

Dr Serenity Aberdour ND
Naturopathic Physician

PATIENT INFORMATION AND HEALTH HISTORY

Name_____ Age____ Birthdate_____ M F
Today's date_____

Address_____ City_____ Province_____

Postal Code_____

Home phone_____ Work phone_____

Fax_____ Email_____

Occupation_____

Marital Status_____

Emergency Contact: Name_____ Relation_____

Number_____

How did you learn about this clinic?_____

Have you had previous treatment by a naturopathic doctor? Y N

If yes when?_____

Other Health Care providers:

MD_____

DC (chiropractor)_____

Other(s)_____

MAIN HEALTH CONCERNS

Please list your major health concerns at this time

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

When did these complaints begin?_____

What other treatment(s) have you received for these complaints?_____

Have any specialists been consulted regarding these complaints? Y N

Please list your current prescription medications_____

HEALTH HISTORY

Please list all prescription medication that you have used in the last 2 years

Please list all non-prescription medications that you currently use (include all over the counter products, herbal medicines and supplements) and dosage.

Please list any known allergies to:

- 1) Medications _____
- 2) Foods _____
- 3) Plants/environment/animals _____

When was your last complete physical exam? _____

When was your last dental exam? _____

Women only When was your last PAP exam _____

- Are you pregnant? Yes No
- Are you breast feeding? Yes No
- Number of pregnancies? _____
- Number of live births? _____
- Age of first period? _____
- Are your periods regular? Yes No
- Do you do regular self breast exams? Yes No
- Do you use birth control pills? Yes No

Please list any major illnesses/injuries/ surgeries/hospitalisations and their approximate dates:

- Are you HIV positive? Yes No
- Have you been diagnosed with hepatitis? Yes No

Do you smoke? **Y** **N** If yes, how much do you smoke per day _____

Number of alcoholic beverages consumed per week _____

Number of caffeinated beverages (tea/coffee/pop) per day _____

Hours of sleep per night _____

Please indicate which of the following disorders you have experienced

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Herpes | <input type="checkbox"/> complaints |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High blood | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> pressure | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hives | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> (please specify): |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sunstroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> consciousness | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Malaria | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Goitre | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Parasites | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pleurisy | |
| <input type="checkbox"/> Heart disease | | |

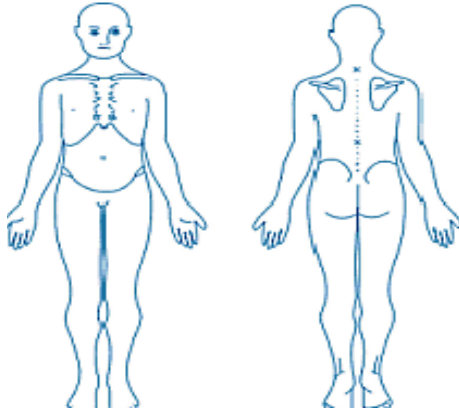
Please list family members who do/have had any of the following complaints

- | | |
|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Other mental disorders (please specify): | <input type="checkbox"/> Chronic digestive tract complaints |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Substance abuse/addiction |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Birth defects |

Please indicate which of the following symptoms/complaints you have currently or have had in past few months:

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Waking at night to urinate |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Unable to hold urine |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Cold hand/feet | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irregular heart beat/palpitations | <input type="checkbox"/> Joint pain (please specify): |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> Muscle pains (specify part(s) of body): | <input type="checkbox"/> Low blood pressure | |
| | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Sweating easily/excessively | <input type="checkbox"/> Gas/bloating | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Weight gain/ loss | <input type="checkbox"/> Constipation | <input type="checkbox"/> Menstrual pain |
| <input type="checkbox"/> Changes in thirst or appetite | <input type="checkbox"/> Diarreah | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Easy bleeding or bruising | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Heavy Menses |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Regular use of laxatives | <input type="checkbox"/> Absence of menses |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Abdominal pain/cramps | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Itching (specify body part): | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Breast pain |
| | <input type="checkbox"/> Haemorrhoids | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Frequent/urgent urination | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Pain on urination | |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Impotence | |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Blood in urine | |
| <input type="checkbox"/> Poor hearing | | |
| <input type="checkbox"/> Fainting | | |

Please indicate Painful or distressed areas:



What are the major stressors in your life?

How do you cope with the stress in your life?

Do you exercise regularly?

If yes, describe typical exercise per week

Diet

Please describe your food intake over the past 24 hours:

Are you currently following a specialized/ restricted diet?

Additional Information:

Please add any additional information about yourself and/or your health that you feel is important (please use the back of this page if more space is required)

Dr. Serenity Aberdour ND
Naturopathic Physician

INFORMED CONSENT TO NATUROPATHIC TREATMENT

Patient _____ Phone No _____
Address _____ Attending N.D. _____
City _____
Province _____

Naturopathic medicine uses non drug and non surgical approaches to the treatment and prevention of disease. Naturopathic doctors (NDs) take into account physical, mental, emotional and spiritual aspects of the individual and develop treatment protocols based on the unique needs of each individual. NDs generally use natural and non-invasive treatment modalities with the intention of stimulating the body's own inherent healing abilities.

Naturopathic Treatment Modalities

Botanical (herbal) medicine

Refers to the use of plant-derived products in the treatment and/or prevention of illness and can include teas, tinctures (alcohol based preparations), baths, topical applications (creams, ointments etc), capsules or tablets.

Oriental medicine and acupuncture

Includes acupuncture (the insertion of thin, sterile needles into specific points in the skin and underlying tissues) as well as diet therapy (the recommendation to eat and/or avoid particular foods), moxa (the burning of a stick of compressed herb over acupuncture needles that have been inserted into the skin and underlying tissues), herbal formulas as well as the examination of the tongue and pulse for diagnostic purposes.

Homeopathy

Refers to the use of minute doses of plant, mineral and/or vegetable matter to treat and/or prevent illness. Homeopathy may work on mental and emotional as well as physical levels.

Dietary counselling and nutritional supplements

Are used to address possible nutrient imbalances and/or deficiencies, to treat and/or prevent illness and to improve overall health. This may include recommendations of inclusion and/or avoidance of particular foods as well as use of nutritional supplements which may include vitamins, minerals and/or other nutrients, plant and or animal matter, enzymes, amino acids.

Intravenous therapies

This refers to the administration of vitamins, minerals or other nutrients, herbal products or homeopathic products into the body through a needle inserted into a patient's vein

Injection therapies

This refers to the administration of natural substances (vitamins, homeopathics, procaine or other local anaesthetic) into the skin or muscle through a thin needle. Therapies that fall under this category include mesotherapy and biopuncture as well as B12 injections.

Physical Medicine

Includes the use of soft tissue and spinal/joint manipulation as well as hydrotherapy (the use of hot and/or cold water to manipulate the circulation of blood and lymphatic fluid in the body and to stimulate the immune system)

Lifestyle Counselling

Your naturopathic doctor will help you to identify the lifestyle factors that may be negatively impacting on your health and happiness. This may include identifying risk factors for illness and providing recommendations for reducing your risk.

Initial and follow up visits

Your initial visit will be approximately 60 minutes in length and will include an extensive health history review, a detailed discussion of your main health concern(s), and physical examination as required. Your naturopathic doctor may also request further information (such as results of recent tests that may have been performed) from your other health care practitioners (medical doctor, chiropractor etc) in order to create the most complete health profile that she/he can. Other laboratory tests may be recommended by your naturopathic doctor depending on your symptoms. Please note that testing performed through your naturopathic doctor are not covered by MSP. You will be informed of the cost of all tests before they are performed and have the right to refuse any test.

Follow up visits will be approximately 30 minutes in length and are arranged for the purposes of discussing, changing and/or monitoring the progress of your naturopathic treatment protocol. During this time additional laboratory tests may be recommended and/or treatments recommended and/or performed by your ND. Acupuncture treatments will be approximately 30 minutes in length.

Treatment risks

Naturopathy uses primarily non-invasive and low-risk treatment modalities. However, all therapies are associated with some potential risks. Side effects from naturopathic treatment are relatively rare but can include (but are not limited to):

Aggravation of symptoms, allergic reactions to herbs, supplements or injections, complications from acupuncture, intravenous or injection therapies (pain, bruising, bleeding, lightheadedness or fainting, nausea and vomiting, puncture of internal organs), injury to soft tissues and/or joints/bone/spine arising from the use of physical medicine, accidental burns associated with the use of moxa, unforeseen interactions between recommended herbs/supplements and over the counter or prescription medications.

Confidentiality

A record of all visits with your ND including health history, exams/tests performed and treatments recommended will be kept by your ND. This record is kept strictly confidential and is not released to others without written consent provided by you or your representative or unless your ND is required to do so by law. Information from your file may be used for the purposes of research, teaching or development of treatment protocols. In all cases your identity will be protected. In the event that you require naturopathic consultation and/or treatment and your regular attending ND is not available the ND substituting for your regular ND will be permitted full access to your naturopathic health record for the purposes of providing you with appropriate advice and/or treatment.

Statement of Consent

I _____ understand the treatment modalities that my naturopathic doctor may use with me. I understand potential risks and side effects of naturopathic treatment and that my naturopathic doctor cannot anticipate and explain all risks and complications that may arise. I understand that naturopathic medicine, like all medicine, cannot guarantee results. I further understand that advice and/or treatments offered to me by my naturopathic doctor are not intended to substitute for or replace advice and/or treatment provided to me by my medical doctor.

With this knowledge I voluntarily consent to the diagnostic and therapeutic procedures outlined above except for (please list exceptions, if any).

This consent form is intended to apply to the entire course of my care by my naturopathic doctor (and/or naturopathic doctor substituting for her/him). I understand that at any time I may (in writing) withdraw consent to any further treatment and discontinue treatment at any time.

Signature of patient/Guardian _____

Date _____