DOWNTOWN BRAMPTON WELLNESS CENTRE

118 QUEEN STREET WEST, SUITE 205, BRAMPTON, ON L6X 1A5
905-451-3963 • downtownbramptonwellness@bellnet.ca • bramptonwellness.ca

PLEASE NOTE THAT THESE FORMS MUST BE SIGNED AND FILLED OUT PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history, and may do a screening physical examination, including a breast exam and take blood and urine samples.

It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. If required, I understand that my Naturopathic Doctor may discuss my case with other health care providers. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee of $0.10 per page. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the Doctors to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Naturopathic care. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent at any time.

Patient Name: (Please Print) _____

Signature of Patient: _____

Date: _____ Naturopathic Doctor: _____

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Name:_____Date: _____

Address:_____ City: _____

Postal Code: _____ e-mail: _____

Phone: (H): _____ (M/W): _____

May we leave phone messages relating to your visits? Y / N

Date of birth _____ (M/D/Y) Age: ____ Sex: M / F

Emergency Contact Name:_____

Phone: _____Relation:_____

Occupation: _____ Do you like your job? _____
Marital Status: _____ No. of Children: _____
Family Physician: _____ Phone: _____

What are your **main health concerns**, in order of importance to **you**:

1. _____
2. _____
3. _____
4. _____
5. _____

Medical History

Date of last physical exam _____ Height _____ Weight_____
Maximum Weight_____ When?_____
Energy level (1-10, 10 highest)_____
Hours of sleep per night? ___ Any problems falling or staying asleep? Y / N
Do you usually wake up feeling refreshed? Y / N
Do you drink alcohol? Y / N - How many drinks per week? _____
Do you smoke? Y / Past / N - How many cigarettes per day? _____
Do you drink caffeinated drinks? Y / N - How many/day? ___
Do you currently or have you ever used recreational drugs? Y / N
If so, which drugs and for how long?

_____

Do you have any known allergies? Y / N To what?

_____
_____
_____
_____
_____

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Medical History cont'd

How would you describe your general health? (circle)
Excellent Good Fair Poor

Current Medications & how long taken

_____
_____
_____
_____

Current vitamins and supplements:

_____
_____
_____
_____

Other treatments or health care?(e.g. physio, massage, chiropractic…)

_____
_____

Please indicate any serious conditions, illnesses or injuries, and any surgeries or hospitalizations; along with approximate dates

_____
_____
_____
_____

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (circle)
Aspirin/ Tylenol/ Advil/ Laxatives/ Antacids/ Diet pills/ Birth control pills

Please indicate if any of the above caused adverse reactions:

_____
_____
_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y / N

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____
_____
_____

TYPICAL DIET:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

FAMILY HISTORY

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other Mental Illness	
Heart Disease		Drug Abuse/Alcoholism	
High Blood Pressure		Kidney Disease	
Cancer		Other	
Diabetes		Other	

☐ I don't know my family medical history

ENVIRONMENT

Hobbies _____

Do you exercise regularly? Y / N

What do you do for exercise, how much, how often?

_____

_____

Are you exposed to significant tobacco smoke(work, home, etc.)? Y / N

ENVIRONMENT (CONT'D)

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?_____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

_____
_____

How would you describe the emotional climate of your home?

_____
_____
_____
_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____
_____
_____
_____

Is there anything that you feel is important that has not been covered?

_____
_____
_____
_____
_____
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_____
_____

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Context of Care Questionnaire

Why did you choose me as your Naturopathic Doctor?

_____

_____

_____

_____

_____

What do you know about my approach?

_____

_____

_____

_____

What three expectations do you have from your first visit with me?

_____

_____

_____

What long-term expectations do you have from working with me?

_____

_____

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? 1-10 (circle)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

_____

_____

_____

_____

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are destructive to your health? (please list)

_____

_____

_____

_____

_____

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

_____

_____

_____

_____

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

_____

_____

_____

_____

Thank you for taking the time to fill out these intake forms.