a new leaf
NATUROPATHIC
CLINIC

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Langley, BC V3A 1K8
Phone: 604.514.8555
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Confidential Patient Health Form

Today's date: ______________________________

Full name: ______________________________ Preferred Name: ______________________________

Care Card Number (PHN): ______________________________

Age: _______ Date of birth: _____/_____/_____ Gender: M ☐ F ☐ Other ☐
Month Day Year

Address: ______________________________

City: ______________________ Province: ______________ Postal Code: ______________

Phone # (home): ______________________ (cell): ______________________ (work): ______________________

Which # would you prefer we use? ______________________ Email address: ______________________

Can clinic staff contact you by phone? Y ☐ N ☐

Is it okay to receive appointment reminders via email? Y ☐ N ☐

Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Common-law ☐ Other

Live with: ☐ Alone ☐ Partner ☐ Parents ☐ Relatives ☐ Children (if yes, how many? _______) ☐ Friends

Occupation: ______________________________ Hours worked per week: ______________

How did you hear about us? ______________________________

If you were referred, please indicate by whom: ______________________________

Emergency contact:

Name: ______________________ Relationship: ______________________ Phone #: ______________________

Do you see a medical doctor? Y ☐ N ☐

Doctor's name: ______________________ Phone #: ______________________ Fax #: ______________________

Other types of healthcare providers seen (e.g. chiropractor, massage therapist, physiotherapist): ______________________

____

Do you have extended medical coverage? Y ☐ N ☐

What are you main health concerns in order of importance:

1) ______________________________ Since: ______________

2) ______________________________ Since: ______________

3) ______________________________ Since: ______________

Personal Past & Current Medical History

Please indicate if you had any of the following as a child:

☐ Rheumatic fever	☐ Diphtheria	☐ Scarlet fever
☐ German measles	☐ Measles	☐ Mumps
☐ Chicken pox	☐ Whooping cough	☐ Other: ____________________________

Vaccinations

Have you received all scheduled vaccinations? Y ☐ N ☐

If not, please specify what you have been vaccinated against:

☐ Polio	☐ Tetanus	☐ MMR (Measles/Mumps/Rubella)
☐ Hepatitis A	☐ Hepatitis B	☐ Pertussis
☐ Diphtheria	☐ HPV (Gardasil)	☐ Other: ____________________________

Did you experience any adverse reactions to immunizations? Please describe: ____

Hospitalizations/Surgery/Imaging

What hospitalizations, surgeries, significant trauma, diagnostic testing (X-ray, CAT scan, MRI, EEG, EKG, etc.) have you had?

1) ______________________________________ year _________ 4)______________________________________ year _________

2) ______________________________________ year _________ 5) ______________________________________ year _________

3) ______________________________________ year _________ 6)______________________________________ year _________

Do you have any known contagious diseases at this time? Y ☐ N ☐ If yes, what? ____

Allergies/Sensitivities

Medications/Drugs: ____

Foods: ____

Environmental, chemical or other: ____

Current Medications and Supplement

1) ____ dose: _____________________ start date: _____________________

2) ____ dose: _____________________ start date: _____________________

3) ____ dose: _____________________ start date: _____________________

4) ____ dose: _____________________ start date: _____________________

5) ____ dose: _____________________ start date: _____________________

6) ____ dose: _____________________ start date: _____________________

7) ____ dose: _____________________ start date: _____________________

8) ____ dose: _____________________ start date: _____________________

Family Medical History

Please indicate **if anyone in your family** has a history of any of the following NOT including yourself. Note whether the condition is from the maternal (M) or paternal (P) side of your family.

M	P		M	P		M	P	
☐	☐	Addiction	☐	☐	Celiac disease	☐	☐	Liver disease
☐	☐	Allergies/Hives	☐	☐	Depression	☐	☐	Lupus
☐	☐	Alzheimer's	☐	☐	Diabetes (include type)	☐	☐	Mental illness
☐	☐	Anemia	☐	☐	Epilepsy/Seizures	☐	☐	Multiple sclerosis
☐	☐	Arthritis (include type)	☐	☐	Glaucoma	☐	☐	Osteoporosis
☐	☐	Asthma	☐	☐	Heart disease	☐	☐	Stroke
☐	☐	Autoimmune disease	☐	☐	High blood pressure	☐	☐	Thyroid disease
☐	☐	Cancer (include type)	☐	☐	Kidney disease	☐	☐	Other: ___________________________

General Health History

Height: ___________________________ Weight: ___________________________ Weight 1 year ago: ___________________________

At what time is your energy generally the highest? ________________(1-10):________ Lowest?________________(1-10):________

Current stress level (1-10): ________ Main causes: ____

Do you exercise? Y ☐ N ☐ If yes, what kind of exercise and how often? ___________________________________

Lifestyle: please report your utilization of the following as well as the frequency

	Daily	Weekly	Monthly
Tobacco	_______	_______	_______
Alcohol	_______	_______	_______
Recreational drugs	_______	_______	_______
Coffee/caffeine	_______	_______	_______
Sugar/sweets	_______	_______	_______
Artificial sweeteners	_______	_______	_______
Soda	_______	_______	_______

I identify as:

☐ Straight
☐ Homosexual
☐ Bisexual
☐ Transgendered
☐ Other
☐ Prefer to not disclose

For past and present tobacco users:

How many years have/did you smoked for?__________________

If you have quit, what year did you quit?__________________

Food Habits

Are there any foods you crave?____________________________

Are there any foods you avoid?____________________________

Sleeping Habits

Hours of sleep per night (on average): _________ Quality of sleep (0=poor, 10=excellent): _________

Do you have trouble falling asleep? Y ☐ N ☐ Do you feel rested upon waking in the morning? Y ☐ N ☐

Women's Health

Last menstrual period (M/D/Y): ________________________

Length of monthly cycle (days): ________________________

Average length of flow (days): ________________________

Last PAP exam (date): ________________________

Last breast exam (date): ________________________

Have you ever had an abnormal PAP result? Y☐ N☐

Do you have any bleeding between periods? Y☐ N☐

Do you have any bleeding after intercourse? Y☐ N☐

Age of onset of menopause (if applicable):________________

Are you currently sexually active? Y☐ N☐

Do you have any sexual problems or concerns? Y☐ N☐

Are you currently pregnant? Y☐ N☐ Weeks: ___________

Men's Health

Last prostate exam (date): ________________________

Was a blood test (PSA) done?________________________

How many times a night do you awaken to urinate? _______

Have you noticed any of the following with urination?

☐ Urgency ☐ Dribbling ☐ Pain

☐ Incomplete ☐ Increased frequency

Have you ever experienced any of the following?

☐ Hernia ☐ Sores ☐ Testicular pain

☐ STDs ☐ Discharge ☐ Prostate disease

☐ Impotence ☐ Erectile dysfunction

Do you have any sexual problems or concerns? Y☐ N☐

Context of Care

What expectations do you have for this visit? ________________________

____

What long-term expectations do you have from working with our clinic? ________________________

____

What is your present level of commitment to address any underlying causes of your health concerns (0-100%)? ______________

What potential obstacles do you foresee in adhering to the therapeutic protocols that I will be sharing with you? ______________

____

____

Review of Systems

Please indicate if you have experienced any of the following symptoms or conditions. Mark **Y** if you are currently experiencing or **P** if you have experienced this condition in the past.

General

- Y ☐ P ☐ Cancer
- Y ☐ P ☐ Sensitivity to cold
- Y ☐ P ☐ Sensitivity to heat
- Y ☐ P ☐ Excess/night sweating
- Y ☐ P ☐ Sleep disturbances
- Y ☐ P ☐ Dizziness
- Y ☐ P ☐ Stress
- Y ☐ P ☐ Exposure to toxins
- Y ☐ P ☐ Rapid weight change
- Y ☐ P ☐ Fatigue
- Y ☐ P ☐ Excessive hair loss
- Y ☐ P ☐ Fever/chills

Head/Eyes/Ears/Nose/Throat

- Y ☐ P ☐ Headaches/Migraines
- Y ☐ P ☐ Jaw or TMJ problems
- Y ☐ P ☐ Head trauma
- Y ☐ P ☐ Facial pain
- Y ☐ P ☐ Ringing in ears
- Y ☐ P ☐ Ear infection
- Y ☐ P ☐ Earache
- Y ☐ P ☐ Hearing loss
- Y ☐ P ☐ Dizziness/Vertigo
- Y ☐ P ☐ Changes in vision
- Y ☐ P ☐ Cataracts
- Y ☐ P ☐ Glaucoma
- Y ☐ P ☐ Eye pain, tearing or dry
- Y ☐ P ☐ Sensitivity to light
- Y ☐ P ☐ Colour blindness
- Y ☐ P ☐ Night blindness
- Y ☐ P ☐ Blurring/spots/stars
- Y ☐ P ☐ Glasses/contact lenses
- Y ☐ P ☐ Frequent nosebleeds
- Y ☐ P ☐ Allergies/hayfever
- Y ☐ P ☐ Stuffiness
- Y ☐ P ☐ Sinus problems
- Y ☐ P ☐ Loss of smell
- Y ☐ P ☐ Nasal obstructions
- Y ☐ P ☐ Nosebleeds
- Y ☐ P ☐ Dental/Gum problems
- Y ☐ P ☐ Dental cavities
- Y ☐ P ☐ Mercury amalgams
- Y ☐ P ☐ Teeth grinding
- Y ☐ P ☐ Mouth/lip/tongue sore
- Y ☐ P ☐ Frequent sore throats
- Y ☐ P ☐ Metallic taste in mouth
- Y ☐ P ☐ Loss of sense of taste
- Y ☐ P ☐ Neck pain/stiffness
- Y ☐ P ☐ Swollen glands/Lumps
- Y ☐ P ☐ Goiter
- Y ☐ P ☐ Difficulty swallowing

Breasts

- Y ☐ P ☐ Pain/Tenderness
- Y ☐ P ☐ Lumps
- Y ☐ P ☐ Fibrous tissue
- Y ☐ P ☐ Discharge

Skin

- Y ☐ P ☐ Eczema
- Y ☐ P ☐ Psoriasis
- Y ☐ P ☐ Hives
- Y ☐ P ☐ Rashes
- Y ☐ P ☐ Acne/Boils
- Y ☐ P ☐ Dry skin/scaling
- Y ☐ P ☐ Lice/Scabies/Mites
- Y ☐ P ☐ New/Changing moles
- Y ☐ P ☐ Infections/fungus
- Y ☐ P ☐ Hair/nail changes
- Y ☐ P ☐ Changes in skin colour
- Y ☐ P ☐ Itching

Respiratory

- Y ☐ P ☐ Chronic cough
- Y ☐ P ☐ Frequent colds
- Y ☐ P ☐ Excess phlegm/mucus
- Y ☐ P ☐ Pain on breathing
- Y ☐ P ☐ Asthma/Wheezing
- Y ☐ P ☐ Bronchitis/COPD
- Y ☐ P ☐ Coughing up blood
- Y ☐ P ☐ Chest pain
- Y ☐ P ☐ Shortness of breath
- Y ☐ P ☐ Pneumonia
- Y ☐ P ☐ Tuberculosis
- ________ Last tuberculosis test
- ________ Last Chest X-Ray

Cardiovascular

- Y ☐ P ☐ Heart disease
- Y ☐ P ☐ Stroke
- Y ☐ P ☐ Arrhythmia
- Y ☐ P ☐ Chest pain/Angina
- Y ☐ P ☐ High/low BP
- Y ☐ P ☐ Murmurs
- Y ☐ P ☐ Swelling of ankles
- Y ☐ P ☐ Rheumatic fever
- Y ☐ P ☐ Phlebitis
- Y ☐ P ☐ Cold hands/feet
- Y ☐ P ☐ Easy bleeding/bruising
- Y ☐ P ☐ Deep leg pain
- Y ☐ P ☐ Varicose veins
- Y ☐ P ☐ Anemia
- Y ☐ P ☐ Swollen lymph nodes
- Y ☐ P ☐ Blood clots
- Y ☐ P ☐ Palpitations/fluttering
- Y ☐ P ☐ Poor circulation

Psychosocial

- Y ☐ P ☐ Anxiety, panic
- Y ☐ P ☐ Depression
- Y ☐ P ☐ Mood swings
- Y ☐ P ☐ Attempted suicide
- Y ☐ P ☐ Schizophrenia
- Y ☐ P ☐ Easily angered
- Y ☐ P ☐ Emotional outbursts
- Y ☐ P ☐ Phobias

Neurological/Endocrine

- Y ☐ P ☐ Fainting
- Y ☐ P ☐ Numbness/tingling
- Y ☐ P ☐ Paralysis
- Y ☐ P ☐ Involuntary movements
- Y ☐ P ☐ Muscle weakness
- Y ☐ P ☐ Sciatica
- Y ☐ P ☐ Change in coordination
- Y ☐ P ☐ Concussion/Head injury
- Y ☐ P ☐ Loss of (poor) memory
- Y ☐ P ☐ Seizures/Convulsions
- Y ☐ P ☐ Loss of balance
- Y ☐ P ☐ Speech difficulties
- Y ☐ P ☐ Hallucinations
- Y ☐ P ☐ Poor concentration
- Y ☐ P ☐ Thyroid problems
- Y ☐ P ☐ Excessive thirst
- Y ☐ P ☐ Excessive hunger
- Y ☐ P ☐ Diabetes
- Y ☐ P ☐ Hormone therapy
- Y ☐ P ☐ Excessive fatigue
- Y ☐ P ☐ Seasonal depression
- Y ☐ P ☐ Hair loss
- Y ☐ P ☐ Brittle nails
- Y ☐ P ☐ Heat or cold intolerance
- Y ☐ P ☐ Blood sugar irregularities
- Y ☐ P ☐ Easy weight gain

Gastrointestinal

- Y ☐ P ☐ Difficulty swallowing
- Y ☐ P ☐ Food allergy/sensitivity
- Y ☐ P ☐ Colitis
- Y ☐ P ☐ Spitting up blood
- Y ☐ P ☐ Jaundice
- Y ☐ P ☐ Nausea/Vomiting
- Y ☐ P ☐ Indigestion/Bloating
- Y ☐ P ☐ Belching/Burping/Gas
- Y ☐ P ☐ Regurgitation/Heartburn
- Y ☐ P ☐ Appendicitis
- Y ☐ P ☐ Abdominal Pain/Cramps
- Y ☐ P ☐ Change in appetite
- Y ☐ P ☐ Change in thirst
- Y ☐ P ☐ Hernias
- Y ☐ P ☐ Hepatitis
- Y ☐ P ☐ Gallbladder problems
- Y ☐ P ☐ Diarrhea/loose stools
- Y ☐ P ☐ Constipation
- Y ☐ P ☐ Black stools
- Y ☐ P ☐ Mucous in stools
- Y ☐ P ☐ Bloody stools
- Y ☐ P ☐ Hemorrhoids
- Y ☐ P ☐ Rectal pain
- Y ☐ P ☐ Bad breath
- Y ☐ P ☐ Ulcer
- Y ☐ P ☐ Liver disease
- Y ☐ P ☐ Pancreatitis
- Y ☐ P ☐ Heartburn
- Y ☐ P ☐ Daily bowel movements
- Y ☐ P ☐ Parasites
- Y ☐ P ☐ Diverticulitis
- Y ☐ P ☐ Itchy rectum
- Y ☐ P ☐ Change in frequency
- ________ Number of bowel movements per day

Urinary

- Y ☐ P ☐ Pain on urination
- Y ☐ P ☐ Increased frequency
- Y ☐ P ☐ Decreased frequency
- Y ☐ P ☐ Inability to urinate
- Y ☐ P ☐ Abnormal thirst
- Y ☐ P ☐ Kidney/bladder infect.
- Y ☐ P ☐ Kidney stones
- Y ☐ P ☐ Coloured/bloody urine
- Y ☐ P ☐ Frequent UTIs
- Y ☐ P ☐ Inability to hold urine

Sexual/Reproductive

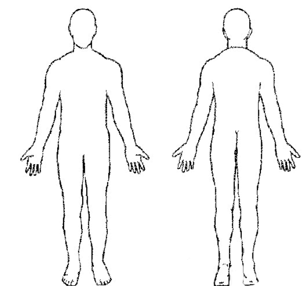
- Y ☐ P ☐ Sexual difficulties
- Y ☐ P ☐ Change in sex drive
- Y ☐ P ☐ Sexually active?
- Y ☐ P ☐ Pain with intercourse
- Y ☐ P ☐ Chlamydia
- Y ☐ P ☐ Gonorrhea
- Y ☐ P ☐ Warts on genitals
- Y ☐ P ☐ HIV+/AIDS
- Y ☐ P ☐ Herpes simplex
- Y ☐ P ☐ Syphilis
- Y ☐ P ☐ Sores on genitals
- Y ☐ P ☐ Abnormal discharge

Female Reproductive

- Y ☐ P ☐ Irregular periods
- Y ☐ P ☐ Spotting
- Y ☐ P ☐ Clots
- Y ☐ P ☐ Regular cycles?
- ________ Age of first period
- ________ No. of pregnancies
- ________ No. of miscarriages
- ________ No. of abortions
- Y ☐ P ☐ Pregnancy complicat.
- Y ☐ P ☐ Vaginal discharge
- Y ☐ P ☐ Yeast/other infections
- Y ☐ P ☐ Endometriosis
- Y ☐ P ☐ Ovarian cysts
- Y ☐ P ☐ Difficulty conceiving
- Y ☐ P ☐ Cervical dysplasia
- Y ☐ P ☐ PMS

Musculoskeletal

- Y ☐ P ☐ Joint pain/stiffness
- Y ☐ P ☐ Arthritis/rheumatism
- Y ☐ P ☐ Broken bones
- Y ☐ P ☐ Muscle spasm/cramps
- Y ☐ P ☐ Muscle weakness



Indicate areas of pain by shading
Circle areas of numbness/tingling

Consent to Naturopathic Treatment

I, ______________________________, hereby authorize A New Leaf Naturopathic Clinic to perform specific procedures as deemed necessary to facilitate my diagnosis and treatment. I understand that I am free to withdraw my consent and discontinue at any time. I consent to my examination and treatment by the doctor and/or any doctor serving as a back-up to him/her.

I understand that my treatment plan may include but may not be limited to any or all of the following core modalities and procedures to assess, treat or otherwise address my health concerns:

- ***Therapeutic Nutrition:*** prescribing of nutritional supplements including intramuscular or subcutaneous vitamin injections.
- ***Acupuncture and Oriental Medicine:*** Insertion of thin sterile needles at specific points of the body, application of ear seeds, cupping, and prescribing of traditional oriental herbal formulas.
- ***Botanical Medicine:*** prescribing of botanicals (e.g. teas, tinctures, solid extracts, powders, creams, suppositories etc.)
- ***Physical Medicine:*** soft tissue massage, stretching, traction, ultrasound
- ***Homeopathy:*** prescribing of minute doses of natural substances (e.g. plants, animals, minerals) to stimulate healing
- ***Lifestyle counseling:*** recommendations on diet, exercise, sleep hygiene and stress reduction
- ***Naturopathic manipulation:*** physical manipulation to correct the musculoskeletal structure
- ***Hydrotherapy:*** use of water treatments (e.g. hot & cold, sauna etc.)
- ***Diagnostic procedures:*** including but not limited to: venipuncture, PAP smears, laboratory evaluations of blood, saliva and urine, ECG, spirometry, physical exams, neurological exams and musculoskeletal assessment
- ***Prescribed medications:*** pharmaceuticals that are within the scope of naturopathic medicine in BC

Potential risks: pain, discomfort, bruising, blistering, itching, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, and hydrotherapies; allergic reactions to prescribed herbs or supplements and medications; soft tissue or bone injury from physical manipulations, and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and other symptoms of disease, assistance in disease and injury recovery, and prevention of disease or it's progression.

Notice for pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant, as some treatments could present a risk to the pregnancy.

I recognize that even the gentlest therapies potentially have their complications in certain conditions, in very young children, in the elderly or in those on multiple medications. I acknowledge that the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy and all medications, including over the counter drugs and supplements.

I understand that the doctor is not able to anticipate or explain all the risks and complications of treatment and therefore rely on her to exercise her judgment during the course of the procedure based on known facts. I acknowledge that no guarantees of service have been made to me concerning results of treatment offered to me.

Cancellation Policy: 48 hours notice is appreciated for all cancellations. A missed appointment or late cancellation (less than 24 hours notice) will result in a fee being charged. All payments are due at the time of treatment.

Email Communications: Doctors give out their email addresses, which are strictly to be used for short questions regarding any current treatment(s). Emails are not to be used in lieu of an office visit.

Prescription Refills: All prescription refills called in or requested will be looked at within 1 week. Please be advised that this is carried out at the doctor's discretion and you may be required to make an appointment.

By signing below, I acknowledge that I have read this form or that it has been read to me. I understand all of the above and give my written consent to evaluation and treatment by the doctor. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment. I hereby acknowledge that the information I have provided is true and complete to the best of my knowledge.

______________________________	______________________________	______________________
Printed Name of Patient	Signature of Patient	Date

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