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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: ____________________________ **Postal 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 /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) __________________________ BRAND ________________________ DOSE _______________________

2) __________________________ BRAND ________________________ DOSE _______________________

3) __________________________ BRAND ________________________ DOSE _______________________

4) __________________________ BRAND ________________________ DOSE _______________________

5) __________________________ BRAND ________________________ DOSE _______________________

6) __________________________ BRAND ________________________ DOSE _______________________

7) __________________________ BRAND ________________________ DOSE _______________________

8) __________________________ BRAND ________________________ DOSE _______________________

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:

Physical Exam: n/a year ______ Dental Exam: n/a year ______ Lab work: n/a year______

Eye Exam: n/a year ______ Papp Exam: n/a year ______ Mammogram: n/a year ______

Prostate Exam: n/a year ______ Bone density scan: n/a year ______

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

Cancer   Diabetes   Heart disease   High blood pressure   Anemia   Kidney disease

Seizures   Asthma   Hay fever/Hives   Tuberculosis   Depression   Schizophrenia

Dementia   Arthritis

Other____

Mother: Age:____ Medical Condition____

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 Condition ___________________________

Living/Deceased, If deceased, cause of death ____

Review of Systems

Check 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 and Hair

Rashes ulceration's hives itching eczema pimples dandruff loss of hair
recent moles

Any other hair and 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 nosebleeds jaw clicks 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 irregular heartbeat
palpitations dizziness swelling of hands fainting cold hands or feet rheumatic fever
murmurs blood clots phlebitis difficulty breathing

Any other heart or blood vessel problems?____

Respiratory

Cough coughing blood asthma production of phlegm pleurisy wheezing bronchitis
shortness of breath at night pneumonia

Any other lung problems?

____

Gastrointestinal

Nausea indigestion chronic laxative use diarrhea ulcer vomiting belching
black in stools abdominal pain bad breath constipation gas rectal pain
liver disease hemorrhoids gallbladder disease

bowel movements: how often?_______ is this a change?_____________

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/odor of urine? ________________________

Any other problems with your urinary system? ____

Male

hernias   testicular pain   herpes   discharge or sores   impotence   prostate disease

testicular masses

std (type)_____________________________

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

Any other problem with your reproductive system? ____

Female

age of first menses_______ date of last menses______ length of cycle_______ 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

vaginal discharge   light menses   self breast exams   clots   std (type)?__________________

breast lumps   vaginal dryness   nipple discharge   sexual difficulties   menopausal symptoms

mood swings   birth control (type)?___________________

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 Collinge, ND, who now or in the future may treat me while working, at Rise Wellness Center located at 101-2504 Skaha Lake Rd. in Penticton, BC.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Collinge ND:
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 ampoules;
- Hydrotherapy (use of hot and cold water);
- 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).
- Intravenous Vitamin Therapy
- Acupuncture, Tui na, cupping, Moxibustion or Cosmetic Acupuncture
- Cosmetic Neurotoxin or Dermal filler

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. Collinge will only prescribe medications if she thinks that it is in my best interest. Appropriate referrals will be provided (if necessary) to manage prescriptive medication, imaging and diagnostic 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, and the USA for years.

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

________I acknowledge that I am financially responsible for all services provided. I understand this is a cash based practice and that payment is due each visit at time of service. I can get a bill and submit it to my insurance, but this does not imply any reimbursement will be forthcoming. Any remaining balance my insurer does not cover I agree to pay in full.

I do not expect Dr. Collinge and/or Rise Wellness Centre care providers, 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 at Rise Wellness Centre, 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.

______________________	______________________	______________________
Print patient’s name	Signature of patient	Date Signed
______________________	______________________	______________________
Print name of patient’s guardian	Signature of guardian	Date Signed

Welcome!

Thank you for taking the time to fill out this extensive questionnaire. Your answers will help us decipher what is going on so we can come up with the steps that will lead you to vibrant health!