



saskatoon
NATUROPATHIC MEDICINE
call. 306-664-2150 | fax. 306-664-2151
14-118 Cope Cres., Saskatoon S7T 0X3
www.saskatoonnaturopathic.com

Please take time to fill out the following information. It provides a basis for further questioning during your visit and helps with the health assessment. All information is for office use only and is strictly confidential.

Date of First Visit: _____ **Circle primary doctor:** Dr. Velichka, ND OR Dr. Reid-Ahenakew, ND OR
Dr. Sieben, ND OR Dr. Loran, ND

Patient Information

Full Name: _____ Date of Birth (D/M/Y): _____ Age: _____ Gender (M/F): _____
Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____
Health Card Number: _____
Occupation: _____ Full or Part-time? _____ Shift work? yes no
Marital Status: single married separated divorced other: _____
Children: yes no If yes, please list ages: _____ Parent's Name (if a minor): _____
How did you find out about the naturopathic services at this clinic? If referred please indicate from whom.

In Case of Emergency Contact

Full Name: _____ Phone: (H) _____ (W) _____ (C) _____
Address: _____ Relationship to Patient: _____

Please List Other Health Care Providers (include speciality if appropriate):

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____

Current Health Concerns

What are your health concerns? (list in order of importance to you and include the date when you first noticed symptoms)

How do you rate your general state of health? poor fair good very good excellent

Comments: _____



Medical History

Current/past illnesses, accidents, conditions and hospitalizations (inc. year of occurrence): _____

Allergies or sensitivities (foods, drugs, environmental, pets etc.): _____

Are you also working with a medical doctor (MD)?

Yes No

State diagnosis (if applicable): _____

List any medications or supplements you are currently taking including dosage: _____

List past prescription medications: _____

How many times have you been treated with antibiotics: ____

Date of last antibiotic use: _____

Date of last screening physical exam: _____

Do you have any dental mercury amalgam fillings? ____#? ____

Females: Are you currently pregnant? Yes No

If so, when was that date of last menses _____

Lifestyle History

Please list a typical day's diet:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

Describe your appetite: _____

Do you exercise? Yes No

If yes, how often? _____ times per week

... how long? _____ minutes per workout

....what type? _____

How much water do you drink? _____ glasses per day

Do you avoid any foods and why? _____

What are your sleep patterns? (Include usual time of sleep and wake, daytime naps and any difficulties in falling asleep or staying asleep): _____

What is your height? _____ Current weight? _____ Max. weight? _____ Min. weight? _____

Have you lost any weight lately? Yes No If yes, how many pounds? _____



Lifestyle History Cont'd

Indicate whether you use or are exposed to the following (and if so, how much/how often)

Tobacco smoke: yes no _____
Coffee: yes no _____
Tea: yes no _____
Pop: yes no _____
Alcohol: yes no _____
Recreational drugs: yes no _____
Excess stress: yes no _____
Chemicals: yes no _____

Family History- Please indicate any health conditions that have affected members of your family:

<u>Relative</u>	<u>Age if Alive</u>	<u>Age at Death</u>	<u>Health Conditions</u>
Mother			
Father			
Siblings			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Social History

Describe your family/ work relationships: _____ List important events/ experiences in your life: _____

What is a typical day like for you? _____

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? _____

When you are feeling stressed, what helps you relax and feel better? _____



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Review of Systems: *Check the box if you have had in the past- Circle it if it is something you have now.*

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Exposure to toxins/chemicals | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eye floaters | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eye redness/discharge | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fainting | <input type="checkbox"/> Osteoporosis/penia |
| <input type="checkbox"/> Arm/Shoulder pain | <input type="checkbox"/> Fibrocystic breasts | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Pain on urination |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Painful menses |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Genital warts | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Bloating/gas | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Blood/mucous in stool | <input type="checkbox"/> Gout | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Heavy menses | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Brittle nails | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernias | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> HIV | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Hoarse voice | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Impaired hearing | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Cold hands/ feet | <input type="checkbox"/> Inability to hold urine | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Infertility | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Dental cavities | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Spitting up blood |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irregular menstrual cycle | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Digestion problems | <input type="checkbox"/> Leg pain/cramps | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Discharge from penis | <input type="checkbox"/> Lines on nails | <input type="checkbox"/> Swollen neck glands |
| <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Testicular mass/pain |
| <input type="checkbox"/> Earache/infections | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Malaria | <input type="checkbox"/> TMJ problems |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraine | <input type="checkbox"/> Urinary urgency |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mono | <input type="checkbox"/> Urination at night |
| <input type="checkbox"/> Excess hunger | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Excess sweating | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Vaginal itching |
| <input type="checkbox"/> Excess thirst | | <input type="checkbox"/> Wheezing |



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Clarification of Goals

What expectations or goals do you have around your care? _____

For your care to be a true win for you, what do you see happening over the next 3 months? _____

What resources do you currently allocate to your health and well being? I.e. how much time, money and energy do you currently invest in your health? _____

How much time, money and energy are you willing to invest in your health? _____

What is your present level of commitment to learn and implement healthy changes which will improve your health and well-being? (*Rate from 1-10*) _____

If below 8, what will it take to increase your level of commitment? _____



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INFORMED CONSENT FORM

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's healing capacity.

Naturopathic Doctors are required to obtain informed consent and to make sure you are aware of possible side effects/risks due to treatment. The doctors of Saskatoon Naturopathic Medicine Incorporated (SNMI) use the following in their practices: diet and nutritional counseling, traditional Chinese medicine and acupuncture, botanical medicine, hydrotherapy, massage, homeopathy, and lifestyle counseling. It is important to know that any treatment or advice provided is not mutually exclusive from any treatment or advice that you may now be receiving or may in the future receive from another licensed health care provider. You are at liberty to continue medical care from a medical doctor or any other health care provider licensed to practice in Saskatchewan.

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, improved gastrointestinal function, enhanced immunity, and general well-being.

Botanical medicine is plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine based on the Law of Similars; that is, the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses, of plant, animal, or mineral origin, are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, the doctors of SNMI will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take urine samples for further testing, or blood samples for lab investigation.

Even the gentlest of therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases including but not limited to diabetes and heart/liver/kidney disease. It is very important therefore that you inform the doctors of SNMI immediately if any of the above applies to you.



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There are some 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/injury from acupuncture and massage, fainting or puncturing of an organ with acupuncture needles.

Initials I understand that my case may be discussed for educational purposes and information from my medical record may be analyzed for research purposes in which my identity will be kept confidential. I acknowledge that I have discussed, or have had the opportunity to discuss, with the doctors of SNMI the nature and purpose of naturopathic treatment in general and my treatment in particular as well as the contents of this consent.

Initials 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 without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

Initials I understand that the doctors of SNMI will answer any questions that I have to the best of their ability. Because each individual responds differently to treatment, I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions): _____

Initials I understand that fees and supplements are to be paid for at the time of the consultation.

Initials I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours notice.

As the patient, you are responsible for the total charges incurred for each visit. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company. The doctors of SNMI may prescribe supplements that can be purchased from our in-house dispensary, or elsewhere. Most insurance companies do not cover the supplements that we prescribe and dispense.

I have read and understand the above-stated policies and information. I hereby authorize and consent to naturopathic treatment and examination by the doctors of SNMI. I intend this consent to apply to all my present and future naturopathic care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print): _____

Signature of Patient or Guardian: _____

Date: _____

Welcome to Naturopathic Medicine!
The doctors of SNMI look forward to working with you on your journey to better health.