

Naturopathic and Allergy Clinic - 2025

Telephone (416) 207-0207, fax (416) 207-0272

Our Address: 5497 Eglinton Avenue West, Suite 107, Etobicoke Ontario M9C 5K6

E-Transfer or 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 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 health. We will only accept to treat your health concerns 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 (**Must list your current 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 physical examination consent 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.

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 messages, then please give us written instructions here: _____

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). (NA) = Not applicable, (*) = Mandatory to completed before your appointment. Thank you.

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"/>	
Any contact with animals	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	

* 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"/>	
Phlegm (Yellow, clear, white)...	<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"/>	
Thymus tatus.....	<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 (MRSA).....	<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"/>	
Brittle Nails.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyperpigmentation	<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"/>	
Baker's Cyst.....	<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"/>	
Tennis elbow.....	<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"/>	
Leg cramps at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Pain (P) or numbness (N) in:

*R/L 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"/>	
*R/L Upper Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Forearms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Elbows.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Fingers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L knuckles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Legs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Thighs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Feet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Heels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Toes.....	<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		
Aneurysm (Vent Aorta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart palpitation.....	<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"/>	Yes	<input type="checkbox"/>	NA	

* 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"/>	
Painful to swallow....	<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"/>	
Acid refluxes.....	<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"/>	
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 <small>Internal or External</small>	<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 distension	<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"/>	
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		
Time you go to bed _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Minutes to fall asleep _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Your wake up time _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is sleep interrupte ___X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Snoring.....	<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"/>			
Using CPAP _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
I do shift work _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Sleeping Meds _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

MOUTH Sx.		NA <input type="checkbox"/>			
	Value	P	F	C	
Mercury filling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bad breath, often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thrush on tongue.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dry mouth Day / Night ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gums bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sensitive teeth to cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Roof of mouth itchiness..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sensitive teeth to hot..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Taste changed lately..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drool during sleep ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged tonsils.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Angular Cheilitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cold sores.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oral herpes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canker sores.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

NOSE Sx.		NA <input type="checkbox"/>			
	Value	P	F	C	
Nose tip itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nose bleed (epistaxis)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nasal obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sneezing spells Am, Pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Post nasal drip.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wears (Perfume, Cologne)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

EARS Sx.		NA <input type="checkbox"/>			
	Value	P	F	C	
Vertigo.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Ear noise.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Ear aches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Ear redness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Ear canal itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Ear discharge.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Perforated eardrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Excessive ear wax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Ear deafness ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

EYES Sx.		NA <input type="checkbox"/>			
	Value	P	F	C	
*R/L Eyes itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Eyes redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Eyes discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Sties on eye lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Failing vision.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Blepharitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Xanthelasma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Glaucoma...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Cataract.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Inflamed eye lids.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Blurry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Eyes dark circle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

THROAT Sx.		NA <input type="checkbox"/>			
	Value	P	F	C	
Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Tonsillitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*R/L Enlarged tonsils...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cold sores.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Throat itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Throat irritation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Voice changed lately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent choking on water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

HEAD Sx..		NA <input type="checkbox"/>			
	Value	P	F	C	
Upper sinuses congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lower sinuses congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Light headed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tension Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cluster Headache....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache after MVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache on waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache if hungry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache per Week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Migraine Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Migraine per Week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

* VACCINATIONS,		NA <input type="checkbox"/>			
	Yes	No			
Vaccination (Infancy)	<input type="checkbox"/>	<input type="checkbox"/>			
Vaccination (Childhood)	<input type="checkbox"/>	<input type="checkbox"/>			
Vaccination (Teenage)	<input type="checkbox"/>	<input type="checkbox"/>			
Vaccination (Adulthood)	<input type="checkbox"/>	<input type="checkbox"/>			
COVID-19 Vaccination	<input type="checkbox"/>	<input type="checkbox"/>			
Allergy shots Now / Past.	<input type="checkbox"/>	<input type="checkbox"/>			
Flu shots: _____	<input type="checkbox"/>	<input type="checkbox"/>			
Others: _____	<input type="checkbox"/>	<input type="checkbox"/>			

* ALLERGIES Sx.		NA <input type="checkbox"/>			
	Value	P	F	C	
Seasonal allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fall.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Winter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spring.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have allergies to dogs ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have allergies to cats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- house dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- dust mites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- dairy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- Sulfur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- weeds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- food additives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- trees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- grains.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- vegetables..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- food.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- grasses.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- animals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- chemicals ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- insects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- Perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy- cosmetics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Perfumes: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cologne: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

ENDOCRINE Sx.,		NA <input type="checkbox"/>			
	Value	P	F	C	
Goiter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes Juvenile.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Puffy face.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Protruded eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hypoglycemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyperthyroidism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hypothyroidism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Intolerant to heat/cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Addison's disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

GENITAL / URINARY Sx.		NA <input type="checkbox"/>			
	Value	P	F	C	
UTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pubic itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in urine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidneys stones.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent urination (Night)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent urination (Day).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cannot hold urine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney's infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Burning urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genital Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urine incontinence.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Slow urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swollen ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult starting urine.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

* NERVOUS Sx.		NA <input type="checkbox"/>			
	Value	P	F	C	
Tics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OCD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depressed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxious.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety due to abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Panic Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ADD Symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ADHD Symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Post Traumatic Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Phobic Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyper-activity.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Schizophrenia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alzheimer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tendency to worry...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loses temper often...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tendency to cry.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low self esteem.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hopeless outlook.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wets pants constantly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tendency to be shy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dislike criticism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frightening dreams...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frightening thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Parkinson's Disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hard to concentrate...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thoughts of suicide...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple sclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure Grand Mal / Petit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grinds teeth during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bell's Palsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Facial nerve Palsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebral Palsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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 salad 1, 2, 3 a day / a week or **Never**

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
- Craft Dinner with cheese

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		
* Must Complete	()	Birth Day	<input type="checkbox"/> I was not breast fed	Or <input type="checkbox"/> I was breast fed for	
		1 Yr.	months & started solid food at	months.	
		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			
		34			
		35			
		36			
		37			
		38			
		39			
		40 Yrs.			
		41			
		42			
		43			
		44			
		45	If over 60 years old, please use plit table bellow		
		46			
		47			
		48			
		49			
		50 Yrs.			
		51			
		52			
		53			
		54			
		55			
		56			
		57			
		58			
		59			
		60 Yrs.			
		61			
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		63			
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		65			
		66			
		67			
		68			
		69			
		70			
		71			
	72				

Please add another sheet or proceed to next page for Covid-19 questionnaire

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 doctors don't write any types of covid exemption...? Yes No
- Did you take Covid vaccinations Once / Twice.? 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.

City	Choice ✓	Code	Explanations (Listed time of visits and therapies are approximate)	Our fee schedule	Exclusion
Toronto Clinic		Adult examination fee	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 and any blood work are NOT included.	\$229.00 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 \$225 deposit to secure the appointment.	\$229.00 None Taxable	
		Requisition Ex2	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 \$225.00. 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.	\$229.00 None Taxable	
		EX5	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	
		Report Reading	Subsequent follow-up examination is up to 30 Mins. To review major symptoms changes. Prescribed remedies are NOT included.	\$99.00 None Taxable	
		No Show	30 minutes of reading, evaluating and reporting any of reading and evaluating blood work or lab results.	\$50.00 None Taxable	
			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 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
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Jaundice
②	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
⑦	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart burn
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
②	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
③	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input 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
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	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.

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 st set of tubes in the ears
		4	
		5	
		6	2 nd set of tubes in ears plus antibiotics
	1957	7	
		8	Asthmatic symptoms, inhalers were prescribed and used daily
	1959	9	
		10	
		11	3 rd set of tubes in the ears
	1962	12	

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, based on what is being disclosed on this form.** 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) and is not a Medical Doctor, therefore his examinations and / or 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.

I consent to non-commercial , pictures or videos, be taken of my condition e.g., Acne, Eczema, psoriasis, Rosacea, etc., as Dr. Srajeldin advises. These videos or pictures are confidential and never to be used for commercial advertisement. They are intended for the patient's future comparisons of the degree of improvements during the process of the treatment.

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 Prostate 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 less than or without 48 hour notice.

* **Signature:** _____

* **Date:** _____

Witness: _____

Date: _____