

Welcome to Naturopathic Medicine at the Village Healing Centre. To better understand how I can help you, please fill out this form to the best of your ability. This is a confidential record of your medical history and information will not be released to any person without your authorization.

Name: _____ Date of birth: _____

Address: _____
Street City Province Postal code

Home phone: _____ Work phone: _____

Mobile phone: _____ Email: _____

Occupation: _____ Place of work: _____

Emergency contact name: _____ Relationship: _____

Home phone: _____ Work phone: _____ Mobile: _____

Please indicate how you found out about my practice: _____

HEALTHCARE PROVIDERS

Primary Healthcare Physician: _____ Phone: _____

When was your last check-up? _____

Are you currently under the care of a specialist? Yes / No

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Are you currently under the care of alternative healthcare providers? Yes / No

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

CURRENT HEALTH ISSUES

What is your **main** reason for coming in today? When did this issue become a concern?

What treatment have you received (when and from whom?)

List in order of importance any **other** health problems that are troubling you.

1. _____

2. _____

3. _____

CURRENT HEALTH INFORMATION

Height: _____ Current weight: _____ One year ago: _____

Are you currently using any non-prescription drugs, vitamins, herbs, homeopathic remedies? Yes / No

Are you currently using any prescription or over-the-counter medication? Yes / No

Supplement/medication (incl brand)	Total per day	Reason for taking supplement/med

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Do you have allergies? _____

FAMILY MEDICAL HISTORY

Please circle any of the following that blood relatives have had (not including yourself):

- | | | | | | | |
|-----------------------------|------------------|-----------------|-------------------------|----------------------------|----------------------------|--------------------------|
| <i>Alcoholism</i> | <i>Allergies</i> | <i>Asthma</i> | <i>Arthritis</i> | <i>Bleeding conditions</i> | <i>Cancer</i> | <i>Diabetes</i> |
| <i>Depression</i> | <i>Epilepsy</i> | <i>Hayfever</i> | <i>Heart conditions</i> | <i>Heart attack</i> | <i>High blood pressure</i> | <i>Kidney conditions</i> |
| <i>Mental health issues</i> | <i>Obesity</i> | <i>Stroke</i> | <i>Substance abuse</i> | <i>Tuberculosis</i> | <i>Thyroid conditions</i> | |

PAST MEDICAL HISTORY

Vaccinations (please circle)

- | | | | |
|------------|-------------------|--------------------|--------------|
| <i>DTP</i> | <i>Chickenpox</i> | <i>Hepatitis A</i> | <i>Other</i> |
| <i>MMR</i> | <i>Flu shot</i> | <i>Hepatitis B</i> | |

Past injuries/accidents/surgeries (please include date and description): _____

Please describe any adverse reactions you have had to prescription drugs, over-the-counter drugs or recreational drugs, vaccinations (childhood, travel, flu, hepatitis), or natural medicines (herbs, vitamins, minerals, homeopathics):

Name of drug, vaccine or natural remedy	Describe the reaction

Please circle all major illnesses you have experienced:

- | | | |
|---------------------------|---------------------------|----------------------------|
| <i>Measles</i> | <i>Mumps</i> | <i>Chicken pox</i> |
| <i>Diphtheria</i> | <i>Rheumatic fever</i> | <i>Whooping cough</i> |
| <i>Small pox</i> | <i>Rubella</i> | <i>Scarlet fever</i> |
| <i>Alcoholism</i> | <i>Anemia</i> | <i>Addiction</i> |
| <i>Diabetes</i> | <i>Jaundice</i> | <i>High blood pressure</i> |
| <i>Chronic infections</i> | <i>Multiple sclerosis</i> | <i>Gout</i> |
| <i>Hepatitis</i> | <i>Weight problems</i> | <i>Leukemia</i> |

<i>Malaria</i>	<i>Worms/parasites</i>	<i>Polio</i>
<i>Typhoid fever</i>	<i>Acne/boils/impetigo</i>	<i>Abscess</i>
<i>German measles</i>	<i>Eating disorder</i>	<i>Mononucleosis</i>
<i>Osteoporosis</i>	<i>Suicidal tendencies</i>	<i>Chronic fatigue syndrome</i>
<i>Cancer</i>	<i>Epilepsy</i>	<i>Substance abuse</i>

MENTAL/EMOTIONAL

<i>Abuse</i>	<i>Easily angered</i>	<i>Bipolar disorder</i>	<i>Panic attacks</i>
<i>Anxiety/nervousness</i>	<i>Indecision</i>	<i>Mood swings</i>	<i>Memory problems</i>
<i>Depression</i>	<i>Irritability</i>	<i>Phobia</i>	<i>Prolonged sadness/grief</i>

What do you do best? _____

What would you change about yourself? _____

What makes you happy? _____

What makes you angry? _____

What makes you worried? _____

What makes you sad? _____

Do you find yourself in one particular mood more than others: Yes _____ No _____

If so, which mood:

Is there anything major happening or happened in your life (deaths, illness, divorce etc.): Yes _____ No _____

If so, please elaborate:

Do you get along with your parents/guardians: Yes _____ No _____

Who lives at home with you:

At home do you have: Rules _____ Responsibilities _____ Privileges _____

When you have a problem or issue, whom do you talk to: Parents/Guardians _____ Friend _____ Relative _____

No one _____ Other _____

Please check if you have any concerns about the following:

Your development _____ Your appearance _____ School _____ Friends _____ Family _____ Sex _____

Other _____

ENDOCRINE

<i>20 lbs change in weight in the last year</i>	<i>Sluggish after eating</i>	<i>Hypoglycemia (low blood sugar)</i>	<i>Generally feel hot</i>
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Mental dullness *Thyroid condition* *Poor concentration* *Generally feel cold*

How is your energy level on a scale of 1 to 10 (1= low energy and 10=high energy):

When you get up in the morning	1	2	3	4	5	6	7	8	9	10
Afternoon	1	2	3	4	5	6	7	8	9	10
Evening	1	2	3	4	5	6	7	8	9	10
Night	1	2	3	4	5	6	7	8	9	10

How would you rate your quality of sleep on a scale of 1 to 10 (10=excellent) 1 2 3 4 5 6 7 8 9 10

How many of hours of sleep do you get each night? _____

What time do you go to bed? _____ Wake up? _____

Do you have trouble falling asleep Yes / No Or staying asleep? Yes / No
 Are you tired through the day? Yes / No Do you need a nap during the day? Yes / No

IMMUNE

<i>Chronic infections</i>	<i>Frequent antibiotics</i>	<i>Frequent colds/flu</i>	<i>Swollen glands/nodes</i>
<i>Frequent sore throats</i>	<i>Slow wound healing</i>	<i>Cold sores</i>	<i>Shingles</i>

How often do you get colds, flu, or sore throats in a year? _____

HEAD

<i>Headaches/migraine</i>	<i>Stroke</i>	<i>Fainting</i>	<i>Cataracts</i>	<i>Glaucoma</i>	<i>Hearing loss</i>
<i>Ringing in ears</i>	<i>Ear infections</i>	<i>Loss of taste</i>	<i>Thyroid problems</i>	<i>Cold sores</i>	<i>Canker sores</i>
<i>Allergies</i>	<i>Hayfever</i>	<i>Influenza</i>	<i>Sinusitis</i>	<i>Strep throat</i>	<i>Vision changes</i>
<i>Paralysis</i>	<i>Seizure/epilepsy</i>	<i>Loss of balance</i>	<i>Concussion</i>	<i>Vertigo</i>	<i>Loss of coordination</i>

CHEST

<i>Heart disease</i>	<i>Chest pain/angina</i>	<i>Palpitations/murmurs</i>	<i>Asthma</i>	<i>Pneumonia</i>
<i>Tuberculosis</i>	<i>Tuberculosis</i>	<i>Emphysema</i>	<i>Heart attack</i>	<i>Pacemaker</i>
<i>Difficulty breathing</i>	<i>Chronic cough</i>	<i>Shortness of breath</i>	<i>Wheezing</i>	<i>Bronchitis</i>

EXTREMITIES

<i>Cold hands/feet</i>	<i>Numbness/tingling</i>	<i>Warts</i>	<i>Varicose veins</i>	<i>Arthritis</i>
<i>Gout</i>	<i>Swelling of limbs</i>	<i>Raynaud's Disease</i>	<i>Eczema/psoriasis</i>	

DIGESTIVE

<i>Heartburn</i>	<i>Nausea/vomiting</i>	<i>Diarrhea</i>
<i>Constipation</i>	<i>Excessive gas</i>	<i>Bloating</i>
<i>Blood in stools</i>	<i>Mucous in stools</i>	<i>Undigested food in stools</i>
<i>Black stools</i>	<i>Light-coloured stools</i>	<i>Floating stools</i>
<i>Hemorrhoids</i>	<i>Parasites</i>	<i>Irritable bowel</i>
<i>Candida (yeast)</i>	<i>Appendicitis</i>	<i>Bad breath</i>
<i>Change in appetite</i>	<i>Change in thirst</i>	<i>Chronic laxative use</i>
<i>Gastric or duodenal ulcers</i>	<i>Gallstones</i>	

KIDNEYS AND BLADDER

<i>Inability to urinate</i>	<i>Frequent urination</i>	<i>Blood in urine</i>	<i>Cloudy urine</i>
<i>Bladder infections</i>	<i>Burning during urination</i>	<i>Incontinence</i>	<i>Kidney stones</i>

REPRODUCTIVE

Have you had sex education: Yes _____ No _____ If so, from whom:

Are you sexually active? Yes / No

Do you use birth control? Yes / No If yes, what type? _____

Please circle if you have:

<i>HIV</i>	<i>Syphilis</i>	<i>Gonorrhea</i>	<i>Genital herpes</i>	<i>Other STD</i>
<i>Human Papilloma virus (HPV)</i>	<i>Low sex drive</i>	<i>Chlamydia</i>		

FEMALE

<i>Excess vaginal discharge</i>	<i>Irregular periods</i>	<i>Mood swings</i>	<i>Vaginal dryness</i>
<i>Vaginal itching</i>	<i>Sores/growths/lumps</i>	<i>Heavy periods</i>	<i>Spotting between periods</i>
<i>Fibrocystic breasts</i>	<i>Nipple discharge</i>	<i>Cramps</i>	<i>Pain with intercourse</i>
<i>Fibroids</i>	<i>Ovarian cysts</i>	<i>Endometriosis</i>	

Have you started your period: Yes _____ No _____ If so, at what age did it start: _____

Do you experience any discomfort with your periods: Yes _____ No _____

Have you ever been pregnant: Yes _____ No _____ If so, did you have the child: Yes _____ No _____

Have your periods ever stopped? Yes / No

Do you have a regular cycle? Yes / No Length of cycle: _____ How long are your periods? _____

Do you use tampons or pads? _____

Date of last PAP smear? _____ Any abnormal PAP smears? Yes / No

Do you perform breast self-examinations? Yes / No Have you noticed any breast lumps? Yes / No

Number of: Pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____

MALE

Abnormal discharge or sores on the penis

Prostate problems

Trouble getting/maintaining an erection

HOUSEHOLD/OCCUPATIONAL

Please circle if any of the following apply to your home: *Damp or mouldy* *Live in city* *Air filtration*

Please circle if any of the following apply to your workplace:

Office building *Windows do not open* *Air filtration* *Work in presence of fumes or chemicals*

Are you currently exposed to second-hand smoke? Yes / No

What type of water do you drink? *Tap* *Bottled* *Filtered* *Reverse osmosis* *Distilled*

Have you ever been exposed to mould, solvents, lead paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations), at work, or while travelling?	Y	N
Have you ever experienced health problems after putting in new carpeting, painting your home, doing renovations, or having your lawn sprayed with herbicide?	Y	N
Are you particularly sensitive to perfume, gasoline or other vapours?	Y	N
Have you ever lived near a refinery or a polluted area?	Y	N
Have you ever lived in a home more than 50 years old?	Y	N
Do you have mercury dental fillings?	Y	N
Have you had any dental root canal procedures?	Y	N
Do you have any surgical implants (cosmetic/medical)?	Y	N
Do you live near large power lines?	Y	N

PERSONAL HABITS

Do you have a job: Yes _____ No _____

Do you have a driver's license: Yes _____ No _____

Please check if you do or have done any of the following:

Drink alcohol _____ Smoke cigarettes _____ Use drugs (marijuana etc.) _____

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Does any of the above pertain to any of your friends, if so, please elaborate: _____

What are your hobbies and interests? _____

What do you do in your free time? _____

Who do you spend your free time with? _____

How many hours/day do you spend watching TV: _____

How many hours per day do you spend on a computer, gaming system, phone, iPad: _____

Are you physically active? Yes / No If yes, how often? _____

What forms of exercise do you do: _____ Duration: _____

If not, why not? _____

Circle any that you are currently using:

Alcohol Antacids Coffee Laxatives Sedatives Tobacco Recreational drugs

How often and how much? _____

Do you eat alone or with whom? _____

Are you on a specific diet: Yes _____ No _____ If yes, please elaborate: _____

Are you satisfied with your weight: Yes _____ No _____ If no, please elaborate: _____

Do you brush and floss your teeth: Yes _____ No _____ How often: _____

Do you visit the dentist: Yes _____ No _____ How often: _____

Do you get your eyes checked: Yes _____ No _____

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

- Y N 1. Has your doctor ever said you have heart trouble and that you should only do physical activity recommended by a doctor?
- Y N 2. Do you feel pain in your chest when you do physical exercise?
- Y N 3. In the past month, have you had chest pain when you were not doing physical activity?
- Y N 4. Do you lose your balance because of dizziness or do you ever lose consciousness?
- Y N 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- Y N 6. Is your doctor currently prescribing drugs (e.g. water pills) for your blood pressure or heart condition?
- Y N 7. Do you know of any other reason why you should not do physical activity?

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

Thank you for taking the time to complete this questionnaire. This information is important for your overall assessment and will be kept in strict confidence.

VISIT FEES

Office visits:

Suzanne Ho-Miecznikowski, B.Sc., N.D.

Suzanne@westtorontonaturopath.com

416-993-5059

Initial consultation (90 minutes) <i>Consultation, complaint-based physical exam, urine test</i>	\$180
Second visit (60 minutes) <i>Screening physical exam, laboratory tests, initiation of treatment plan</i>	\$120
Follow-up visits (30-45 minutes) <i>Consultation and monitoring of treatment plan</i>	\$100

- All fees include G.S.T.
Special rates available for children (12 years and under) and seniors (65 years and over).

Telephone consultations:

Please note: these are generally intended for follow-up consultations and clarification of treatment protocols. Telephone consultations are offered to new patients only after an initial visit has been conducted and a treatment plan has been initiated.

First 5 minutes	No charge
20 minute consults	\$45
30 minutes or longer	Follow-up visit fees apply

Diagnostic services and Naturopathic medicines

The Village Healing Centre has functional laboratory services provided by Gamma-Dynacare and Rocky Mountain Analytical. This enables Suzanne to perform comprehensive blood work, urine and stool testing, as well as special tests using saliva and hair. OHIP does not cover laboratory services requested by naturopathic doctors, therefore, patients are required to pay for these services.

The Village Healing Centre also carries a limited selection of professional quality products that are not available through health food stores. OHIP does not cover the cost of these products, thus patients are required to pay for products that they choose to purchase from Suzanne.

Booking appointments

Please schedule your appointments and plan to arrive for appointments on time. I try my best to be punctual for appointments.

Cancelled and missed appointments

Please ensure to give at least one business day cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled ON THE SAME DAY or missed appointments, the FULL COST of the appointment will be charged. Consideration will be given to unforeseeable circumstances.

Payment for services

Payment for services is due at the end of each visit and a receipt will be given when payment is received. Please retain your receipt for claiming your insurance, if applicable. **Fees may be paid by cash or cheque.** Any prescribed botanicals, supplements, or homeopathics are not included in the above consultation fees.

Confidentiality

Everything that you communicate, directly or indirectly, to Suzanne is confidential unless you give written permission to disclose information to a third party.

It is important to note that there are exceptions to confidentiality that include the legal and/or ethical obligations to:

1. report incidents of child abuse (physical, sexual or emotional) and neglect;
2. comply with court-ordered subpoena;
3. prevent harm to yourself or another person should such plans be disclosed;
4. report a health professional who has sexually abused a patient;

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5. share information in a supervision format.

In case of emergency

Emergency services are not available at The Village Healing Centre. In case of an emergency, patients should dial 911, or proceed to the Emergency Department at the nearest hospital.

Statement of Acknowledgement

I, _____ have read, understood, and agree to the contents herein. I also attest that the information
Print name

provided about me is true and accurate to the best of my knowledge.

Patient signature: _____ Date: _____