To communicate with other treating health care providers;
* To allow us to efficiently follow up for treatment, care and billing;
* To complete claims for insurance purposes;
* To comply with legal and regulatory requirements of our regulatory body, the BDDT-N acting under the authority of the *Drugless Practitioners Act*;
* To invoice for goods and services;
* To process credit card payments;
* To collect accounts receivable;
* To assist this clinic to comply with all regulatory requirements;
* To comply generally with the law;
* To allow potential purchases, practice brokers or advisors to conduct an audit in preparation for a practice sale.

By signing the consent section (below) of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

**PATIENT CONSENT**

I agree that the Wyer Wellness Centre can collect, use and disclose personal information

about **me / my child**, (*print patient name*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as set out in the information about the clinic’s privacy policies above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of patient (18+) or parent/guardian of child (<18) Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of witness Date**

Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Home) (\_\_\_\_)-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work)(\_\_\_\_\_)-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OK to leave a message? YES / NO

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: SGL MAR DIV SEP CL Widowed # of Children \_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find out about my office?

* Referred by a friend/family member Name of Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Yellow Pages
* Attended a talk
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Physician or Health Care Practitioner seen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last physical exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood tests done? YES / NO Blood Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONFIDENTIAL HEALTH HISTORY**

What is your **main** reason for coming in today?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List in order of importance other health problems that are troubling you:

1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_& length of time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_& length of time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_& length of time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_& length of time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of medical treatment have you received?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever seen a:

Naturopathic Doctor Chiropractor Acupuncturist Massage Therapist Osteopath

Other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the therapy and what were the results?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Health History**

The general state of your health is: **excellent\_\_\_\_\_\_ good\_\_\_\_\_\_ avg\_\_\_\_\_\_ fair\_\_\_\_\_\_ poor\_\_\_\_\_\_\_**

What is your current level of energy from 1 to 10 (where 10 is the best you have ever felt)? \_\_\_\_\_

What is your approx. weight?\_\_\_\_\_\_ One year ago?\_\_\_\_\_\_Ideal Weight?\_\_\_\_\_\_ Height\_\_\_\_\_\_

Please list the 5 most significant, stressful events in your life:

1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

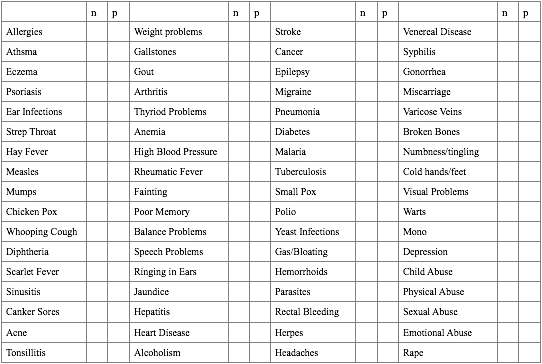
4)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are any of these situations continuing to impact your life? YES / NO (Please circle)

Are you currently working with a professional counselor, psychologist, social worker, pastor, or other therapist?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you in the past?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which of the following have you had and indicate now (n) or past (p):



Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any of these from which you feel you have never been well since? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to any drugs, herbs, foods, animals, or other? YES / NO

Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any major injuries? If so, what happened and when?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous surgeries and hospializations (include dates)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you vaccinated? YES / NO Did you have any adverse reactions (e.g. fever)? YES / NO

**Which of the following do you currently use?** Please indicate how much, how often & how long:

alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ tobacco\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hormones\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ coffee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

cortisone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

laxatives\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

sedatives\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ antacids\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

recreational drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other medications** (please give name, dose, and amount of time on the medication)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vitamins/Herbs**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other supplementation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

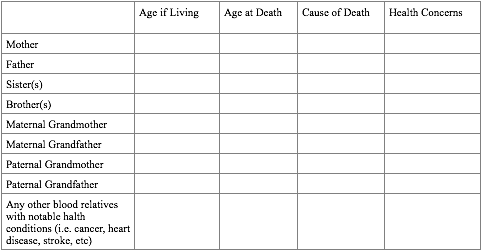
Do you currently live with? Spouse\_\_\_\_ Partner\_\_\_\_ Parents\_\_\_\_ Friends\_\_\_\_ Children\_\_\_\_ Alone\_\_\_

Are you currently in a happy supportive relationship? **Ver Mostly Somewhat Not**

What is your weakest organ system and why? (example: digestive, immune, etc)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**



**Personal Habits**

What do you enjoy most in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your main interests or hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you worry about most in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What nurtures you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? YES / NO If yes, what, and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a religious or spiritual practice? YES / NO

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) \_\_\_\_\_\_\_\_\_\_\_\_

Do you have a problem falling asleep?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staying asleep?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-

How much do you sleep? \_\_\_\_\_\_\_\_\_\_\_hrs

How many hours of sleep do you think you need?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wake refreshed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you nap or rest horizontally throughout the day? YES / NO

For how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your body temperature compared to others? **Warmer Cooler Average**

Do you enjoy your work? YES / NO Do you take vacations? YES / NO

How often do you get colds, flu, sore throats in a year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you learn? **I read I listen Television Stories Visual Hands on**

**Reproductive**

Are you sexually active? YES / NO

Is this more or less than one year ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Preference: Heterosexual\_\_\_\_\_\_\_ Bisexual\_\_\_\_\_\_\_\_\_\_ Homosexual\_\_\_\_\_\_\_\_\_\_\_

Do you use birth control? YES / NO What type of birth control?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Female**

Age of first meses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If periods have stopped, at what age did they stop?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your cycles regular? YES / NO

Periods begin every\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_days, and last\_\_\_\_\_\_\_\_\_\_\_\_\_\_days

Are your periods **heavy medium light**

What colour is the blood?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any clots? YES / NO Any cramps with your period? YES / NO

Do you have any spotting or bleeding between your periods? YES / NO

Every month? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any premenstrual symptoms? **Water retention breast tenderness irritability depression headaches anger mood swings crying bloating acne cravings Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Number of pregnancies\_\_\_\_\_\_\_\_ Number of abortions\_\_\_\_\_\_\_\_\_\_\_\_

Number of miscarriages\_\_\_\_\_\_\_ Number of live births\_\_\_\_\_\_\_\_\_\_\_

Any problems getting pregnant?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get regular PAP smears? YES / NO Any abnormal PAP smears? YES / NO

Do you do regular breast self-exams? YES / NO Have you noticed any lumps? YES/ NO

**Male**

How often do you get up in the night to urinate?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has this increased recently? YES / NO

Any problems with impotency? (Getting or maintaining an erection) YES / NO

Do you have any sores on your penis? YES / NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any abnormal discharge from the penis? YES / NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any venereal diseases?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any prostate problems? YES / NO

Have you had your prostate examined? YES / NO When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Kidneys and Bladder**

Have you had a bladder infection? YES / NO How often?\_\_\_\_\_\_\_\_\_\_\_

How was it treated?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any burning sensation during or after urination? **Past Present**

Is your urine **Dark yellow bright yellow cloudy pale or clear strong odour**

Do you have any difficulty starting or stopping when urinating? YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Perspiration**

Do you have any difficulty perspiring? YES / NO

Does your sweat have a strong odour?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-

Do you perspire when exercising? **Lightly moderately heavily**

Do you perspire at times other than when you exercise? YES / NO When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Digestion and Elimination**

Do you have any problems with gas, bloating, or fullness after eating? YES / NO

How often is this a problem? **Often sometimes never**

How severe?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you have bowel movements?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-

Do you ever have any **blood mucous undigested food black stools**

Any rectal itching? YES / NO Are your stools **formed or loose?** Any diarrhea?\_\_\_\_\_\_

Ever have alternating constipation and diarrhea? YES / NO How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ever have yellow or light coloured stools? YES / NO

Do you ever have to strain to pass stool? YES / NO How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ever pass gas (flatus) frequently?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you burp frequently?\_\_\_\_\_\_\_\_

Do your stools or gas have a strong disagreeable odour? YES / NO

Have you traveled outside of Canada in the last 5 years? YES / NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been camping in the last 5 years? YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever fasted? YES / NO (juice or water)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupational/Household**

Is your home damp or moldy at all? YES / NO

Do you live in the city? YES / NO

Do you have a specialized air filtration at home? YES / NO

Do you work in an office building? YES / NO Do the windows open? YES / NO

Do you work in the presence of toxic fumes or chemicals? YES / NO

Do any of your hobbies involve toxic materials? YES / NO

Are you currently exposed to second hand smoke? YES / NO

What do you use for drinking water? **Tap water bottled water filtered water reverse osmosis**

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_