Naturopathic and Allergy Clinic -2022

Telephone (416) 207-0207, fax (416) 207-0272
E-transfer and Email :clinic@live.com

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

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Dear Patient: This form was specifically designed by our **Naturopathic Doctor, the clinic director Dr. Fateh Srajeldin BSc., ND,** (for patients from infancy to age 16 years). It is to help our medical team evaluate your child's 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 your child's case if we believe that you are intending to apply our ① instructions, ② remedies, ③ therapies and ④diet as given to treat your child. Rest assured that all information will remain completely confidential. **Please make sure to answer all questions that have the mark (✳), Thank you.**

Child's information

✳Last name: _____ ✳First name: _____ Middle name: _____.
✳Date of birth: MM. DD. YY. Sex: ❑ Male, ❑ Female, Height: _____ Weight: ___ Last physical date: _____.
✳Child has been unwell for: _____ Yrs., Physician's name who treated my child as: _____.
My child was treated by a ❑ Medical Dr., ❑ Chiropractor, ❑ Naturopath Dr., ❑ Psychiatrist, ❑ Hospital, ❑ Homeopath, ❑ Herbs.
Was treatment terminated? : ❑ Yes, ❑ No, Did treatment achieve its goal % (explain): _____.
✳ My child was treated for: _____.
✳ My child is currently suffering from and needs treatment for: _____.
Family members who have similar conditions: ❑ Mother, ❑ Father, ❑ Brother(s), ❑ Sister(s), ❑ Daughter(s), ❑ Son(s), ❑ Adopted.
Number of older brothers: _____ Number of older sisters: _____ Child's rank in the family is: _____.
Number of younger brothers: _____ Number of younger sisters: _____ Child's favorite sport is: _____.
✳Child's home address: _____ Suite: _____ City: _____ Province: _____ PC code: _____.
Child livs: ❑ With Both Parents, ❑ With Father, ❑ With Mother, ❑ Alternates Between Parents, ❑ With Relatives, ❑ Foster Home.

Father's Information

Last name: _____ First name: _____ Father's occupation: _____ Age: _____.
Home address: ⇧ Same as above _____ Suite: _____ City: _____ Province: _____ PC code: _____.
Home telephone ( ): _____ Office telephone ( ): _____ Ext. _____.
Cellular number ( ): _____ email: _____ @ _____.

Mother's Information

Last name: _____ First name: _____ Mother'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 one or both parents 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, ❑ Currently a patient, ❑ **Word of mouth**, ❑ Surfing the Net, ❑ Office Pamphlet, ❑ TV Interview

Dear Parents / Guardians:

The following several pages contain ① declaration form, ② physical examination consent form (no internals), 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 child's 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 and your child will spend approximately thirty minutes with your physician to setup your child's general diet thereafter. Your child is expected to apply the diet as given no ifs and buts. Along with the diet, your daily remedies, frequency and therapies will be set too.

I consent to request a written permission from the Naturopath should I wish to record, video tape or photograph the session or any part at the clinic whether the video tape or photograph includes the naturopath or not.

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 massages, then please give us written instructions here: _____.
_____.

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Parents' or Guardians' Declaration & Consent to Child Examination and Treatment

Child's Name (please print) _____ **Date:** _____

Consent to Assessment and Treatment

I understand that the clinics Naturopath, Dr. Fateh Srajeldin, B.Sc., ND, practices with an eclectic approach to health care. Initial patients' visit to see the naturopath will include discussing your child's medical history from birth to present date, standard physical examination, evaluation of your child's diet and prescribing remedies based on your child's ❶ medical history, ❷physical examination, ❸current symptoms and ❹the results of your child's blood works (if available). Further, I understand that testing with traditional blood work and functional testing may be requested. I understand that the treatments can include Clinical Nutrition, Vitamins, Minerals, Enzymes, Co-Enzymes, Anti-Oxidants, Botanical medicine and Homeopathic medicine, Orthomolecular Supplementation, Acupuncture and Intravenous Therapy.
I understand that the clinic's mission statement is "***a Naturopathic Doctor is to provide safe and effective treatments to restore health permanently in the quickest, gentlest, least harmful way***."

I understand that Dr. Fateh Srajeldin, B.Sc., ND is a licensed Naturopathic Doctor (ND) not a Medical Doctor and his examinations and treatments and laboratory blood requisitions are not covered by OHIP. I also understand that Naturopathic examination, treatments, therapies and remedies are not covered by the Ontario Health Insurance Plan (OHIP). I understand that my child's Naturopathic examinations, treatments and therapies could be covered by my extended health insurance plan at my place of employment (if available). I understand that 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.
I understand that any treatment provided to my child as a patient of Dr. Fateh Srajeldin B.Sc., ND is not mutually exclusive from any treatment or any advice that I may be receiving or may in the future be receiving from another licensed health care provider. I understand that 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. I understand that medical therapy and naturopathic/drugless therapy, including homeopathy, are different kinds of therapies.
Dr. Fateh Srajeldin, B.Sc., ND strives to provide the best possible diagnosis and course of treatment. However, 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 examination may last approximately ninety minutes more or less. Further, I understand that the naturopath may spend approximately sixty minutes with me to setup my child's diet thereafter. I will apply the diet as given. Along with the diet, my child's daily remedies, frequency and therapies will be set too.

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 Naturopathic Doctor.
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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 of my child as been described above and as the examining naturopath sees necessary to help my child overcome his/her symptoms.
I will provide a copy of my child's most recent blood work done in the past six months. Alternatively, I will arrange, bring, mail or fax all my child's medical tests, (blood, urine, x-ray, ultrasound, MRI, and surgery results), pertaining to his/her health from his/her physician's office or the hospital if he/she was treated at a hospital.

I will answer the questionnaire concerning my child's health to the best of my ability and knowledge. I will pay for all my child's 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 any 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 without a notice.

Parent's / Gradian's Signature: _____ Date: _____

Office 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 child's health from your child's physician's office or the hospital if your child was treated at a hospital.

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Read through the following list of symptoms that apply to your child now or in the past. Please ignore symptoms that are not related to your child's condition. Please check mark ☑ the boxes under the appropriate columns if a symptom is **(P)** = **Past**, **(F)** = **F**requent and **(C)** = **C**onstant then place a numerical value under **Value, ie** (1 = very low and 10 = very high). **Thank you.**

IN GENERAL. NA ❑

	Value	P	F	C
Anemia ……..	❑	❑	❑	❑
Fever or Chills……	❑	❑	❑	❑
Exhaustion……..	❑	❑	❑	❑
Chronic Fatigue…….	❑	❑	❑	❑
Mononucleosis……	❑	❑	❑	❑
Sweats (cold or warm)	❑	❑	❑	❑
Central obesity…	❑	❑	❑	❑
Sudden weight loss…	❑	❑	❑	❑
Cannot lose weight…	❑	❑	❑	❑

RESPIRATORY Sx. . NA ❑

	Value	P	F	C
COVID-19 Exppposure..	❑	❑	❑	❑
Croup……..	❑	❑	❑	❑
Pleurisy……..	❑	❑	❑	❑
Wheezing……..	❑	❑	❑	❑
Chest pain……..	❑	❑	❑	❑
Chronic cough……..	❑	❑	❑	❑
Whooping Cough…..	❑	❑	❑	❑
Difficult to breath…	❑	❑	❑	❑
Spitting blood / phlegm	❑	❑	❑	❑
Asthmatic symptoms	❑	❑	❑	❑
Common Cold……	❑	❑	❑	❑
Bronchitis, Chronic/Acute	❑	❑	❑	❑
Sarcoidosis……	❑	❑	❑	❑
Tuberculosis……..	❑	❑	❑	❑
Emphysema……..	❑	❑	❑	❑
Pneumonia……..	❑	❑	❑	❑
Diphtheria……	❑	❑	❑	❑
Influenza……	❑	❑	❑	❑
Smoking Now / Past..	❑	❑	❑	❑
Marijuana Now / Past..	❑	❑	❑	❑

SKIN Sx. . NA ❑

	Value	P	F	C
Acne……	❑	❑	❑	❑
Boils……	❑	❑	❑	❑
Warts……..	❑	❑	❑	❑
Lupus……..	❑	❑	❑	❑
Blisters……..	❑	❑	❑	❑
Rosacea……..	❑	❑	❑	❑
Shingles……..	❑	❑	❑	❑
Vitiligo……..	❑	❑	❑	❑
Impetigo……..	❑	❑	❑	❑
Melasma……..	❑	❑	❑	❑
Eczema……..	❑	❑	❑	❑
Psoriasis.. ……..	❑	❑	❑	❑
Athletes foot……..	❑	❑	❑	❑
Dry skin……..	❑	❑	❑	❑
Varicose veins……..	❑	❑	❑	❑
Skin Tags……..	❑	❑	❑	❑
Brittle Nails……..	❑	❑	❑	❑
Skin, dryness …..	❑	❑	❑	❑
Skin, ring worms…..	❑	❑	❑	❑
Skin, itch or burn……	❑	❑	❑	❑
Sweats profusely…..	❑	❑	❑	❑
Hives Large or Small…..	❑	❑	❑	❑
Corns on Feet / Toes…..	❑	❑	❑	❑

Current Treatments, Circle if :

Proactive acne therapy	Yes ❑	**No ❑**
Chemical peels ……	Yes ❑	**No ❑**
Microdermabrasion	Yes ❑	**No ❑**
Hydra Facial ……	Yes ❑	**No ❑**
Laser hair removal …	Yes ❑	**No ❑**

BONES, JOINTS, MUSCLES Sx NA ❑

	Value	P	F	C
TMJ……	❑	❑	❑	❑
Gout ……..……..	❑	❑	❑	❑
Scoliosis ……..	❑	❑	❑	❑
Arthritis ……	❑	❑	❑	❑
Bursitis ……..	❑	❑	❑	❑
Tremor ……..	❑	❑	❑	❑
Neuralgia ……	❑	❑	❑	❑
Herniated Disc ……	❑	❑	❑	❑
Uric Acid Sx……	❑	❑	❑	❑
Neck stiffness……..	❑	❑	❑	❑
Fibromyalgia……..	❑	❑	❑	❑
Painful tail bone……..	❑	❑	❑	❑
Growing pain……..	❑	❑	❑	❑
Sciatica pain……..	❑	❑	❑	❑
Swollen Joints……..	❑	❑	❑	❑
Osteosclerosis……..	❑	❑	❑	❑
Osteoporosis……..	❑	❑	❑	❑
Muscle twitches……..	❑	❑	❑	❑
Upper back pain……..	❑	❑	❑	❑
Middle back pain……	❑	❑	❑	❑
Lower back pain…….	❑	❑	❑	❑
Pain between ribs……	❑	❑	❑	❑
Sternum joints pain…	❑	❑	❑	❑
Rheumatoid arthritis..	❑	❑	❑	❑
Baker's Cyst	❑	❑	❑	❑
Joint stiffness,	❑	❑	❑	❑
Leg cramps at night…	❑	❑	❑	❑
*Arch of feet…….	❑	❑	❑	❑
Carpal Tunnel Syndrome	❑	❑	❑	❑
Tennis elbow……	❑	❑	❑	❑
Pain (P) or numbness (N) in:				
*Shoulders ……	❑	❑	❑	❑
*Between shoulders…	❑	❑	❑	❑
*Arms …..……	❑	❑	❑	❑
*Elbows……	❑	❑	❑	❑
*Hand …….	❑	❑	❑	❑
*Fingers……	❑	❑	❑	❑
*knuckles……	❑	❑	❑	❑
*Hips ……	❑	❑	❑	❑
*Legs……	❑	❑	❑	❑
*Knees ……	❑	❑	❑	❑
*Ankles ……	❑	❑	❑	❑
*Feet……..	❑	❑	❑	❑
*Heels ……..	❑	❑	❑	❑

CARDIO-VASCULAR NA ❑

	Value	P	F	C
Heart palpitation…..	❑	❑	❑	❑
Aneurysm (Vent Aorta)	❑	❑	❑	❑
Arrhythmia……..	❑	❑	❑	❑
Slow heart beat……..	❑	❑	❑	❑
Septal defect…….	❑	❑	❑	❑
Heart Murmur……..	❑	❑	❑	❑
Angina / Chest pain…	❑	❑	❑	❑
Poor circulation……..	❑	❑	❑	❑
High blood pressure...	❑	❑	❑	❑
Low blood pressure…	❑	❑	❑	❑
Dyspnea on exertion..	❑	❑	❑	❑
Shortness of breath….	❑	❑	❑	❑
High cholesterol……..	❑	❑	❑	❑
Ablation procedure…	❑	❑	**Yes**	❑ **NA**

GASTRO-INTESTINAL Sx. NA ❑

	Value	P	F	C
Gas ……	❑	❑	❑	❑
Fissures ……..	❑	❑	❑	❑
Diarrhea…….	❑	❑	❑	❑
Constipation…….	❑	❑	❑	❑
Colitis…….	❑	❑	❑	❑
Bulimia……..	❑	❑	❑	❑
Burping …….	❑	❑	❑	❑
Belching…….	❑	❑	❑	❑
Heart burn…….	❑	❑	❑	❑
Acid reflexes……..	❑	❑	❑	❑
Stomach ulcers……..	❑	❑	❑	❑
Indigestion…….	❑	❑	❑	❑
Poor appetite…….	❑	❑	❑	❑
Hemorrhoids…….	❑	❑	❑	❑
Liver trouble…….	❑	❑	❑	❑
Colon trouble…….	❑	❑	❑	❑
Intestinal worms…….	❑	❑	❑	❑
Excessive hunger……	❑	❑	❑	❑
Stomach pain…….	❑	❑	❑	❑
Gall bladder pain…….	❑	❑	❑	❑
Hepatitis A / B / C....	❑	❑	❑	❑
Abdominal distension	❑	❑	❑	❑
Bloated after meals....	❑	❑	❑	❑
Lactose intolerant …	❑	❑	❑	❑
Ulcerative colitis…….	❑	❑	❑	❑
Rectal bleeding …….	❑	❑	❑	❑
Rectal itch……..	❑	❑	❑	❑
Crohn's disease……..	❑	❑	❑	❑
Diverticulitis……...	❑	❑	❑	❑
Colon polyps…….	❑	❑	❑	❑
Sleepy after meals…..	❑	❑	❑	❑
Painful to swallow…..	❑	❑	❑	❑
Food particles in stool.	❑	❑	❑	❑
Pyloric Stenosis……..	❑	❑	❑	❑
Recent Colonoscopy…..	❑	❑	❑	❑

SCALP & HAIR NA ❑

	Value	P	F	C
Dandruff …….	❑	❑	❑	❑
Psoriasis……	❑	❑	❑	❑
Hair loss……	❑	❑	❑	❑
Hair lice……..	❑	❑	❑	❑
Hair splits……...	❑	❑	❑	❑
Scalp itchy……..	❑	❑	❑	❑
Alopecia Areata …….	❑	❑	❑	❑
Alopecia Universalis	❑	❑	❑	❑
Scalp painful……...	❑	❑	❑	❑
Hair implant……..	❑	❑	❑	❑
Hair is (Dry or Oily)…..	❑	❑	❑	❑
Baldness patches…..	❑	❑	❑	❑

SLEEP Sx. NA ❑

	Value	P	F	C
Child sleeps at _____.	❑	❑	❑	❑
Insomnia_____Min.	❑	❑	❑	❑
Child wakes up at ____.	❑	❑	❑	❑
Interrupted sleep __X.	❑	❑	❑	❑

Does child day-nap?	Yes ❑	**No ❑**
Child sleepy all day ____	Yes ❑	**No ❑**
Sleeping Medications___	Yes ❑	**No ❑**
Child uses CPAP_____	Yes ❑	**No ❑**
Child shift-works_____	Yes ❑	**No ❑**

MOUTH Sx . NA ❑

	Value	P	F	C
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 ❑

	Value	P	F	C
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 ❑

	Value	P	F	C
Vertigo……..	❑	❑	❑	❑
Tinnitus …….	❑	❑	❑	❑
Ear noise……	❑	❑	❑	❑
Ear aches……	❑	❑	❑	❑
Ear redness……	❑	❑	❑	❑
Ear canal itch……	❑	❑	❑	❑
Ear discharge……	❑	❑	❑	❑
Perforated eardrum…	❑	❑	❑	❑
Excessive ear wax…	❑	❑	❑	❑

EYES Sx. NA ❑

	Value	P	F	C
Eyes itch…….	❑	❑	❑	❑
Eyes redness …….	❑	❑	❑	❑
Eyes discharge …….	❑	❑	❑	❑
Sties on eye lid …….	❑	❑	❑	❑
Failing vision…….	❑	❑	❑	❑
Sight (Near or Far) .	❑	❑	❑	❑
Glaucoma…….	❑	❑	❑	❑
Eyes infection …….	❑	❑	❑	❑
Bags under eyes…….	❑	❑	❑	❑
Dark circle under eyes	❑	❑	❑	❑

THROAT Sx. NA ❑

	Value	P	F	C
Colds …….	❑	❑	❑	❑
Tonsillitis…….	❑	❑	❑	❑
Cold sores…….	❑	❑	❑	❑
Sore throat…….	❑	❑	❑	❑
Throat itch…….	❑	❑	❑	❑
Enlarged tonsils…….	❑	❑	❑	❑
Throat irritation…….	❑	❑	❑	❑
Voice changed lately	❑	❑	❑	❑

HEAD Sx.. NA ❑

	Value	P	F	C
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 ❑

	Yes	No
Vaccination (Infancy)	❑	❑
Vaccination (Childhood)	❑	❑
Vaccination (Teenage)	❑	❑
Vaccination (Adulthood)	❑	❑
COVID-19 Vaccination	❑	❑
Allergy shots Now / Past.	❑	❑
Flu shots: _____.	❑	❑
Others: _____.	❑	❑

ALLERGIES Sx. NA ❑

	Value	P	F	C
Seasonal allergies…..	❑	❑	❑	❑
Summer ……..	❑	❑	❑	❑
Fall……	❑	❑	❑	❑
Winter……	❑	❑	❑	❑
Spring……	❑	❑	❑	❑
Allergy- house dust	❑	❑	❑	❑
Allergy- dust mites	❑	❑	❑	❑
Allergy- dairy…….	❑	❑	❑	❑
Allergy- Sulfur……	❑	❑	❑	❑
Allergy- medication	❑			
Name: _____.	❑	❑	❑	❑
Allergy- weeds……	❑			
Name: _____	❑	❑	❑	❑
Allergy- food additives	❑			
Name: _____.	❑	❑	❑	❑
Allergy- trees……..	❑			
Name: _____.	❑	❑	❑	❑
Allergy- grains…….	❑			
Name: _____.	❑	❑	❑	❑
Allergy- vegetables..	❑			
Name: _____.	❑	❑	❑	❑
Allergy- food……..	❑			
Name: _____.	❑	❑	❑	❑
Allergy- grasses…..	❑			
Name: _____.	❑	❑	❑	❑
Allergy- animals…..	❑			
Name: _____.	❑	❑	❑	❑
Allergy- chemicals ..	❑			
Name: _____.	❑	❑	❑	❑
Allergy- insects…..	❑			
Name: _____.	❑	❑	❑	❑
Allergy- Perfumes	❑			
Name: _____.	❑	❑	❑	❑
Allergy- cosmetics…..	❑			
Perfumes: _____.	❑	❑	❑	❑
Cologne: _____.	❑	❑	❑	❑

ENDOCRINE Sx, NA ❑

	Value	P	F	C
Goiter…….....	❑	❑	❑	❑
Diabetes Mellitus…..	❑	❑	❑	❑
Diabetes Juvenile…..	❑	❑	❑	❑
Puffy face….....	❑	❑	❑	❑
Protruded eyes….....	❑	❑	❑	❑
Hypoglycemia….....	❑	❑	❑	❑
Hyperthyroidism…..	❑	❑	❑	❑
Hypothyroidism…..	❑	❑	❑	❑
Intolerant to heat/cold	❑	❑	❑	❑
Addison's disease…..	❑	❑	❑	❑

GENITAL/URINARY Sx . NA ❑

	Value	P	F	C
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 ❑

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

MALIGNANCIES Sx. NA ❑

	Value	P	F	C
Leukemia	❑	❑	❑	❑
Lymphoma	❑	❑	❑	❑
Type of Cancer				
Malignancy Stage				
Metastasized Cancer	Yes ❑		No ❑	
Receiving Chemo	Yes ❑		No ❑	
Receiving Radiation	Yes ❑		No ❑	

LIST OF YOUR DRUGS NA ❑

Medications	Past	Taking	Allergic
Antibiotics……	❑	❑	❑
Warfarin …….	❑	❑	❑
Cortisone……..	❑	❑	❑
Cannabis Oil……	❑	❑	❑
Mistletoe Therapy……	❑	❑	❑
Ventolin ……	❑	❑	❑
Symbicort ……	❑	❑	❑
Janumet ……	❑	❑	❑
Metformin ……	❑	❑	❑
Sitagliptin ……	❑	❑	❑
Zoloft ……	❑	❑	❑
Insulin meds. ……	❑	❑	❑
Metformin meds.....	❑	❑	❑
Aspirin ……	❑	❑	❑
Tylenol ……	❑	❑	❑
Advil ……	❑	❑	❑
Gravol ……	❑	❑	❑
Antacids……	❑	❑	❑
Anxiety meds. …...	❑	❑	❑
Depression meds.....	❑	❑	❑
Sleeping pills……	❑	❑	❑
Hormones…….	❑	❑	❑
Thyroid meds……	❑	❑	❑
Hypertension……..	❑	❑	❑
Intravenous Therapy	❑	❑	❑
Chelation Therapy….	❑	❑	❑
Myer's cocktail IV…..	❑	❑	❑
Mega Vit C IV……	❑	❑	❑
B_{12} Injections……..	❑	❑	❑
Acupuncture Therapy	❑	❑	❑
Massage Therapy ……	❑	❑	❑
Colon Therapy …….	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑

FOR MATURED MALES NA ❑

	Value	P	F	C
Testicular hernia ….	❑	❑	❑	❑
Painful testicles …….	❑	❑	❑	❑
Lumps in testicles….	❑	❑	❑	❑
Bed wetting issues….	❑	❑	❑	❑

FOR MATURED FEMALES NA ❑

	Value	P	F	C
Constant PMS …….	❑	❑	❑	❑
Congested breasts ….	❑	❑	❑	❑
Heavy menstrual flow	❑	❑	❑	❑
Hot flashes ……	❑	❑	❑	❑
Irregular cycle……	❑	❑	❑	❑
Lumps in breast…….	❑	❑	❑	❑
Painful menstruation	❑	❑	❑	❑
Vaginal discharge….	❑	❑	❑	❑
Vaginal itch……..	❑	❑	❑	❑
Vaginal bleeding…..	❑	❑	❑	❑
Bleed between cycles	❑	❑	❑	❑
Pads ……..	❑	❑	❑	❑
Tampons ……..	❑	❑	❑	❑
Oral contraceptive…	❑	❑	❑	❑

Date of last cycle: _____

HABITS

If street drugs usage	Current	Past
_____	❑	❑
_____	❑	❑
_____	❑	❑
_____	❑	❑
_____	❑	❑
_____	❑	❑
_____	❑	❑

FINE MOTORS EFFICIENCY (Without your assistance)

Have your child draw or write any thing in this space below

Personal Notes

❑ **No parental history, child was adopted**
❑ **Did not have a healthy childhood**

HABITS and frequencies

	Value	P	F	C
Water, cups per day: __	❑	❑	❑	❑
Milk Servings Per day / Wk	❑	❑	❑	❑
Cheese Servings Per day / Wk	❑	❑	❑	❑
Yogurt Servings Per day / Wk	❑	❑	❑	❑
Ice Cream Serv. Per day / Wk	❑	❑	❑	❑
Eggs # -------- Per day / Wk …	❑	❑	❑	❑
Alcohol Per day / Wk ……	❑	❑	❑	❑
Beer Per day / Wk …..	❑	❑	❑	❑
Wine R / W Per day / Wk	❑	❑	❑	❑
Whey Protein Per day / Wk	❑	❑	❑	❑
Smoothies, Shakes Per day / Wk	❑	❑	❑	❑
Butter / Margarine Per day / Wk	❑	❑	❑	❑
Nutella Per day / Wk	❑	❑	❑	❑
Peanut Butter Per day / Wk	❑	❑	❑	❑
Chocolate Milk Per day / Wk	❑	❑	❑	❑
Sugar White / Brown Per day / Wk	❑	❑	❑	❑
Sugar Products Per day / Wk	❑	❑	❑	❑
Cakes Per day / Wk	❑	❑	❑	❑
Cookies Per day / Wk	❑	❑	❑	❑
Candies Per day / Wk	❑	❑	❑	❑
Donuts, Muffins Per day / Wk	❑	❑	❑	❑
Eat three meals a day……..	❑	❑	❑	❑
Eat two meals a day……	❑	❑	❑	❑
Eat one meal a day……..	❑	❑	❑	❑
Cigarettes per day_____	❑	❑	❑	❑
Marijuana Per day / Wk	❑	❑	❑	❑
Street drugs now / past…….	❑	❑	❑	❑
Hard drugs now / past……..	❑	❑	❑	❑

YOUR PARENTS

The following questions pertain to your parents health before and while your mother was pregnant with you. The answer to the following would help determine the strength of your inner constitution.

	Value	Mom	None	Dad
Allergies				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Alcoholism				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Smoking				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Epilepsy				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Asthma				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Prescribed drugs				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Street drugs/narcotics				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Communicable diseases				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑

Personal Notes

No parental history, I was adopted ❑
Did not have a healthy childhood ❑

My Child's Current Diet (Please Complete)

The next table revolves around your child's dietary habits. The intention is to unfold food that contain Aluminium and MSG or whether your child's food stimulates or contains histamine. This may be very beneficial in understanding the real causes behind your child's conditions. Please answer the following questions to the best of your abilities.

My child eats the following during breakfast?

1-
2-
3-
4-
5-

My child eats the following during lunch?

1-
2-
3-
4-
5-

My child eats the following during dinner?

1-
2-
3-
4-
5-

My child eats the following during snacks?

Mid-Day:

Afternoon:

Before bed time:

Foods that your child craves?

My child craves the following:

- ❑ 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

My child craves following types of food

- ❑ My child follows a strict dietary plan
- ❑ Most of my child's meals are whole home cooked
- ❑ My child eats out lesser today than 5 years ago
- ❑ My child avoids refined grains, breads & pastas
- ❑ My child avoids deep fried foods
- ❑ My child eats sugary foods & dessert 3 times/wk.
- ❑ My child avoids diet foods
- ❑ My child avoids Colas, Pops, Sodas
- ❑ My child eats gluten free food
- ❑ My child avoids potential Allergic foods .
- ❑ My child eats frozen or canned foods

My child consumes fruits and vegetables as follows

My child consumes:

- ❑ **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
- ❑ My child makes eats fruits &/or vegetables daily
- ❑ My child eats **canned** or **frozen** fruits & veggie
- ❑ My child eats 1, 2, 3 salads a day / a week

My child eats the following

My child consumes:

- ❑ 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
- ❑ My child adds Lemon / Lime juice to the salad

My child digestion is best describes as follows

- ❑ My child is often bloated
- ❑ My child has low energy after eating
- ❑ My child is often constipated
- ❑ My child's brain is foggy after eating
- ❑ My child has a general digestive upset after eating
- ❑ My child has excess mucus after eating
- ❑ My child has gas or flatulence
- ❑ My child has acid reflux &/or heartburn
- ❑ Having a bowel movement is often difficult
- ❑ My child runs to the bathroom after food
- ❑ My child's stool varies in size & consistency

My child consumes the followings

My child must add the following to food

- ❑ Vinegar
- ❑ Balsamic Vinegar
- ❑ Apple Cider
- ❑ Cheese
- ❑ Butter
- ❑ Mayonnaise
- ❑ White sugar
- ❑ Salt
- ❑ MSG

I do not understand why my child has the following symptoms

My child always feel like

- ❑ Eating often eat when I feel guilt or depressed
- ❑ Eating & not knowing why
- ❑ Eat to reward myself
- ❑ My child eats when low of energy
- ❑ My child is hungry & often don't know why?

The following section is required to list your child's medical history, sicknesses, rough times and hospitalizations, I am interested in every medication given to your child especially antibiotics, cortisone and oral contraceptive bill. You should list the starting year of diseases and the year of their cure such as tonsillitis, ears, lungs, throat, skin smoking, street drugs etc. Also list the year of admission to hospital for whatever reason.

INSTRUCTIONS AS IT IS VERY IMPORTANT)

Information should be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. Some important notes to consider are : 1- How many months were you breast fed for after birth, 2- When did you start your period, 3- time of solids introduction during infancy, 4- Time of starting smoking and drugs if any 5- List all your diseases and corresponding Pharmaceutical drugs of any kind, (age at first cycle).

Duration	Year	Age	❑ I was not breast fed **Or** ❑ I was breast fed for _ _ months & started solid food at _ _ months.		
		Yr. of Birth			
		3 Months			
		6 Months			
		9 Months			
		1 Yr.			
		3 Months			
		6 Months			
		9 Months			
		2 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		3 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		4 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		5 Yrs.			
		6 Yrs.			
		7 Yrs.			
		8 Yrs.			
		9 Yrs.			
		10 Yrs.			
		11 Yrs.			
		12 Yrs.			
		13 Yrs.			
		14 Yrs.			
		15 Yrs.			
		16 Yrs.			

Please add another sheet

Fees of Examinations and services

Fees for first examination are pre-paid at time of booking the appointment by cash, Visa, Master Card, American Express and Interac. **We do not bill insurance companies.**

City	Choice ✔	Code	Explanations (Listed time of visits and therapies are approximate)	Our fee schedule	Exclusion
Toronto Clinic		Adult examination fee	First Examination for those who are under 16 years old is up to 1.5 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 and blood work are **NOT** included.	**$189.00** None Taxable	Remedies and blood work are NOT included in the first examination or any subsequent examination fee.
		Deposits before examinations	All New patients' appointments require $198 deposit to secure the appointment.	**$189.00** None Taxable	
			All New appointments scheduled **out-side our regular hours** ie before our opening hours, closing hours, Sundays and other holidays require a full payment of first visit $198.00. A receipt can be emailed to you upon receiving the fee or an invoice will handed to you on your appointment day. . Prescribed remedies or lab tests are NOT included.	**$189.00** None Taxable	
		Requisition Ex2	First visit for food sensitivity blood test is up to 30 Min., to obtain an allergy testing **requisition**. The visit includes a discussion about your allergies, causes , symptoms and provide a requisition for **Food Sensitivity** IgG Test. The Cost of the 222 food allergens testing is $420 @ Life Labs, or @ DynaCare. No physical examination, remedies or other blood tests are included.	**$135.00** None Taxable	
		EX5	Subsequent follow-up examination is up to 30 **Mins**. To review major symptoms changes. Prescribed remedies are **NOT** included.	**$90.00** None Taxable	
		Report Reading	30 minutes of reading, evaluating and reporting any of reading and evaluating blood work or lab results.	**$50.00** None Taxable	
		No Show	We ask for your courtesy to give us **heads up of 48 hours cancellation** 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 one 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.

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

For example:

GASTRO-INTESTINAL

Value	P	F	C	
③	❑	❑	☑	Gas
	❑	☑	❑	Jaundice
②	☑	❑	❑	Diarrhea
⑦	❑	❑	☑	Heart burn
③	❑	❑	☑	Indigestion
③	❑	❑	☑	Constipation
③	❑	☑	❑	Poor appetite
②	☑	❑	❑	Hemorrhoids
③	❑	☑	❑	Liver trouble
	❑	☑	❑	Colon trouble
②	❑	❑	☑	Pain over stomach
	❑	☑	❑	Gall bladder trouble

Gas here is a constant symptom that appears daily and little bothersome given number 3.

Heart burn here is a constant daily symptom that appears which is very disturbing given the number 7.

Poor appetite here is a moderate symptom that appears frequently and bothersome, given the number 3

Pain over stomach here is a daily symptom, with a little discomfort, given the number 2.

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
	(2006)	Birth Day	❑ I was not breast fed **Or** ❑ I was breast fed for _ ? months & started solid food at _ ? months.
	2007	1	**Was not breast fed, used formula**
		2	
		3	**1st set of tubes in the ears**
		4	
		5	
		6	**2nd set of tubes in ears plus antibiotics**
	2013	7	
		8	**Asthmatic symptoms, inhalers were prescribed and used daily**
	2015	9	
		10	
		11	**3rd set of tubes in the ears**
	2018	12	

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 or Chills ❒ 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
  - 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

Signature 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.