

# Naturopathic and Allergy Clinic - 2021

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## Confidential Adult Patient's Case History (to be completed before your visit in **INK** only please)

\*\*Version Sept. 2021\*\*

**Dear Patient:** This form was specifically designed by our **Naturopathic Doctor, the clinic director Fateh Srajeldin ND**, to help our medical team evaluate your current health condition. Please complete this health questionnaire to the best of your knowledge. Your answers will help us determine in what ways we can help restore your child's health. We will only accept to treat your medical case if we believe that you are intending to apply our ① instructions, ② remedies, ③ therapies and ④ diet as given to treat your condition. Rest assured that all information will remain completely confidential.

**Please make sure to answer all questions that have the mark ( \* ) Thank you.**

### Personal information

\*Last name: \_\_\_\_\_ \*First name: \_\_\_\_\_ Middle name: \_\_\_\_\_  
\*Date of birth: MM. DD. YY. Sex:  Male,  Female, Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Last physical date: \_\_\_\_\_  
\*My Occupation is: \_\_\_\_\_ My employer is: \_\_\_\_\_  
\*I have been unwell for: \_\_\_\_\_ Yrs., Physician's name who treated me was: \_\_\_\_\_  
I was treated by a  Medical Dr.,  Chiropractor,  Naturopath Dr.,  Psychiatrist,  Hospital,  Homeopath,  Herbs.  
Was treatment terminated? :  Yes,  No, Did treatment achieve its goal % (explain): \_\_\_\_\_  
\*I was treated for: \_\_\_\_\_  
\*I am currently suffering from the following and need treatment for (**List symptoms here Please**): \_\_\_\_\_

Family members who have similar conditions:  Mother,  Father,  Brother(s),  Sister(s),  Daughter(s),  Son(s),  Adopted.  
I am:  Single,  Married,  Divorced,  Separated,  Common Law,  Widow. Number of children: (Males \_\_\_\_\_, Females \_\_\_\_\_)  
Number of older brothers: \_\_\_\_\_ Number of older sisters: \_\_\_\_\_ My rank in the family is: \_\_\_\_\_  
Number of younger brothers: \_\_\_\_\_ Number of younger sisters: \_\_\_\_\_ My favorite sport is: \_\_\_\_\_  
\*My home address: \_\_\_\_\_ Suite: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ PC code: \_\_\_\_\_  
\*My home telephone ( ): \_\_\_\_\_ \*My office telephone ( ): \_\_\_\_\_ Ext. \_\_\_\_\_  
\*My Cellular number ( ): \_\_\_\_\_ \*My email: \_\_\_\_\_ @ \_\_\_\_\_  
My Fax number ( ): \_\_\_\_\_

### My Spouse's / Partners Information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ My spouse's occupation: \_\_\_\_\_ Age: \_\_\_\_\_  
Home address: \* Same as above Suite: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ PC code: \_\_\_\_\_  
Home telephone ( ): \_\_\_\_\_ Office telephone ( ): \_\_\_\_\_ Ext. \_\_\_\_\_  
Cellular number ( ): \_\_\_\_\_ email: \_\_\_\_\_ @ \_\_\_\_\_

### In case of an emergency who may we contact

\*First name: \_\_\_\_\_ \*Last name: \_\_\_\_\_ \*Relationship: \_\_\_\_\_  
Telephone (H): ( ) \_\_\_\_\_ (W): ( ) \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
Do you or your spouse have an extended health insurance at work  Yes,  No.? Name of Insurance company: \_\_\_\_\_  
Do we have your permission to email you information and updates concerning your health plus seasonal promotions Yes , No   
\*Who referred you to this Clinic : \_\_\_\_\_  
 Office sign,  Our Website,  Surfing the Net,  Office Pamphlet,  Word of mouth.

Do you consent to the presence of a student from the Canadian College of Naturopathy to observe during your visit : Yes , No

### Dear Patient:

The following several pages contain ① declaration form, ② consent to examination form, ③ medical health questionnaire, ④ medical history form and ⑤ dietary questionnaire. There is a section that contains some crucial questions concerning both parents which pertain to your total health as well. Please take some time to answer all of the following questions as accurately as possible. The total interview and the actual examination may last approximately ninety minutes more or less. Further, you will spend approximately thirty minutes with your physician to setup your diet thereafter. You are expected to apply the diet as given. Along with the diet, your daily remedies, frequency and therapies will be set too.

**Please note** that naturopathic services are not covered by the Ontario Health Insurance Plan

(OHIP). Naturopathic examinations, treatments and therapies could be covered by an extended health insurance plan at your place of Employment. You may consult with your insurance company directly about their coverage. We, at the clinic, do not deal directly with insurance companies and we have no Information about your coverage.

**Privacy:** All your files and information are extremely confidential, however if you have any extra information concerning more steps of privacy concerning mail, email, phone calls or leaving phone messages, then please give us written instructions here: \_\_\_\_\_

Continue on page (2) please

## Adult Declaration & Consent to Examination and Treatment

Name (please print) \_\_\_\_\_ Date: \_\_\_\_\_

I understand that the clinic's Naturopath, Dr. Fateh Srajeldin, B.Sc., ND, practices with an eclectic approach to health care. The initial patients' visit to see the naturopath at this clinic will include ① **discussing my medical history from birth to date**, ② **standard external physical examination**, ③ **evaluation of my diet and** ④ **prescribing remedies** based on the outcome of my total visit plus my current symptoms and my current laboratory blood work (if available). I understand that blood testing is not included in today's examination fee. I understand that the treatments may include Clinical Nutrition, Vitamins, Minerals, Enzymes, Co-Enzymes, Anti-Oxidants, Botanical remedies, Homeopathic remedies, Orthomolecular Supplementation, Acupuncture and Intravenous Therapy.

I understand that the Dr. Srajeldin's mission statement is to "provide safe and effective treatments to restore health as permanently as possible in the quickest, gentlest, least harmful way." I understand that the success of the treatment hinges on my compliance and application of the treatments.

I understand that Dr. Fateh Srajeldin, B.Sc., ND is a licensed Naturopathic Doctor (ND) not a Medical Doctor and his examinations and treatments are **not covered by OHIP**. I understand that Naturopathic examinations, treatments and therapies could be covered by my extended health insurance plan at my place of employment (if available). It is my responsibility to consult with my insurance company directly. I understand that The Naturopathic and Allergy Clinic does not deal directly with insurance companies and have no information about my coverage.

Any treatment provided to me as a patient of Dr. Fateh Srajeldin B.Sc., ND is not mutually exclusive from any treatment or advice that I may be receiving or may in the future be receiving from another licensed health care provider. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario or elsewhere. I understand that medical therapy and naturopathic/drugless therapy, including homeopathy, are different kinds of therapies.

I understand that Dr. Fateh Srajeldin, B.Sc., ND strives to provide the best possible diagnosis and course of treatment. However, I understand that many factors will be important in determining actual results. Therefore, no representation or warranty is made with respect to any treatment, action or application of medical advice or information given.

I understand that the total interview and the actual physical examination (without an internal) may last approximately ninety minutes more or less. Further, I understand that the naturopath may spend approximately sixty minutes with me to setup my diet thereafter if I choose to have my diet restructured. I will apply the diet as given. Along with the diet, my daily remedies, frequency and therapies will be set too.

### For female patients, (NO routine Breast or internal examination).

I understand that while the option of breast examination on page (6) is recommended during first visit for all females over the age of 40 years or starting at age 30 years for those who use or have used alcohol, use or have used oral contraception and / or smoke or have smoked, the examination will only be performed if my health condition warrants an examination in the presence of a female (staff or relative) and I consent and initial "**Breast examination**" in the female section on page (6).

### For male patients (NO routine Brostate examination).

I understand that the option for prostate examination on page (6) is recommended during first visit for males over the age of 40 years or starting at age 35 years for those men who use or have used steroids for body building, those men who drink or have drunk alcohol and those who smoke or have smoked, the examination will be performed if my health condition warrants an examination and I consent and initial "**Prostate examination**" in the male section on page (6).

I understand that, in the event of a medical emergency, I am advised to seek conventional medical care at a hospital if I am unable to Reach my Naturopathic Doctor.

This is to acknowledge that I have read the above information and understand that these are the terms and conditions at the Naturopathic and Allergy Clinic. I also consent to the examination as been described above and as the examining naturopath sees necessary to help me overcome my symptoms.

I will provide a copy of my most recent blood work done in the past six months. Alternatively, I will arrange, bring, mail or fax all medical tests, ( blood, urine, x- ray, ultrasound, MRI, and surgery results), pertaining to my health from my physician's office or the hospital if I was treated at a hospital. I will answer the questionnaire concerning my health to the best of my ability and knowledge. I will pay for all examinations, treatments, therapies and intravenous therapy immediately when rendered.

I understand that remedies and laboratory blood works are not included in the examination fee. I understand that appointment(s) cancellation requires 48 hours advanced notice for full refund otherwise there will be a \$50 surcharge applied on each and every examination or therapy missed or cancelled.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

### Note

Before the date of your appointment, if possible, please arrange, bring, mail or fax all your medical tests, ( blood, urine, x-ray, ultrasound, MRI, and surgery results), pertaining to your health from your physician's office or the hospital if you were treated at a hospital.

Continue on page (3) please

Read through the following list of symptoms that apply to you now or in the past. Please ignore symptoms that are not related to your condition. Please check mark  the boxes under the appropriate columns if a symptom is (P) = Past, (F) = Frequent and (C) = Constant then place a numerical value under Value, ie (1 = very low and 10 = very high). Thank you. \*\*SEE PAGE 8 FOR COVID-19 and MORE INSTRUCTIONS\*\*

IN GENERAL.	NA <input type="checkbox"/>			
	Value	P	F	C
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever or Chills.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhaustion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats (cold or warm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Central obesity...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden weight loss...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot lose weight...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY Sx. .	NA <input type="checkbox"/>			
	Value	P	F	C
COVID-19 Sx.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Croup.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pleurisy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whooping Cough.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult to breath...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting blood / phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthmatic symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Common Cold.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis, Chronic/Acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sarcoidosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking Now / Past..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana Now / Past..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SKIN Sx. .	NA <input type="checkbox"/>			
	Value	P	F	C
Acne.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boils.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warts.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blisters.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rosacea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitiligo.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impetigo.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melasma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Athletes foot.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Tags.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brittle Nails.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin, ring worms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin, itch or burn.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats profusely.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives Large or Small.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corns on Feet / Toes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Current Treatments. Circle if:**

Proactive acne therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chemical peels .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Microdermabrasion	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hydra Facial .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Laser hair removal ...	Yes <input type="checkbox"/>	No <input type="checkbox"/>

BONES, JOINTS, MUSCLES Sx NA <input type="checkbox"/>				
	Value	P	F	C
TMJ.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuralgia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herniated Disc .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uric Acid Sx.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck stiffness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful tail bone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Growing pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle twitches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain between ribs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sternum joints pain...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baker's Cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps at night...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tennis elbow.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Pain (P) or numbness (N) in:**

*Shoulders .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Between shoulders...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Arms .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Elbows.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Hand .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Fingers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*knuckles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Hips .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Legs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Knees .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Ankles .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Feet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Heels .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Toes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Bottom of feet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Arch of feet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CARDIO-VASCULAR	NA <input type="checkbox"/>			
	Value	P	F	C
Heart palpitation....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm ( Vent Aorta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow heart beat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Septal defect.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina / Chest pain...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnea on exertion..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ablation procedure...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GASTRO-INTESTINAL Sx. NA <input type="checkbox"/>				
	Value	P	F	C
Gas .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fissures .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burping .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Belching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart burn.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acid refluxes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal worms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive hunger.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A / B / C....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal distention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloated after meals...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lactose intolerant ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyps.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleepy after meals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful to swallow....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food particles in stool.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pyloric Stenosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recent Colonoscopy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCALP & HAIR	NA <input type="checkbox"/>			
	Value	P	F	C
Dandruff .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair lice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair splits.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp itchy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alopecia Areata .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alopecia Universalis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp painful.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair implant.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair is (Dry or Oily)....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baldness patches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SLEEP Sx.	NA <input type="checkbox"/>			
	Value	P	F	C
I sleep at _____.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia _____ Min.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wake up at _____.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interrupted sleep _X.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you day-nap? Yes <input type="checkbox"/>			No <input type="checkbox"/>	
Sleepy all day _____ Yes <input type="checkbox"/>			No <input type="checkbox"/>	
Sleeping Meds _____ Yes <input type="checkbox"/>			No <input type="checkbox"/>	
Using CPAP _____ Yes <input type="checkbox"/>			No <input type="checkbox"/>	
I do shift work _____ Yes <input type="checkbox"/>			No <input type="checkbox"/>	

MOUTH Sx. NA

Table with columns: Value, P, F, C. Rows include: Mercury filling, Bad breath often, Thrush on tongue, Mumps, Snore, Teeth trouble, Gums bleeding, Sensitive teeth to cold, Sensitive teeth to hot, Taste changed lately, Drool during sleep, Enlarged tonsils, Cold sores, Oral herpes, Canker sores.

NOSE Sx. NA

Table with columns: Value, P, F, C. Rows include: Nose tip itch, Nose bleed (epistaxis), Nasal obstruction, Nasal congestion, Sneezing spells Am, Pm, Sinus infection, Post nasal drip, Wears (Perfume, Cologne).

EARS Sx. NA

Table with columns: Value, P, F, C. Rows include: Vertigo, Tinnitus, Ear noise, Ear aches, Ear redness, Ear canal itch, Ear discharge, Perforated eardrum, Excessive ear wax.

EYES Sx. NA

Table with columns: Value, P, F, C. Rows include: Eyes itch, Eyes redness, Eyes discharge, Sties on eye lid R/L, Failing vision, Blepharitis R or L, Glaucoma, Eyes infection, Bags under eyes, Dark circle under eyes.

THROAT Sx. NA

Table with columns: Value, P, F, C. Rows include: Colds, Tonsillitis, Cold sores, Sore throat, Throat itch, Enlarged tonsils, Throat irritation, Voice changed lately.

HEAD Sx.. NA

Table with columns: Value, P, F, C. Rows include: Upper sinuses congestion, Fainting, Dizziness, Migraine, Headache, Light headed, Tension Headache, Cluster Headache, Headache after MVA, Headache on waking, Headache if hungry, Headache Meds, Headache per Week, Migraine Meds, Migraine per Week.

VACCINATIONS, NA

Table with columns: Yes, No. Rows include: Vaccination (Infancy), Vaccination (Childhood), Vaccination (Teenage), Vaccination (Adulthood), COVID-19 Vaccination, Allergy shots Now / Past, Flu shots, Others.

ALLERGIES Sx. NA

Table with columns: Value, P, F, C. Rows include: Seasonal allergies (Summer, Fall, Winter, Spring), Allergy- house dust, Allergy- dust mites, Allergy- dairy, Allergy- Sulfur, Allergy- medication, Allergy- weeds, Allergy- food additives, Allergy- trees, Allergy- grains, Allergy- vegetables, Allergy- food, Allergy- grasses, Allergy- animals, Allergy- chemicals, Allergy- insects, Allergy- Perfumes, Allergy- cosmetics, Perfumes, Cologne.

ENDOCRINE Sx, NA

Table with columns: Value, P, F, C. Rows include: Goiter, Diabetes Mellitus, Diabetes Juvenile, Puffy face, Protruded eyes, Hypoglycemia, Hyperthyroidism, Hypothyroidism, Intolerant to heat/cold, Addison's disease.

GENITAL/URINARY Sx. NA

Table with columns: Value, P, F, C. Rows include: UTI, Pubic itch, Bed wetting, Blood in urine, Kidneys stones, Frequent urination (Night), Frequent urination (Day), Cannot hold urine, Kidneys infections, Burning urination, Genital Herpes, Urine incontinence, Slow urination, Swollen ankles, Difficult starting urine.

NERVOUS Sx. NA

Table with columns: Value, P, F, C. Rows include: Tics, OCD, Unhappy, Depressed, Anxious, Anxiety due to abuse, Panic Disorder, ADD Symptoms, ADHD Symptoms, Post Traumatic Stress, Phobic Disorder, Hyperactivity, Schizophrenia, Alzheimer, Tendency to worry, Loses temper often, Tendency to cry, Low self esteem, Hopeless outlook, Wets pants constantly, Tendency to be shy, Dislike criticism, Frightening dreams, Frightening thoughts, Convulsions, Parkinson's Disease, Hard to concentrate, Thoughts of suicide, Multiple sclerosis, Epilepsy, Seizure Grand Mal / Petit, Grinds teeth during sleep, Bell's Palsy, Facial nerve Palsy, Cerebral Palsy.



## DIET (must be completed accurately)

The next table revolves around your dietary habits. This may be very beneficial in understanding the real causes behind your conditions. Please answer the following questions to the best of your abilities.

### What do you eat during breakfast?

- 1-
- 2-
- 3-
- 4-
- 5-

### What do you eat during lunch?

- 1-
- 2-
- 3-
- 4-
- 5-

### What do you eat during dinner?

- 1-
- 2-
- 3-
- 4-
- 5-

### What do you eat or during snacks?

#### Mid-Day:

#### Afternoon:

#### Before bed time:

### FOODS THAT YOU CRAVE?

#### I crave:

- Chocolate
- Crunchy foods such as chips & crackers
- Caffeine such as coffee, tea, & energy drinks
- Cola, Pop, Soda
- Sugary foods and Desserts
- Hard Candy or Gum
- Protein
- Dairy
- Salty foods
- Fast foods
- Wine with meals
- Beer with meals

### TYPE OF FOOD THAT YOU CONSUME?

- I have a strict dietary plan that I follow
- Most of my meals are home cooked whole foods
- I eat out less often today than I did 5 years ago
- I avoid refined grains, breads & pastas
- I avoid deep fried foods
- I eat sugary foods & dessert less than 3 times wk.
- I avoid diet foods
- I avoid Colas, Pops, Sodas
- I eat gluten free food
- I avoid foods that I have allergies to \_\_\_\_\_.
- I buy frozen or canned fruits and vegetables

### When do you consume fruits / vegetables?

#### I consume:

- NO** servings of fruit and vegetables at all
- Fruits &/or vegetables during breakfast
- Fruits &/or vegetables during lunch
- Fruits &/or vegetables during dinner
- Fruits &/or vegetables for snacks
- I make time to eat fruits &/or vegetables daily
- I prepare **fresh** fruits & vegetables
- I prepare **canned** or **frozen** fruits & vegetables
- I eat 1, 2, 3 salads a day / a week

### WHAT FRUITS & VEGETABLES DO YOU CONSUME?

#### I consume:

- A wide variety of **organic** fruits
- A wide variety of **regular** fruits
- A wide variety of **organic** vegetables
- A wide variety of **regular** vegetables
- A wide variety of vegetables
- A wide range of green leafy vegetables
- A wide color range of fruits & vegetables
- Broccoli, cauliflower, kale & Brussels sprouts
- I add Lemon / Lime juice to my salad

### THE FOLLOWING BEST DESCRIBE YOUR DIGESTION?

- I am often bloated
- I have low energy after eating
- I am often constipated
- I have general digestive upset after eating
- I have excess mucus after eating
- I often have gas or flatulence
- I often have acid reflux &/or heartburn
- Going to the bathroom is often difficult
- I run to the bathroom immediately after food
- My stool varies in size & consistency

### DO YOU CONSUME THE FOLLOWING IN MY FOOD ?

#### I must add the following to my food

- Vinegar
- Balsamic Vinegar
- Apple Cider
- Cheese
- Butter
- Mayonnaise
- I am hungry & often don't know why
- White sugar
- Salt
- MSG

### THE FOLLOWING YOU DO NOT UNDERSTAND WHY ?

#### I always feel like

- Eating often eat when I feel guilt or depressed
- Eating & not knowing why
- Eat to reward myself
- I often eat when I am low energy especially in the
- I am hungry & often don't know why

Please be as specific as possible since the medical history may hold the key to your complete recovery.

\*\*\*\*\*PLEASE COMPLETE BEFORE YOUR VISIT\*\*\*\*\*

The following section is required to list your medical history, sicknesses, rough times and hospitalizations, I am interested in every medication taken in your life especially antibiotics, cortisone and oral contraceptive pills. You should list the starting year of diseases and the year of their cure such as tonsillitis, problems with your ears, lungs, throat, skin etc. Also list the year of admission to the hospital for whatever reason. SEE AN EXAMPLE ON PAGE 9. (PLEASE READ THE INSTRUCTIONS IT IS VERY IMPORTANT)

Information should be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. *You may choose to fill this sheet with your doctor before your examination.*

Some important notes to consider are

1- breast feeding at birth, 2- Start of cycle, 3- time of Solids introduction during infancy, 4- smoking and 5- drugs of any kind, (age at first cycle).

Duration	Year	Age	Description of incidents	
( )	Birth Day	<input type="checkbox"/> I was not breast fed Or <input type="checkbox"/> I was breast fed for	months & started solid food at	months.
	1 Yr.			
	2 Yrs.			
	3 Yrs.			
	4 Yrs.			
	5 Yrs.			
	6 Yrs.			
	7 Yrs.			
	8 Yrs.			
	9 Yrs.			
	10 Yrs.			
	11			
	12			
	13			
	14			
	15			
	16			
	17			
	18			
	19			
	20 Yrs.			
	21			
	22			
	23			
	24			
	25			
	26			
	27			
	28			
	29			
	30 Yrs.			
	31			
	32			
	33			
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	35			
	36			
	37			
	38			
	39			
	40 Yrs.			
	41			
	42			
	43			
	44			
	45			
	46			
	47			
	48			
	49			
	50 Yrs.			
	51			
	52			
	53			
	54			
	55			
	56			
	57			
	58			
	59			
	60 Yrs.			
	61			
	62			
	63			
	64			
	65			
	66			
	67			
	68			
	69			
	70			
	71			
	72			

Please add another sheet

### Mandatory by law that COVID questionnaire for everyone and every visit

Naturopathic Doctors and all other regulated health practitioners are required by the Ontario Ministry of Health & Long-Term Care to screen every patient attending an in-person appointment. If you answer "yes" to any of the following questions, we cannot see you for an in-person appointment and you must get tested for COVID-19.

**Do you have now or recently developed any of the following symptoms?**

- Fever  Yes  No
- New onset of cough  Yes  No
- Worsening chronic cough  Yes  No
- Shortness of breath  Yes  No
- Difficulty breathing  Yes  No
- Sore throat  Yes  No
- Difficulty swallowing  Yes  No
- Decrease or loss of sense of taste or smell  Yes  No
- Chills  Yes  No
- Headaches  Yes  No
- Unexplained fatigue/muscle aches  Yes  No
- Nausea/vomiting/diarrhea, abdominal pain  Yes  No
- Pink eye (conjunctivitis)  Yes  No
- Runny nose or nasal congestion  Yes  No

- Have you travelled outside Canada in the last 14 days?  Yes  No
  - Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?  Yes  No
- It must be clear and understood that the Naturopathic doctor does not write any note for mask exemption...?  Yes  No

Sig. \_\_\_\_\_ Date \_\_\_\_\_

*Date & signature of the patient + Accompanied persons or the guardian (MUST). Please list the names of people accompany the patient who live at your same residence. Those who don't live with you must fill a new COVID-19 FORM.*

**Due to the length of new appointments (120 Min). All New appointment require \$50 deposit to secure the appointment. It is refundable with a 48 Hrs. cancellation note.**

City	Choice ✓	Code	Explanations (Listed time of visits and therapies are approximate)	Our fee schedule	Exclusion
Toronto Clinic		EX1-Adult	First Examination is up to 2 Hrs. that includes evaluations of your symptoms listed in the application form, physical examination (no internals), discussion of the examination findings, adjust your diet according to findings and prescribe remedies. Prescribed remedies are <b>NOT</b> included.	\$225.00 None Taxable	Remedies and blood work are <b>NOT</b> included in the first examination or any subsequent examination fee.
			All New appointment require \$50 deposit to secure the appointment.	\$50.00 None Taxable	
			Appointments scheduled before or after regular business hours or appointments scheduled on Sundays or holidays require full payment of the total visits, for front desk will not be in. Prescribed remedies are <b>NOT</b> included.	\$225.00 None Taxable	
	EX5	Subsequent Examination is up to 30 Mins. To review major symptoms. Prescribed remedies are <b>NOT</b> included.	\$95.00 None Taxable		
	No Show	No Show	We ask for your courtesy to give us <b>heads up of 48 hours cancellation</b> call so that a lengthy chunk of the day (2 hours) in our busy day won't be wasted idling while someone else may, desperately, need the same slot. Unfortunately a cancellation fee will apply to those who do not respect our time.	\$50.00 non-taxable	

### Hints to help you fill in this medical history application:

The following are some hints on how to fill the application form as accurate as possible. Every question has two forms of answers. The first group of answers are placed under **Value** which explains the intensity of the symptom when it come using numbers from (1 to 10). Intensity of a symptom has nothing to do with the frequency of the symptom whether daily or once a week or once a month. Number (1 to 3) indicates the symptom's intensity is very small when it comes. On the other hand, a number (4 or 7) indicates that the symptom's intensity is disturbing and bothersome when it comes. The number (8 to 10) symptom's intensity is very painful whether the symptom appears every day or once a month. You should assign or estimate number to every question as you see it. This is not a right or wrong questions.

The second group of answers determines whether a symptom should be marked as **one** of the following answers

- C...  symptoms are present daily or
- F...  symptoms come and go frequently every few days, every week or every month or
- P...  symptoms appear every several months or every season.

#### GASTRO-INTESTINAL

Value	P	F	C	
3	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Gas Gas here is a constant symptom that appears daily and little bothersome given number 3.
2	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
7	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Diarrhea
3	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart burn Heart burn here is a constant daily symptom that appears which is very disturbing given the number 7.
3	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Indigestion
3	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Constipation
3	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Poor appetite Poor appetite here is a moderate symptom that appears frequently and bothersome, given the number 3
2	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
3	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Liver trouble
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Colon trouble
2	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pain over stomach Pain over stomach here is a daily symptom, with a little discomfort, given the number 2.
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble

1- breast feeding at birth, 2- time of food introduction during infancy, 3- smoking and 4- drugs of any kind.

The following section is required to list your medical history, sicknesses, rough times and hospitalizations, I am interested in every medication taken in your life especially antibiotics, cortisone and oral contraceptive pills. You should list the starting year of diseases and the year of their cure such as tonsillitis, problems with your ears, lungs, throat, skin etc. Information should be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. *You may choose to fill this sheet with your doctor before your examination.*

Some important notes to consider are:

Duration	Year	Age	Description of incidents
	(1950 )	Birth Day	<input type="checkbox"/> I was not breast fed Or <input type="checkbox"/> I was breast fed for _____ months & started solid food at _____ months.
	1951	1	Was not breast fed, used formula
		2	
		3	1 <sup>st</sup> set of tubes in the ears
		4	
		5	
		6	2 <sup>nd</sup> set of tubes in ears plus antibiotics
	1957	7	
		8	Asthmatic symptoms, inhalers were prescribed and used daily
	1959	9	
		10	
		11	3 <sup>rd</sup> set of tubes in the ears
	1962	12	