HEALTH HISTORY FORM

How did you hear about our clinic?
Yellow Pages ______Website ______Our sign______ Facebook______Other?_____________
Family/Friend/Co-Worker___ WHO?_______________________________
Permission to acknowledge the person who referred you________(Initials)

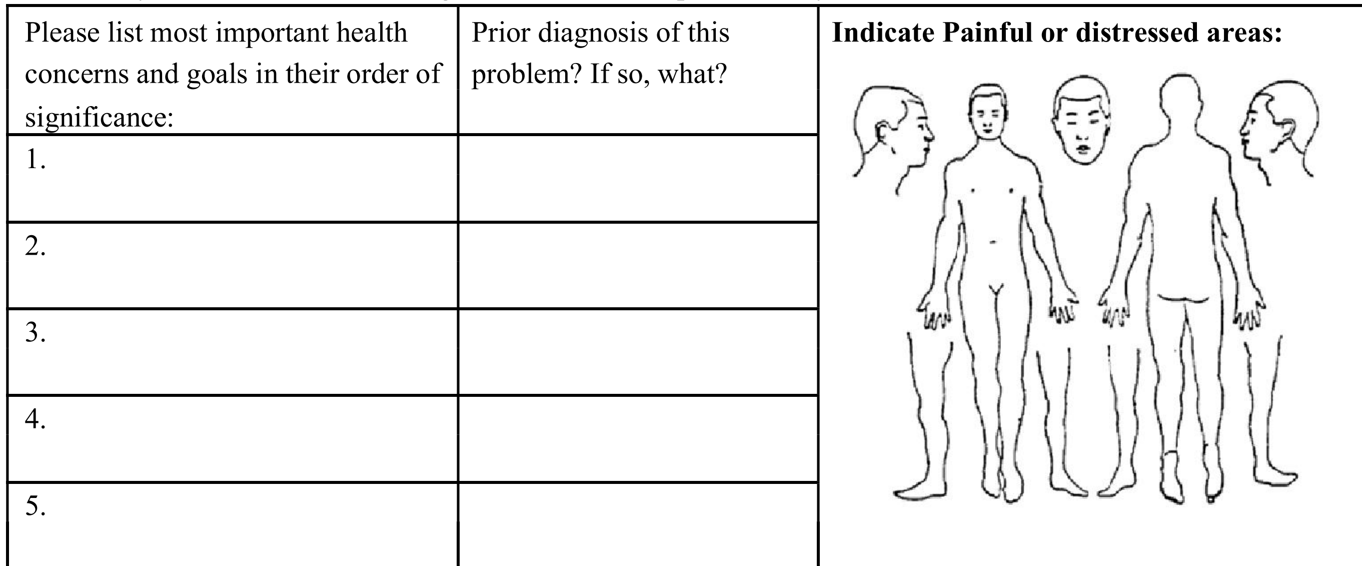
Name:_______________________________________ Date:________________________
Address:________________________________ Telephone:(Home)______________________
City:_______________________ Postal Code:______________ (Cell)______________________
(Work)_____________________
Occupation:_____________________________ Company:________________________________
Email Address:_______________________________ Date of Birth(mm/dd/yy)_______________
Emergency Contact:_______________________________ Telephone:_____________________
Do you have Extended Health Care Insurance Coverage for Naturopathy? ☐ Yes ☐ No

Doctor's Name:________________________________ Telephone #:_________________________
Permission to consult with your Doctor: ☐ Yes ☐ No Initials:_________________________

Primary Complaint?_________________________ Aggravates/Relieves?____________________
Have you seen a Doctor for this problem? ☐ Yes ☐ No When?_____________________________
Overall, how is your general health?____

Health Goals

What are your health concerns and goals, in order of importance to you:

Please list most important health concerns and goals in their order of significance:	Prior diagnosis of this problem? If so, what?	**Indicate Painful or distressed areas:**
1.		
2.		
3.		
4.		
5.		

Please indicate conditions you are experiencing or have experienced:

Respiratory

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Emphysema
- ☐ Asthma
- ☐ Allergies
- ☐ Other________________

Cardiovascular

- ☐ High/Low Blood Pressure
- ☐ Blood Clots
- ☐ Heart Disease/Heart Failure
- ☐ Myocardial Infarction
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Other__________________

Digestive

- ☐ Constipation/Diarrhea
- ☐ Gas/Bloating
- ☐ IBS
- ☐ Other_______________

Nervous System

- ☐ Herpes/Shingles
- ☐ Numbness/Tingling

Where?____________

- ☐ Chronic Pain
- ☐ Loss of Sensation

Where?_____________

- ☐ Other_______________

Musculo-Skeletal

- ☐ Bone or Joint Disease
- ☐ Arthritis-Type______________

Family Hx:________________

- ☐ Tendonitis
- ☐ Bursitis
- ☐ Sprains/Strains
- ☐ Low back/Hip/Leg pain
- ☐ Neck/Shoulder/Arm pain
- ☐ Jaw Pain/TMJ
- ☐ Other:_______________________

Reproductive

- ☐ Pregnant
- ☐ Due Date:________________
- ☐ Gynaecological:____________

Infections:

- ☐ Allergies- ______________
- ☐ TB
- ☐ HIV/AIDS
- ☐ Other:________________
- ☐ Eczema/Psoriasis

Skin

- ☐ Bruise Easily
- ☐ Allergy to creams/lotions
- ☐ Athletes Foot
- ☐ Warts
- ☐ CFS/Fibromyalgia
- ☐ Other:__________________

Other

- ☐ Hepatitis
- ☐ Depression
- ☐ Diabetes-Type________
- ☐ Vision/Hearing Loss
- ☐ Headaches/Migraines
- ☐ Epilepsy
- ☐ Kidney Disease _______
- ☐ Other:______________

☐ Cancer-_____________

Personal and Family History

Please check the "yes" box next to each condition that applies to you and/or one of your family members. Please circle all who the condition applies to: "**Self**" if it relates to you and/or Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**), your child (**C**). Please circle **Past** if the condition is resolved, or **Current** if it is on-going and current

	Yes (☐)	Relation Please circle	Dates Resolved		Yes (☐)	Relation Please circle	Dates Resolved
Alcoholism/Drug Addiction		Self F M S G C	Past Current	High Blood pressure		Self F M S G C	Past Current
Allergies		Self F M S G C	Past Current	Heart Disease		Self F M S G C	Past Current
Anemia		Self F M S G C	Past Current	Hepatitis		Self F M S G C	Past Current
Arthritis		Self F M S G C	Past Current	Headaches		Self F M S G C	Past Current
Asthma		Self F M S G C	Past Current	Kidney disease		Self F M S G C	Past Current
Cancer		Self F M S G C	Past Current	Stroke		Self F M S G C	Past Current
Diabetes		Self F M S G C	Past Current	Tuberculosis		Self F M S G C	Past Current
Eczema		Self F M S G C	Past Current	Osteoporosis		Self F M S G C	Past Current
Epilepsy		Self F M S G C	Past Current	Others:		Self F M S G C	Past Current
Depression/other Mental Illness		Self F M S G C	Past Current				

☐ I don't know my family medical history

Diet

Do you have any food allergies or intolerances? Please list.

1) ______________________________ 4) ______________________________

2) ______________________________ 5) ______________________________

3) ______________________________ 6) ______________________________

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____

Environment

Occupation ____

Hobbies____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

____

____

____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?____

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

____

____

Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)? ____

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?

____

____

Is there anything that you feel is important that has not been covered?

____

____

____

Please turn over and complete other side⇒

Current Medications, Vitamins, Herbal Remedies & Conditions they treat:

Name:______________________________ Condition:______________________________

Name:______________________________ Condition:______________________________

Name:______________________________ Condition:______________________________

Name:______________________________ Condition:______________________________

Surgeries and Approximate Date:
Surgery:____ Date:_________________________
Surgery:____ Date:_________________________
Surgery:____ Date:_________________________

Motor Vehicle Accidents and Date
Accident & Injuries:____________________________________ Date:_________________________
Accident & Injuries:____________________________________ Date:_________________________

Other Accidents and Injuries:______________________________ Date:_________________________
Presence of Internal Pins, Wires, Artificial Joints, Special Equipment, Etc.:___________________________

Other Therapies (Massage Therapy, Chiropractic, Physiotherapy
etc.):_______________________________________

Do you have any other conditions not listed or is there anything about yourself you feel would be important for your naturopathic doctor to know:____

Consent Form: Naturopathic medicine focuses on treatment and prevention of diseases by natural means. Gentle, noninvasive techniques are generally used in order to promote healing. As a patient, you will receive information about your diagnosis, your treatment, and alternative courses of action. You will also be advised of the material effects, expected benefits, risks, side effects, and consequences of not acting upon your diagnosis or treatment.
There are some slight risks associated with treatment by naturopathic therapies. These include but are not limited to:

- Some patients may experience allergic reactions to some supplements and herbs.
- Pain, bruising from acupuncture.

Your ND will explain risks associated with the treatment with you when these exist.
I UNDERSTAND:

- Any treatment or advice provided to me as a patient of the clinic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider.
- I am at liberty to seek or continue medical care from a medical doctor or other healthcare provider licensed to practice in Ontario.
- My naturopathic doctor does not guarantee treatment results.
- No part of my treatment or testing is covered by OHIP. I am solely responsible for payment at the time of each visit or treatment.
- I am free to withdraw my consent and to discontinue treatment at any time. I declare that I have received a full and complete explanation of all of the treatments and services offered by my Naturopathic Doctor and hereby authorize and consent to treatments by Dr.Sunil Mam,ND_________________________________ ______________________ ____________________

Signature:____ Date:_________________________
Parent/Guardian Signature:________________________________ Date:_________________________
(if under 16 years of age)

Cancellation Policy: There will be a 50% cancellation fee applied to any missed appointments or appointments cancelled with less than 24 hrs. notice (not illness related)
Our late cancellation fee will be waived if you cancel due to illness or suspected illness. We would prefer to reschedule your appointment if you are ill. Please try to give our office appropriate notice.

Signature:____ Date:_________________________

Covid-19 Question Check List (According to Ontario Government Document)

<u>Niagara Therapeutics Screening Questions:</u>

1. Is the client presenting with fever, new onset of cough, worsening chronic cough, shortness of breath, or difficulty breathing? **[ ] Yes/ [ ] No**

2. Did the person have close contact with anyone with acute respiratory illness or travelled outside of Canada in the past 14 days? **[ ] Yes/ [ ] No**

3. Has the client had/have a confirmed case of Covid-19 or had close contact with a confirmed case of Covid-19? **[ ] Yes/ [ ] No**

4. Does the person have two (2) or more of the following symptoms (Sudden onset: Not including if persistent over the last 6 months)

   [ ] Sore throat [ ] Runny nose/sneezing [ ] Nasal congestion [ ] Hoarse voice

   [ ] Difficulty swallowing [ ] Decrease or loss of sense of smell [ ] Chills

   [ ] Headaches [ ] Unexplained fatigue [ ] Diarrhea [ ] Abdominal pain

   [ ] Red eyes [ ] Nausea [ ] Vomiting

5. If the person is over 65 years of age, are they experiencing any of the following;
   [ ] Delirium [ ] Falls [ ] Acute functional decline [ ] worsening of chronic conditions.

6. I __________________________________(Print name), understand that while Niagara Therapeutics have taken extreme measures to minimize risk of transmission; Just to list a few thing that will be implementing;
   - > Increased cleaning protocols throughout the clinic
   - > Each treatment room will be fully disinfected after each treatment.
   - > Therapist to wear a new pair of gloves with each treatment
   - > Therapist to wear a mask while in the clinic at all times.
   - > Therapist to wear a new pair of scrubs with each treatment provided
   - > Washroom is to be full cleaned after each use

The nature of Massage Therapy or Osteopathy makes it not possible to maintain physical distancing while in the treatment room. Please sign if you consent to treatment.

Name Sign:___________________________________

Date:_______________________________________

Turn over: Page 1/2

Covid-19 Question Check List (According to Ontario Government Document)

7. Consent to have forehead temperature take before treatment. Please sign.

I,_______________________________________(name), give consent to have my body temperature taken by an infrared forehead thermometer. This temperature will be recorded before each treatment in accordance with Covid -19 guidelines. The thermometer is sanitized between each use according to public health guidelines. Niagara Therapeutics has the right to refuse treatment if a fever is indicated.

Client signature:________________________________

Date:____