Naturopathic and Allergy Clinic

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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 understand the reasons behind your current condition. This form is confidential and will not be shared or discussed with any establishment outside our office.

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

Personal information

✳Last name: _____ ✳First name:
✳Date of birth: MM. DD. YY. Sex: ❑ Male, ❑ Female, Height: _____ Weight: _____ .
✳My Occupation is: _____ My employer is: _____
✳I have been unwell for: _____ Yrs., Physician's name who treated me: _____
I was treated by a ❑ Medical Dr., ❑ Chiropractor, ❑ Naturopath Dr., ❑ Psychiatrist, ❑ Hospital, ❑ Homeopath,
Was treatment terminated? : ❑ Yes, ❑ No, Did treatment achieve its goal % (explain): _____
✳I was treated for: _____
✳I am currently suffering from and need treatment for: _____

✳Phone number ( ): _____ ✳Email: _____ @ _____

Do you or your partner have an extended health insurance at work ❑ Yes, ❑ No.?
Name of Insurance company: _____

✳Who referred you to this Clinic : _____
❑ Office sign, ❑ Etobicoke Guardian., ❑ Our Website, ❑ Surfing the Net, ❑ Office Pamphlet, ❑ TV Interview

Please check the system that has your symptoms

- ❑ **Allergy symptoms**
  - ❑ **Seasonal**
  - ❑ **Year round**
- ❑ **Respiratory symptoms**
- ❑ **Muscle/bone/joints issues**
- ❑ **Digestive symptoms**
- ❑ **Oral symptoms**
- ❑ **Throat symptoms**
- ❑ **Nasal symptoms**
- ❑ **Scalp & hair symptoms**
- ❑ **Ear issues**
- ❑ **Eyes issues**
- ❑ **Head related issues**
- ❑ **Heart symptoms**
- ❑ **Skin symptoms**
- ❑ **Fatigue issues**
- ❑ **Sleep issues**
- ❑ **Endocrine glands sx**
- ❑ **Nervous system symptoms**
- ❑ **Genital / urinary symptoms**
- ❑ **Malignancies**
- ❑ **Female issues**
- ❑ **Male issues**
- ❑ **Surgeries**
- ❑ **Medications taken now**
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
- ❑ **Dietary habits**
  - ❑ Water per day: ____ .
  - ❑ Tea per day: ____ .
  - ❑ Milk per day: ____ .
  - ❑ Cheese per day: ____ .
  - ❑ Yogurt per day: ____ .
  - ❑ Ice Cream per day: ____ .
  - ❑ Cola per day: ____ .
  - ❑ Coffee per day: ____ .
  - ❑ Beer per day: ____ .
  - ❑ Wine per day: ____ .
  - ❑ Cigarettes per day: ____ .
  - ❑ Chocolate per day: ____ .
  - ❑ Nutella per day: ____ .
  - ❑ Peanutbutter Scoops per day: ____ .
  - ❑ Whey Scoops per day: ____ .

Sign _____ . **Date** _____ .