peak
health and wellness

Date _____

Health History Summary

Name _____ Age _____ Date of Birth (y/m/d) _____

Address _____

_____

Home Phone _____ Work Phone _____ Email _____

Emergency Contact _____ Phone_____

Family Physician _____ Phone_____

How did you hear about us? _____

Your Current Health Concerns

What is your main reason for coming in today? _____

_____

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

1) _____ How long? _____
2) _____ How long? _____
3) _____ How long? _____
4) _____ How long? _____
5) _____ How long? _____

What kind of conventional treatment have you received? _____

_____

Please circle all of the following complementary healthcare practitioners you have seen:

Naturopathic Doctor Chiropractor Acupuncturist Massage Therapist Osteopath Other _____

What was the therapy and what were the results? _____

_____

Last Physician or Health Practitioner seen _____ When _____

When was your last physical exam? _____ Were blood tests done? **Y/N** Blood Type _____

Your Health History

What is the general state of your health? **Excellent Good Average Fair Poor**

What is your current level of energy from 1-10 (where 10 is the best you've ever felt)? _____

What is your current approximate 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? **Y/N** (*if yes, please circle which one*)

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist? **Y/N**

Have you in the past? **Y/N**

Do you have any allergies to any drugs, herbs, foods, animals or other? **Y/N** *If yes, please specify* _____

_____

Have you had any major injuries? **Y/N** *If yes, what happened and when?* _____

_____

Previous surgeries and hospitalizations (include dates) _____

_____

Please indicate which of the following conditions you have had and indicate "now" (N) or "past" (P)

	N	P		N	P		N	P		N	P
Allergies			Weight Problems			Anemia			Measles		
Asthma			Gallstones			High Blood Pressure			Mumps		
Hayfever			Gout			Stroke			Chicken Pox		
Sinusitis			Thyroid Problems			Cancer			Whooping Cough		
Ear Infections			Speech Problems			Jaundice			Shingles		
Strep Throat			Tooth/Gum Problems			Alcoholism			Diphtheria		
Tonsillitis			Ringing in Ears			Hepatitis			Scarlet Fever		
Mono			Visual Problems			Gas/Bloating			Polio		
Eczema			Fainting			Diarrhea			Rheumatic Fever		
Psoriasis			Poor Memory			Constipation			Small Pox		
Acne			Balance Problems			Hemorrhoids			Malaria		
Warts			Broken Bones			Rectal Bleeding			Pneumonia		
Varicose Veins			Numbness/Tingling			Parasite			Tuberculosis		
Canker Sores			Cold Hands/Feet			Herpes			Child Abuse		
Headaches			Arthritis			STD			Physical Abuse		
Migraines			Epilepsy			Gonorrhea			Sexual Abuse		
Depression			Diabetes			Syphilis			Emotional Abuse		
Miscarriage			Heart Disease			HIV/AIDS			Rape		

Other?_____

Are there any ailments from which you feel you have never been well since? _____

Were you vaccinated? **Y/N** Did you have any adverse reactions (ex: fever)? **Y/N**

Which of the following do you currently use? (Please indicate how much, how often and how long.)

Alcohol	_____	Tobacco	_____
Hormones	_____	Coffee	_____
Cortisone	_____	Tea	_____
Sedatives	_____	Laxatives	_____
Antacids	_____	Recreational Drugs	_____

Other Medications? (Please give name, dose, and amount of time on the medication.)

_____ _____ _____

_____ _____ _____

Vitamins/Herbs?

_____ _____ _____

_____ _____ _____

Any other supplementation?

_____ _____ _____

Family History

	Mother	Father	Sibling	Grandparent		Mother	Father	Sibling	Grandparent
Cancer					Kidney Disease				
Tuberculosis					Diabetes				
Heart Disease					Asthma				
Stroke					Depression				
High Blood Pressure					Other _____				

General Information

Marital Status? **Single** **Married** **Divorced** **Separated** **Widow** **Other** _____ Number of Children _____

Who do you currently live with? **Spouse** **Partner** **Parents** **Children** **Friends** **Alone**

Are you currently in a happy and supportive relationship? **Very** **Mostly** **Somewhat** **No**

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

_____

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? **Y/N** *If yes, what do you do and how often?* _____

Do you have a religious or spiritual practice? **Y/N**

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? **Y/N** Staying asleep? **Y/N**

How many hours do you sleep per night? _____ How many hours do you think you need? _____ Do you wake refreshed? **Y/N**

Do you nap or rest horizontally throughout the day? **Y/N** *If yes, for how long?* _____

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

Occupation _____ Employer _____

Do you enjoy your work? **Y/N** Do you take vacations? **Y/N**

How often do you get colds, flus, and sore throats in a year? _____

Digestion and Elimination

Do you have any problems with gas, bloating or fullness after eating? **Y/N**

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 or undigested food in your stool? **Y/N** Do you ever have black, tarry or grey stool? **Y/N**

Do you ever have yellow or light coloured stool? **Y/N** Do you ever have rectal itching? **Y/N**

Are your stools formed or loose? _____

Do you ever have alternating constipation and diarrhea? **Y/N** *If yes, how often?* _____

Do you ever have to strain to pass stool? **Y/N** *If yes, how often?* _____

Do you pass gas (flatus) frequently? **Y/N** Do you burp frequently? **Y/N**

Do your stools or gas have a strong disagreeable odour? **Y/N**

Have you traveled outside of Canada in the last 5 years? **Y/N**

Have you been camping in the last 5 years? **Y/N**

Have you ever fasted? Y/N *If yes, what type of fast did you do (ex: juice or water)?* _____

Female

Age of first menses _____ If periods have stopped, at what age did they stop? _____

Are your cycles regular? **Y/N** *If yes,* period begins every_____ days and lasts _____ days

How heavy/light is the flow? _____ What colour is the blood? _____

Are there any clots? **Y/N** Any cramps with your period? **Y/N**

Do you have any spotting between your periods? Y/**N** (*If yes, does it happen every month?* _____)

Do you have any premenstrual symptoms? _____

Are you sexually active? **Y/N** Is this more or less than one year ago? _____

Do you use birth control? **Y/N** What type of birth control? _____

Number of pregnancies _____ Number of abortions _____ Number of miscarriages _____

Number of live births _____ Any problems getting pregnant? _____

Do you get regular PAP smears? **Y/N** Any abnormal PAP smears? **Y/N**

Any sexually transmitted diseases? _____

Do you do regular breast self-exam? **Y/N** Have you noticed any breast lumps? **Y/N**

Male

How often do you get up in the night to urinate? _____ Has this increased recently? **Y/N**

Any problems getting or maintaining an erection? **Y/N** Do you have any sores on your penis? **Y/N**

Have you had your prostate examined? **Y/N** When? _____ Any prostate problems? **Y/N**

Are you sexually active? **Y/N** Is this more or less than one year ago? _____

Do you use birth control? **Y/N** What type of birth control? _____

Any sexually transmitted diseases? _____

Kidney/Bladder

Have you had a bladder infection? **Y/N** How often? _____ How was it treated? _____

Do you have any burning sensation during or after urination? **Y/N** Have you in the past? **Y/N**

What colour is your urine? (ex: dark yellow, bright yellow, cloudy, pale, clear) _____

Does your urine have an odour? (ex: strong, sweet) _____

Do you have any difficulty starting or stopping when urinating? **Y/N**

Perspiration

Do you have any difficulty perspiring? **Y/N** Does your sweat have a strong odour? **Y/N**

Do you perspire when exercising? **Lightly** **Moderately** **Heavily**

Do you perspire at times other than when you exercise? **Y/N** When? _____

Occupational/Household

Is your home damp or moldy at all? **Y/N** Do you have specialized air filtration at home? **Y/N**

Do you work in an office building? **Y/N** Do the windows open? **Y/N**

Do you work in the presence of toxic fumes or chemicals? **Y/N** Do your hobbies involved toxic materials? **Y/N**

Are you currently exposed to second hand smoke? **Y/N**

What do you use for drinking water? *(circle all that apply)* **Tap Water** **Bottled Water** **Filtered Water** **Reverse Osmosis**

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

_____

Thank you for taking the time to fill out this lengthy questionnaire. It will be a valuable resource in understanding your health.

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PATIENT CONSENT FORM

Welcome to Naturopathic Medicine at Peak Health and Wellness. By coming in today, you've made a commitment to your health. We hope that you enjoy your experience as we work together to help you achieve your full health potential.

Naturopathic Medicine is a unique and comprehensive approach to improving health and treating illness. As primary health care practitioners, our goal is to provide safe and effective health care to each patient in a compassionate and efficient manner. In order to assess your individual condition, your Naturopathic Doctor will take a through case history, perform a screening physical exam and laboratory tests. Therapeutics include clinical nutrition and supplementation, botanical medicine, acupuncture and Traditional Chinese Medicine, homeopathy and lifestyle counseling.

Each person must sign this document prior to the initial visit.

My signature acknowledges that I have been informed and understand that:

1) I am encouraged to create a comprehensive health care team working towards my best interests and continue to seek medical care from other qualified health practitioners (physician, chiropractor, dentist etc.) as required.

2) I understand that Naturopathic Doctors are required by their licensing board to perform a screening physical exam on each new patient. This will be adhered to unless the referring practitioner sends a full report to the ND.

3) I am aware of the slight health risks concerning some treatments, which may include but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from injections, venipuncture or acupuncture. I have received a full and complete explanation of the treatment or services that I may receive at this office and hereby authorize consent to treatment.

4) I understand that working with a Naturopathic Doctor involves a team-like approach and while appropriate individualized advice regarding obtaining my treatment goals will be provided, I also commit to being responsible for my own health. If I am having difficulty following a treatment plan, I will contact my ND so that we can make the necessary modifications to ensure that I am able to continue to work towards my health and wellness goals.

5) I am aware that I can purchase the products recommended by my Naturopathic Doctor at the location of my choice. I am under no obligation to purchase products at Peak Health and Wellness. However, if I do purchase products at the clinic, I am aware that they cannot be returned for refund, as they will not be re-sold. Just as a pharmacy cannot accept returns on pharmaceutical products, we cannot accept returns on nutraceutical products so that we can guarantee that all of our products have been stored in appropriate conditions until they are dispensed.

Please Initial Here: _____

6) I understand that a record will be kept of my personal information and the health services provided to me. I understand that I may look at my medical record at anytime and that a copy of my file will be

provided to me, for a fee, upon request. I have reviewed Peak Health and Wellness's Privacy Policy and I understand how it applies to me. I agree to Peak Health and Wellness collecting, using and disclosing personal information about me as set out in this policy.

7) I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

I have carefully and explicitly read and understood the above statement regarding the treatment that is pertinent to my specific medical and health conditions. I hereby consent to allow Peak Health and Wellness in the management and treatment of my medical and health conditions. I also understand that failure to provide all pertinent health information which could be vital in my management care releases Peak Health and Wellness from medical negligence and liability.

I, _____, have read, understood and acknowledge the above statements.
(print name)

_____ _____
(patient name, if minor) (relationship to minor)

_____ Date: _____
(signature of patient or parent/guardian)

_____ Date: _____
(signature of ND)

PRIVACY CONSENT

Includes insurance company correspondence

I understand that in signing this document I am giving permission to Peak Health and Wellness to obtain and keep on file my personal information that I have provided to them. I understand that the personal information provided will not be publicly published without prior consent. The private information may include, but is not limited to:

Personal data
Personal health history
Personal treatment of data and outcome
Financial information

I understand that Peak Health and Wellness may use and disclose information in order to:

Communicate with me in a timely and effective manner
Communicate with insurance companies
Assist with my care between other health professionals
Efficiently operate a Chiropractic and Health Care Clinic
Prepare and mail documents to me, as appropriate

I understand that as a patient of Peak Health and Wellness, I have the following rights concerning my privacy:

I have the right to know why an organization or individual collects, uses or discloses my personal information
I have the right to expect an organization to handle my information reasonably and to not use it for any other purpose that the one to which I consented
I have the right to expect an organization to protect my information from unauthorized disclosure
I have the right to ensure the identification information an organization holds about me is accurate, complete and current
I have the right to expect an organization to destroy my identification information when requested or when no longer required for the intended original purpose (except when destruction is not allowed by law, or for insurance purposes or allowed under the College of Chiropractors of Ontario or other governing body)
I have the right to confidentially complain to an organization about how it handles my identification information and may escalate my complaint to the Privacy Commissioner of Canada, if need be
I have the right to remove my consent at any time by contacting Peak Health and Wellness in writing

I understand that Peak Health and Wellness will not:

Sell my information to anyone without prior consent
Share my information with organizations outside of our normal relationship that would use it to contact me, the patient about their own products or services without prior consent (this includes audits from insurance companies).

I, the undersigned, understand and consent to this document under the Privacy Act.

Patient Name	Patient Signature	Date

Clinical Staff Signature

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Name: _____

Date of Birth: ____/____/____
mm dd yy

E-mail Address: _____

❒ **Yes,** please send me **e-mail reminders** for my appointments.

❒ **No** appointment reminders needed.

❒ **Yes**, I would like to receive your **inspiring e-newsletter** (sent twice monthly) covering a variety of health and wellness topics.

By joining our website, you authorize us to send occasional health care related e-mails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

MISSED/CANCELLATION POLICY

It is our desire to provide you with the best possible care and attention that we are able to offer. **We kindly ask that if you need to cancel or change your appointment to please let us know by 6pm the day before.** This will allow us to offer that time slot to another patient and get your appointment rescheduled to a more convenient time.

IMPORTANT: Our e-mail reminders are sent as a **courtesy only**. Please ask for an appointment card if needed or make a note of the date and time of your appointment for your own records as you are responsible for any missed appointments.

****Missed/ last minute cancellations will be charged 50% of the scheduled appointment fee****

Please note that these appointments will be billed as a missed appointment and your insurance company will not reimburse these dollars. If there are any questions, please contact the office manager at the clinic. Cancellation/missed fees are the responsibility of the patient and must be paid in full before the next visit.

Sincerely,

Lucy Malarkey
Office Manager, Peak Health and Wellness

Patient Initials _____