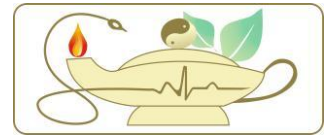


Naturopathic and Allergy Clinic

Toronto Office: Telephone (416) 207-0207, Telefax (416) 207-0272

Caledon East Office.....: Telephone (905) 584-6776, Telefax (416) 207-0272

Email: clinic@live.com



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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

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

Sign _____ Date _____