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Successful health care and preventative medicine are possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. If you have any questions, mark them with a question mark. Thank you!

Confidential Adult Case History

Name: _____ Date: _____
Address: _____
City: _____ Zip Code: _____
Home #: _____ Work #: _____ Cell #: _____
Email Address: _____ Permission to Email Updates & Promotions? Y / N
Date of Birth: _____/_____/_____ Age: _____ Sex: M / F / O
(mm) (dd) (yryr)
Occupation:_____
Number of Children: _____ Spouse/Partner's Name: _____
Person to Contact in Emergency: _____
Name _____Relationship _____
Home #: _____ Work #: _____ Cell #: _____
How did you hear about me? _____

Names of Other Healthcare Providers:

MD (Medical Doctor) _____
ND (Naturopathic Doctor) _____
Chiropractor/ Acupuncturist _____
Other _____

List your main health concerns in order of importance:

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

Please describe the reason for today's visit?

_____
_____
_____
_____

What are your short term health goals?

•
•
•

What are your long-term health goals?

•
•
•

What expectations do you have of me personally as your clinician?

-
-
-

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your short and long term health goals? (Rate from 1 to 10, 10 being 100% commitment; please circle one)
1 2 3 4 5 6 7 8 9 10

What potential obstacles do you foresee in achieving your health goals and adhering to the therapeutic protocols, which we will be sharing with you?_____
_____

Past Medical History
Please circle and date (year) if any of these apply to you.

Significant illnesses: Cancer Diabetes Hepatitis Epilepsy HIV

Heart Disease Rheumatic Fever Thyroid Disease Venereal Disease

Hormonal Imbalance Immune disorder Migraine headache neurological disease

Other_____
Surgeries_____
Major Illnesses_____
Significant Trauma (auto accidents, falls, etc.) _____
Your Birth (Prolonged labor, forceps delivery, etc.)_____

Current History

Height_____ Weight_____ Weight 1 Yr ago _____Max Weight _____
Smoker Y / N Smoked: _____years Amount/day: _____ Years stopped: _____
Drink coffee/cola/tea: Y / N ____cups/ day Use alcohol: Y / N drugs: Y / N Amount: _____
Exercise: Types_____ Duration _____Frequency _____
Allergies_____
Diet: List any food groups that you avoid_____

List ALL prescriptions, over the counter medications, vitamins and herbs you are currently taking (please include BRAND and DOSE):

1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____ 8)_____

9)_____ 10)_____ 11)_____ 12)_____

Medication Allergies:_____

Other allergies (circle all that apply):

Latex Ibuprofen Pollen/Hay Fever "-cillin" meds Metals
Aspirin Animals Fragrance/Perfume "-caine" meds
Others not listed:_____
Food: (specify)_____

Implants/Pain Questions

Do you have any metal implants? ___No ___Yes: (Location?)_____
Do you suffer from chronic pain? ___No ___Yes
Do you have a history of taking chronic pain medications? ___No ___Yes

General Health Questions:
Plain Water (# of 8oz glasses/day):___1-2 ___3-5 ___6-8+
Bowel Movements: How often? _____
Substance Abuse History _____No ____Yes Regular Sleep Patterns: ___No ___Yes

Health Maintenance:
When was your last (if applicable given your age and gender, please circle):
Physical Exam: n/a year _____ Dental Exam: n/a year _____
Lab work: n/a year _____ Eye Exam: n/a year _____
Breast Exam: n/a year _____ Mammogram: n/a year _____
Bone Scan/DEXA: n/a year _____ Colonoscopy/FIT test: n/a year _____
Digital Rectal/Prostate Exam: n/a year _____ Pap Smear: n/a year _____

Family History: Please circle if any of these apply to you or your family.

Cancer Diabetes Heart Disease High BP Anemia Kidney Disease
Seizures Asthma Hay fever/Hives Tuberculosis Depression Schizophrenia
Dementia Arthritis
Other_____

Mother: Age:_____ Medical Conditions:_____
Living / Deceased, If deceased, cause of death: _____
Father: Age: _____ Medical Conditions: _____
Living / Deceased, If deceased, cause of death: _____
Brother(s): How many _____ Age (s) : _____ _____ Medical Conditions: _____
Living / Deceased, If deceased, cause of death _____
Sister(s): How many _____ Age(s): _____ _____ Medical Conditions:_____
Living / Deceased, If deceased, cause of death _____
Maternal Grandmother: Age: _____ Medical Conditions:_____
Living / Deceased, If deceased, cause of death _____
Maternal Grandfather: Age: _____ Medical Conditions:_____
Living / Deceased, If deceased, cause of death _____
Paternal Grandmother: Age: _____ Medical Conditions:_____
Living / Deceased, If deceased, cause of death _____
Paternal Grandfather: Age: _____ Medical Conditions:_____
Living / Deceased, If deceased, cause of death _____

Review of Systems

Circule any symptoms that are current or recurring concerns

General:

Poor appetite	Strong thirst	Night sweats	Tremors	Sudden energy drop
Change in appetite	Poor balance	Fever	Chills	Localized weakness
Weight loss	Sweat easily	Cravings	Bleed/bruise easily	Weight gain
Poor sleep	Fatigue			

Skin & Hair:

Rashes	Ulcerations	Hives	Itching	eczema
Pimples	dandruff	Loss of hair	Recent moles	

Other hair or skin problems: _____

Head, Eyes, Ears, Nose and Throat:

dizziness	Glasses/contacts	Spots in front of eyes	Sinus problems	Swollen glands
Headaches	Poor vision	Blurry vision	Sore throats	Copious saliva
concussions	cataracts	Poor hearing	Teeth problems	Grinding teeth
migraines	Eye strain	Earaches	Nose bleeds	Jaw clicking
Eye pain	Night blindness	Ringing in ears	cavities	Sore lips/tongue
Facial pain	Colour blindness	Loss of smell		

Any other head or neck problems?_____

Cardiovascular:

High blood pressure	Low blood pressure	Chest pain	Swelling of feet	fainting
dizziness	Swelling of hands	Irregular heart beat	Cold hands/feet	Rheumatic fever
Blood clots	Palpitations	Difficulty breathing	Phlebitis	Murmurs

other heart or blood vessel problems: _____

Respiratory:

Cough	Coughing blood	Asthma	Production of phlegm	Pleurisy
Wheezing	Bronchtis	Shortness of breath at night	Pneumonia	

Other lung problems: _____

Gastrointestinal:

Nausea	Indigestion	Chronic laxative use	diarrhea	ulcers
Vommitting	Belching	Black in stools	Abdominal pain	Bad breath
constipation	gas	Rectal pain	Liver disease	hemorrhoids
Gallbladder disease				

Recent changes in bowel movement frequency: _____

Any other problems with your digestion? _____

Genito-urinary:

Pain on urination	Frequent urination	Blood in urine	Urgency to urinate	Unable to hold urine
Kidney stones	Decrease in flow			

Do you wake to urinate (how often)?_____

Any particular colour/odour of urine? _____

Any other problems with your urinary system? _____

Male:

Hernias	Testicular pain	Herpes	Discharge or sores	Erectile dysfunction
Prostate disease	Lack of libido	Testicular masses	STI (type) :_____	

Do you practice birth control? What type and for how long? _____

Any other problem with your reproductive system? _____

Female:

Age of 1st menses:____	Date of last menses: _____	Cycle Length (days): ____	Duration of menses: ____
# of pregnancies:____	# of births:____	# of miscarriages: ____	# of abortions: ____
Heavy menses	Pain on intercourse	Irregular periods	Abnormal pap
Painful periods	Bleeding in between periods	Ovarian cysts	endometriosis
Vaginal sores	Abnormal menses clots	Vaginal discharge	Light menses
Self breast exams	Mood swings	Std (type)?_____	Vaginal dryness
Breast lumps	nipple discharge	Sexual difficulties	Menopausal symptoms

Musculoskeletal:

Neck pain	Muscle pain	Knee pain	Hand/wrist pain	Arthritis
Shoulder pain	Back pain	Muscle weakness	Foot/ankle pain	Sciatica
Hip pain	Broken bones			

Any other bone problems?_____

Neurological:

Seizures	Depression	Tingling	Loss of balance	Quick temper
concussions	Poor memory	Anxiety	Very susceptible to stress	Irritable
Numbness	Nervousness	Lack of coordination		

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____-

Any other neurological or psychological problems? _____

INFORMED CONSENT AND REQUEST FOR NATUROPATHIC TREATMENT

I, as a patient, have the right to be informed about my condition and recommended care. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care, having had the opportunity to discuss the potential benefits, risks, and hazards involved.
I hereby request and consent (or for the patient for whom I am legally responsible) to examination and treatment with Naturopathic Medicine by Dr. Hayley, at my home, office or SKIN Kamloops Medical Spa who now or in the future may treat me.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Hayley:

1. My suspected diagnosis or condition;
2. The nature, purpose and potential benefits of the proposed care;
3. The inherent risks, complications, potential hazards, or side effects of treatments or procedures;
4. The probability or likelihood of success;
5. Reasonable available alternatives to the proposed treatments or procedures;
6. The possible consequences if treatment or advice is not followed and/or nothing is done.

I understand that naturopathic evaluation and treatment may include, but is not limited to:

- Physical exam (general, musculoskeletal, orthopedic, and neurological assessments);
- Common diagnostic procedures (venipuncture, diagnostic imaging, laboratory evaluation of the blood, urine, stool, and saliva);
- Soft tissue and osseous manipulation (massage, osseous manipulation of the spine);
- Electromagnetic and thermal therapies (electroacupuncture, TENS, and moxibustion);
- Dietary advice and therapeutic nutrition (use of foods, diet plans, nutritional supplements, and intramuscular vitamin injections);
- Herbs/natural medicines (prescribing of various therapeutic substances including plants, mineral and animal materials.) Substances may be given in the forms of teas, pills, creams, powders, tinctures, suppositories which may contain alcohol, topical creams, pastes, plasters, washes or other forms.
- Homeopathic remedies (often highly diluted quantities of naturally-occurring substances) given orally or by injection in the form of pellets, tablets, drops, creams, gels, or sterile injectable ampules;
- Hydrotherapy (use of hot and cold water);
- Acupuncture and Cupping;
- Counseling (including, but not limited to talk therapy, emotional freedom technique, and visualization for improved lifestyle strategies and wellness);
- Over the counter and prescription medications (including only medications approved by the CNPBC Naturopathic Regulatory Board); and/or
- Telemedicine

I understand and I am informed that in the practice of Naturopathic Medicine that there are some risks and benefits with evaluation and treatment including, but not limited to the following:

- Potential Risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; an aggravation of pre-existing symptoms; emotional response from somatic or other therapies.

- Potential Benefits: Restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

- Notice to Pregnant Women: All female patients must alert the provider if they know or suspect that they are

pregnant, since some of the therapies could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. The treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such treatment.

- Notice to individuals with bleeding disorders, pace makers, and cancer: For your safety, it is important to alert the provider of these conditions.

Please indicate that you have read and understand the following by initialing next to each.

_____I understand that Dr. Hayley will only prescribe medications if she thinks that it is in the best interest of the patient. Appropriate referrals will be provided (if necessary) to manage prescriptive medication needs of patients.

_____I understand that Health Canada has not approved some nutritional, herbal, and homeopathic substances; however, they have been widely used in Europe, China, Canada and the USA for years.

_____I understand that Dr. Hayley is not a psychologist or psychiatrist. Counseling services are for the improvement of lifestyle strategies and wellness.

_____I acknowledge that I am responsible for all services provided. I understand this is a cash based practice and that payment is due each visit. I can get a bill and submit it to my insurance, but this does not imply any reimbursement will be forthcoming.

I do not expect Dr. Hayley, to be able to anticipate and explain all risks and complications, but I wish to rely on the provider to exercise best judgment, during the course of the assessment and treatment, based on the known facts. I also understand that it is my responsibility to request that the provider explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees or services have been made to me concerning the results intended from the treatment. Should a claim arise, as a result of services rendered by Dr. Hayley, the patient agrees to settle the dispute via arbitration and waives any and all rights to injunctive relief. By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand the above and have given my oral and written consent to evaluation and treatment. 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 am seeking treatment.

_____	_____	_____
Patient Name (please print)	Patient Signature	Date Signed
_____	_____	_____
Name of Guardian (please print)	Signature of Guardian	Date Signed

Welcome!

Thank you for taking the time to fill out this extensive questionnaire. Your answers will help Dr. Hayley to decipher what is going on so she can come up with an individualized, comprehensive treatment plan to help you along your path towards vibrant health!