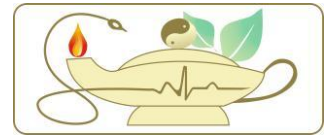


# Naturopathic and Allergy Clinic

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

Sign \_\_\_\_\_ Date \_\_\_\_\_