2020

Naturopathic and Allergy Clinic

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

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 your case if we believe that you are intending to apply our ① instructions, ② remedies, ③ therapies and ④diet as given to treat you. 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 and need treatment for: ______________

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.

Dear Patient:

The following several pages contain ① declaration form, ② consent to examination 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.

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: ______________

____

Continue on page (2) please

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,** 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) not a Medical Doctor and his examinations and 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.

For female patients

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

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 drank 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.

Signature: _________________________________ **Date:** _______________________________

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 health from your physician's office or the hospital if you were treated at a hospital.

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). **Thank you.** **********SEE PAGE 8 FOR MORE INSTRUCTIONS********

GENERAL Sx. 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
Croup	❑	❑	❑	❑
Pleurisy	❑	❑	❑	❑
Wheezing	❑	❑	❑	❑
Chest pain	❑	❑	❑	❑
Chronic cough	❑	❑	❑	❑
Whooping Cough	❑	❑	❑	❑
Difficult to breath	❑	❑	❑	❑
Spitting blood / phlegm	❑	❑	❑	❑
Asthmatic symptoms	❑	❑	❑	❑
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	❑	❑	❑	❑
Athletes foot	❑	❑	❑	❑
Bruise easily	❑	❑	❑	❑
Varicose veins	❑	❑	❑	❑
Brittle Nails	❑	❑	❑	❑
Skin, ring worms	❑	❑	❑	❑
Skin, itch or burn	❑	❑	❑	❑
Sweats profusely	❑	❑	❑	❑
Hives Large or Small	❑	❑	❑	❑
Eczema or Psoriasis	❑	❑	❑	❑
Feet (Cold or Dry)	❑	❑	❑	❑
Corns on Feet / Toes	❑	❑	❑	❑

Current Treatments, Circle if :

Proactive	Yes ❑	No ❑
Over the counter	Yes ❑	No ❑
Salicylic Acid Facial	Yes ❑	No ❑
Microdermabrasion	Yes ❑	No ❑

Skeletal Sx. NA ❑

	Value	P	F	C
TMJ	❑	❑	❑	❑
Gout	❑	❑	❑	❑
Scoliosis	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑
Bursitis	❑	❑	❑	❑
Tremor	❑	❑	❑	❑
Neuralgia	❑	❑	❑	❑
Disc hernia	❑	❑	❑	❑
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	❑	❑	❑	❑
Joint stiffness, Reiter's	❑	❑	❑	❑
Leg cramps at night	❑	❑	❑	❑
Tennis elbow	❑	❑	❑	❑
Pain (P) or numbness (N) in:				
*Shoulders	❑	❑	❑	❑
*Between shoulders	❑	❑	❑	❑
*Arms	❑	❑	❑	❑
*Elbows	❑	❑	❑	❑
*Hand	❑	❑	❑	❑
*Fingers	❑	❑	❑	❑
*Hips	❑	❑	❑	❑
*Legs	❑	❑	❑	❑
*Knees	❑	❑	❑	❑
*Ankles	❑	❑	❑	❑
*Feet	❑	❑	❑	❑
*Heels	❑	❑	❑	❑
*Toes	❑	❑	❑	❑
*Bottom of feet	❑	❑	❑	❑
*Arch of feet	❑	❑	❑	❑

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	❑	❑	❑	❑

GASTRO-INTESTINAL Sx. NA ❑

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

SCALP & HAIR NA ❑

	Value	P	F	C
Dandruff	❑	❑	❑	❑
Psoriasis	❑	❑	❑	❑
Hair loss	❑	❑	❑	❑
Hair lice	❑	❑	❑	❑
Hair splits	❑	❑	❑	❑
Scalp itchy	❑	❑	❑	❑
Scalp painful	❑	❑	❑	❑
Hair implant	❑	❑	❑	❑
Hair (Dry or Oily)	❑	❑	❑	❑
Baldness patches	❑	❑	❑	❑

SLEEP Sx. NA ❑

	Value	P	F	C
I sleep at ________.	❑	❑	❑	❑
Insomnia ______Min.	❑	❑	❑	❑
I wake up at ______.	❑	❑	❑	❑
Interrupted sleep __X.	❑	❑	❑	❑
Do you day-nap?		Yes ❑	No ❑	
Sleepy all day ______		Yes ❑	No ❑	
Sleeping Meds ______		Yes ❑	No ❑	
Using CPAP ______		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	☐	☐	☐	☐
Cold sores	☐	☐	☐	☐
Enlarged tonsils	☐	☐	☐	☐
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	☐	☐	☐	☐
Wear (Perfume, Cologne)	☐	☐	☐	☐

EARS Sx. NA ☐

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

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 per Week ____________

Migraine Meds ____________

Headache Meds ____________

IMMUNIZATION,ALLERGY Sx. NA ☐

	Yes	No
Immunization (Infant)	☐	☐
Immunization (Child)	☐	☐
Immunization (Teens)	☐	☐
Immunization (Adult)	☐	☐
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	☐	☐	☐	☐
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	☐	☐	☐	☐
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 ☐

Surgeries dates: NA ☐

Hernia operation ____________

Gallbladder removed ____________

Tonsillectomy ____________

Tubes in ears ____________

Appendectomy ____________

Nasal adenoids ____________

Cancer surgery ____________

Knee operation ____________

Hysterectomy ____________

C Section ____________

Prosthesis (Implants) ____________

List drugs known to you whether :

Medications	Past	Taking	Allergic
Antibiotics………….	☐	☐	☐
Inhalers Ventolin, Symbicort ..	☐	☐	☐
Insulin meds. ………	☐	☐	☐
Metformin meds.......	☐	☐	☐
Aspirin, Tylenol……	☐	☐	☐
Gravol /Antacids…..	☐	☐	☐
Anxiety meds. ……..	☐	☐	☐
Depression meds......	☐	☐	☐
Sleeping pills………	☐	☐	☐
Warfarin meds……..	☐	☐	☐
Cortisone…………..	☐	☐	☐
Hormones………….	☐	☐	☐
Thyroid meds………	☐	☐	☐
Hypertension……..	☐	☐	☐
Intravenous Therapy	☐	☐	☐
Chelation Therapy….	☐	☐	☐
Myer's cocktail IV…..	☐	☐	☐
Mega Vit C IV………	☐	☐	☐
Cannabis Oil…………	☐	☐	☐
Mistletoe Therapy……	☐	☐	☐
B12 Injections………..	☐	☐	☐
Acupuncture Therapy	☐	☐	☐
Massage Therapy	☐	☐	☐
Colon Therapy	☐	☐	☐
____________	☐	☐	☐
____________	☐	☐	☐
____________	☐	☐	☐
____________	☐	☐	☐
____________	☐	☐	☐
____________	☐	☐	☐

Date of Tests : NA ☐

Chest X-Ray ____________

Colon X-Ray ____________

Gallbladder X-Ray ____________

Electrocardiogram

Sigmoidoscopy ____________

Pap Smear ____________

Gastro-intestinal series ____________

SEXUALITY

	No	Yes
Abstainer …………….	☐	☐
Sexually active …………	☐	☐
Heterosexual ……………	☐	☐
Homosexual …………….	☐	☐
Bisexual …………….	☐	☐

FOR MEN

	Value	P	F	C
*Enlarged prostate…	☐	☐	☐	☐
*Penile discharge	☐	☐	☐	☐
Painful testicles	☐	☐	☐	☐
Lumps in testicles	☐	☐	☐	☐
Impotence	☐	☐	☐	☐
Vasectomy	☐	☐	☐	☐
Erectile Dysfunction	☐	☐	☐	☐
Condom (Lubricated)	☐	☐	☐	☐
Condom (Dry)	☐	☐	☐	☐

Date of prostate exam ____________

If needs prostate exam **Yes** ☐ **No** ☐

Your initials please: (**must**)

FOR FEMALES

My **maiden name** is ____________

	Value	P	F	C
*Vaginal discharge	☐	☐	☐	☐
Vaginitis	☐	☐	☐	☐
Vaginal warts	☐	☐	☐	☐
Trichomoniasis	☐	☐	☐	☐
Cervical HPV	☐	☐	☐	☐
Volvudynia	☐	☐	☐	☐
Cervical HPV	☐	☐	☐	☐
Genital herpes Yrs.__	☐	☐	☐	☐
Infertility Yrs. __	☐	☐	☐	☐
Uterine fibroids	☐	☐	☐	☐
Constant PMS	☐	☐	☐	☐
Hot flashes	☐	☐	☐	☐
Irregular cycle	☐	☐	☐	☐
Lumps in breast	☐	☐	☐	☐
Menopausal symptom	☐	☐	☐	☐
Birth control				
*Oral contraceptive	☐	☐	☐	☐
Intrauterine device	☐	☐	☐	☐
Withdrawal	☐	☐	☐	☐
Rhythm	☐	☐	☐	☐
Tubal ligation	☐	☐	☐	☐
Diaphragm	☐	☐	☐	☐
Spermicidal cream	☐	☐	☐	☐
Condom (Lubricated)	☐	☐	☐	☐
Condom (Dry)	☐	☐	☐	☐
Pads	☐	☐	☐	☐
Tampons	☐	☐	☐	☐

Date of last cycle ____________.

*Pap smear date ____________.

Total of pregnancies____________.

Total of premature ____________.

Total of Miscarriages ____________.

Total of abortions ____________.

Total of stillbirths ____________.

Date last breast exam ____________.

If needs breasts exam **Yes** ☐ **No** ☐

Your initials please: (**must**) ____________.

HABITS and their 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………….	☐	☐	☐	☐
Coffee/milk/sugar Per day / Wk…	☐	☐	☐	☐
Wine R / W Per day / Wk..	☐	☐	☐	☐
Whey Protein Shakes Per day / Wk	☐	☐	☐	☐
Butter / Margarine Per day / Wk….	☐	☐	☐	☐
Nutella / Peanut Butter Per day / Wk	☐	☐	☐	☐
Chocolate Milk Per day / Wk…….	☐	☐	☐	☐
Sugar, Sugar Products Per day / Wk	☐	☐	☐	☐
Cakes, Cookies, Candies day / Wk	☐	☐	☐	☐
Donuts, Muffins, day / Wk	☐	☐	☐	☐
Eat three meals a day……..	☐	☐	☐	☐
Eat two meals a day………	☐	☐	☐	☐
Eat one meal a day………..	☐	☐	☐	☐
Cigarettes per day_______	☐	☐	☐	☐
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 ☐

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

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 foggy brain after eating
- ❑ 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
- ❑ MSG

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 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- time of Solids introduction during infancy, 3- smoking and 4- drugs of any kind, (age at first cycle).

Duration	Year	Age	Description of incidents		
	( )	Birth Day	❑ I was not breast fed **Or** ❑ I was breast fed for _ _ months & started solid food at _ _ months.		
		1 Yr.			
		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			
		46			
		47			
		48			
		49			
		50 Yrs.			
		51			
		52			
		53			
		54			
		55			
		56			
		57			
		58			
		59			
		60 Yrs.			
		61			
		62			
		63			

Please add another sheet

Fees of Examinations and services,

City	Choice ✔	Code	Explanations (Listed time of visits and therapies are approximate)	Our fee schedule	Exclusion
Toronto Clinic		EX1-Adult	First Examination 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 are extra.	**$210.00** None Taxable	Remedies and blood work are NOT included in the first examination or any subsequent examination fee.
			Saturday or special holiday appointments require **$50** deposit	**$50.00** None Taxable	
			Appointments scheduled before or after regular business hours or appointments scheduled on Sundays or holidays require full payment of the total visits, for front desk will not be in.	**$210.00** None Taxable	
		EX5	Subsequent Examination are **30 Mins**. To review major symptoms	**$90.00** 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.

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

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:

1- breast feeding at birth, 2- time of food introduction during infancy, 3- smoking and 4- drugs of any kind.

Duration	Year	Age	Description of incidents
	(1950)	Birth Day	❑ I was not breast fed **Or** ❑ I was breast fed for ____ months & started solid food at ____ months.
	1951	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
	1957	7	
		8	Asthmatic symptoms, inhalers were prescribed and used daily
	1959	9	
		10	
		11	3rd set of tubes in the ears
	1962	12	
		13	
		14	
		15	
		16	
		19	Asthma symptoms disappeared
		20	Motor vehicle accident, hospitalized for broken leg

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