LONSDALE NATUROPATHIC CLINIC

Confidential Adult Case History

Please help me to understand your health needs by carefully completing this intake form.
All information is strictly confidential.

Patient Information:

Name: _____ _____ **Gender:** _____
(First) (Last)

Date of Birth: _____ _____ _____ **Age:** _____ **Care Card # (PHN):** _____
(Month) (Day) (Year)

Contact Information:

Phone #: _____ **Alt. Phone #:** _____

Home Address: _____ **City:** _____ **Province:** _____

Postal Code: _____ **E-mail:** _____ **Relationship Status:** _____

Emergency Contact Name: _____ **Phone:** _____ **Relation:** _____

Do you have a family doctor? Yes ☐ No ☐ Doctor/Clinic Name: _____

How did you hear about us? _____

Current Health:

Do you have any known allergies ? Yes ☐ No ☐ If yes, please list: _____

Height: _____ **Weight:** _____ **lbs. Any recent weight changes?** _____

Your main health concerns in order of importance:

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

Please list any medications and natural supplements you are currently taking, with dosages: _____

_____

_____

Diet and Lifestyle:

Please describe a typical day of eating for you:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks/Beverages: _____

How often do you consume the following? (daily, weekly, monthly, yearly, in the past, never)

Alcohol? _____ **Cigarettes?** _____ **Marijuana?** _____ **Recreational drugs?** _____
Coffee? _____ **Pop?** _____ **Sugar?** _____

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Past Medical History:

Please list all past hospitalizations, surgeries, accidents and major illnesses:

_____ **Year:** _____ _____ **Year:** _____

_____ **Year:** _____ _____ **Year:** _____

Family Medical History:

Has anyone in your immediate family been diagnosed with any of the following?

☐ Autoimmune condition ☐ Diabetes ☐ Heart Disease ☐ Cancer: type(s) _____

☐ Mental illness ☐ Thyroid disease ☐ Other _____

Overview of Body Systems:

Please check any boxes that are current or recurrent concerns:

General
- ☐ Fatigue
- ☐ Weight loss
- ☐ Night sweats
- ☐ Headaches
- ☐ Sweat easily
- ☐ Numbness or tingling
- ☐ Lightheadedness
- ☐ Dizziness
- ☐ Fainting

Eyes
- ☐ Eye pain
- ☐ Light sensitivity
- ☐ Hearing loss/impairment
- ☐ Visual loss/impairment
- ☐ Blurred vision

Ears
- ☐ Ear aches/infections
- ☐ Ringing in ears

Nose & Sinuses
- ☐ Loss of smell
- ☐ Nosebleeds
- ☐ Sinus infections
- ☐ Post-nasal drip
- ☐ Chronic congestion

Mouth
- ☐ Loss of taste
- ☐ Tooth problems
- ☐ Mercury fillings
- ☐ Sores on lips or mouth
- ☐ Painful/Bleeding gums
- ☐ Sores on/painful tongue

Throat
- ☐ Swollen/enlarged glands
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Feeling of lump in throat
- ☐ Difficulty swallowing
- ☐ Thyroid condition

Respiratory
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Coughing blood
- ☐ Pneumonia/bronchitis
- ☐ Asthma
- ☐ Allergies (pollen, pets)

Blood
- ☐ Easy bruising
- ☐ Anemia

Cardiovascular
- ☐ High/low blood pressure
- ☐ Heart flutters/skips
- ☐ Chest pain
- ☐ Swelling of limbs
- ☐ Murmurs
- ☐ Varicose veins

Skin, Hair and Nails
- ☐ Eczema/Psoriasis
- ☐ Rashes/Hives
- ☐ Itching
- ☐ Acne, boils
- ☐ Irregular moles
- ☐ Hair loss
- ☐ Weak/brittle nails

Musculoskeletal
- ☐ Muscle pain/spasm where? _____
- ☐ Chronic Injury
- ☐ Joint pain
- ☐ Bone pain

Gastrointestinal
- ☐ Low appetite
- ☐ Heartburn/reflux
- ☐ Gas
- ☐ Blood in stool
- ☐ Undigested food in stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Bowel movements: how often: _____

Urinary
- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Recurrent urinary infections
- ☐ Urinary incontinence
- ☐ Waking to urinate
- ☐ Decrease in urine flow
- ☐ Kidney stones

Sexual
- ☐ Pain during intercourse
- ☐ Sexually transmitted infection
- ☐ Low/high sex drive
- ☐ Birth control use

Emotional
- ☐ Depression
- ☐ Irritability/quick temper
- ☐ Anxiety
- ☐ Abuse of any form

Male
- ☐ Hernia
- ☐ Testicular pain/mass
- ☐ Difficulty with erections
- ☐ Prostate problems

Female - Gynecologic
- ☐ Menopause
- ☐ # Births ____
- ☐ # Pregnancies ____
- ☐ # days menstruating ____
- ☐ # days in cycle _____
- ☐ Date of last PAP _____
- ☐ Recurrent yeast infections
- ☐ Vaginal discharge
- ☐ Bleeding between periods
- ☐ Excessive/light flow
- ☐ Painful periods/cramps
- ☐ Missed Periods

Female - Breast
- ☐ Breast pain / tenderness
- ☐ Breast lumps
- ☐ Nipple discharge
- ☐ Pain during intercourse

Neurological
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Headaches/Migraines

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Consent to Naturopathic Treatment

Naturopathic examination includes: physical and clinical diagnosis, traditional Chinese medical diagnosis and lab work. Therapeutic procedures include: homeopathy, spinal adjustment, botanical medicine, acupuncture, manual muscle therapy, cranio-sacral therapy, clinical nutrition, lifestyle counseling, and Inter-Muscular Injection Therapy.

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, stroke, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure result.

I understand the visit costs for Naturopathic treatment are as follows:

Initial Adult Consultation $150.00
Initial Student/ Senior (65+) Consultation $140.00
The Initial visit is 40 minutes with Dr. Dayal

Subsequent Adult Consultation $75.00
Subsequent Student/ Senior Consultation $70.00
Subsequent visits are 20 minutes with Dr. Dayal

I also understand that if I miss an appointment or cancel on short notice (less than 24 hours), I may be charged a fee for the missed appointment.

Patient Name | Patient Signature

Guardian Signature (If patient is under 16 years old) | Date

Doctor's Signature | Doctor's Name

Welcome! Thank you for taking the time to fill out this extensive questionnaire. Your time and care is appreciated.