

Naturopathic and Allergy Clinic - 2021

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 child's health. We will only accept your child's case if we believe that you are intending to apply our ① instructions, ② remedies, ③ therapies and ④ diet as given to treat your child. 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.

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 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 messages, 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 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.

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.

Continue on page (3) please

| 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"/> |
| Snore..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Teeth trouble..... | <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"/> |
| 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"/> |
| Drop 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"/> |
| 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"/> |
| Ear noise..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear aches..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear redness..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear canal itch..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear discharge..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Perforated eardrum... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive ear wax... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| EYES Sx. | | NA <input type="checkbox"/> | | |
|------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| | Value | P | F | C |
| Eyes itch..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eyes redness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eyes discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sties on eye lid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Failing vision..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sight (Near or Far) . | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eyes infection | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bags under eyes..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dark circle under eyes | <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"/> |
| Tonsillitis..... | <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"/> |
| Enlarged tonsils..... | <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"/> |

| HEAD Sx.. | | NA <input type="checkbox"/> | | |
|-------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| | Value | P | F | C |
| 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 _____ | | | | |
| Headache per Week _____ | | | | |
| Migraine Meds _____ | | | | |
| Migraine per Week _____ | | | | |

| 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"/> |
| 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"/> |
| Kidneys 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 |
| OCD..... | <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"/> |
| 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"/> |
| 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"/> |
| Cerebral Palsy..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety..... | <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"/> |
| 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"/> |
| Hyperactivity..... | <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"/> |
| 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"/> |
| Wets pants constantly | <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"/> |

| MALIGNANCIES Sx. | | NA <input type="checkbox"/> | |
|----------------------|------------------------------|-----------------------------|--------------------------|
| Value | P | F | C |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lymphoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Type of Cancer | _____ | | |
| Malignancy Stage | _____ | | |
| Metastazied Cancer | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Receiving Chemo | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Receiving Radiation | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Mistletoe treatments | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

| LIST OF YOUR DRUGS | | | | NA <input type="checkbox"/> |
|-------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|
| Medications | Past | Taking | Allergic | |
| Antibiotics..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Warfarin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cannabis Oil..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mistletoe Therapy..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ventolin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Symbicort | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Janumet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Metformin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitagliptin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Zoloft | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin meds. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Metformin meds..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tylenol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Advil | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gravol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Antacids..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety meds. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression meds..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleeping pills..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hormones..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid meds..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypertension..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Intravenous Therapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chelation Therapy.... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Myer's cocktail IV..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mega Vit C IV..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B12 Injections..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Acupuncture Therapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Massage Therapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Colon Therapy | <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"/> | <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"/> | <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"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| SURGERIES DATES | | NA <input type="checkbox"/> |
|-----------------------|-------|-----------------------------|
| Hernia operation | _____ | |
| Gallbladder removeall | _____ | |
| Tonsillectomy | _____ | |
| Tubes in ears | _____ | |
| Appendectomy | _____ | |
| Nasal adenoids | _____ | |
| Cancer surgery | _____ | |
| Knee operation | _____ | |
| Hysterectomy | _____ | |
| Tubal ligation | _____ | |
| C Section | _____ | |
| Prosthesis (Implants) | _____ | |

| SEXUALITY | | |
|-----------------------|--------------------------|--------------------------|
| | No | Yes |
| Abstainer | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually active | <input type="checkbox"/> | <input type="checkbox"/> |
| Heterosexual | <input type="checkbox"/> | <input type="checkbox"/> |
| Homosexual | <input type="checkbox"/> | <input type="checkbox"/> |
| Bisexual | <input type="checkbox"/> | <input type="checkbox"/> |

| FOR MEN | | | |
|------------------------------|------------------------------|-----------------------------|--------------------------|
| Value | P | F | C |
| *Enlarged prostate... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| *Penile discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Painful testicles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lumps in testicles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Testicular varicocele | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Impotence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vasectomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Erectile Dysfunction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Condom Uses (OCC. All Times) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of prostate exam | _____ | | |
| If need prostate exam | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

| FOR FEMALES | | | |
|------------------------|--------------------------|--------------------------|--------------------------|
| Value | P | F | C |
| My maiden name is | _____ | | |
| *Vaginal discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vaginitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vaginal warts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Trichomoniasis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gonorrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Genital herpes Yrs. __ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cervical HPV | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Endometriosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vulvodynia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cervical HPV | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Infertility Yrs. __ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Uterine fibroids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Constant PMS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hot flashes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular cycle | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lumps in breast | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Menopausal symptom | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Birth control | | | |
|-----------------------|------------------------------|-----------------------------|--------------------------|
| Value | P | F | C |
| *Oral contraceptive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Intrauterine device | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Withdrawal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rhythm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tubal ligation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diaphragm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| NuvaRing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spermicidal cream | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diva Cup | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pads | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tampons | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Condom (Lubricated) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Condom (Dry) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of last cycle | _____ | | |
| *Pap smear date | _____ | | |
| Total of pregnancies | _____ | | |
| Total of Miscarriages | _____ | | |
| Total of abortions | _____ | | |
| Total of stillbirths | _____ | | |
| Date last breast exam | _____ | | |
| If need breasts exam | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

Your initials please: (must) _____

| HABITS and their frequencies | | | |
|----------------------------------|--------------------------|--------------------------|--------------------------|
| Value | P | F | C |
| Water, cups per day: __ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Milk Servings Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cheese Servings Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Yogurt Servings Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ice Cream Serv. Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eggs # ----- Per day / Wk ... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Beer Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Wine R / W Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Whey Protein Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Smoothies, Shakes Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Butter / Margarine Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nutella Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Peanut Butter Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chocolate Milk Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sugar White / Brown Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sugar Products Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cakes Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cookies Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Candies Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Donuts, Muffins Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eat three meals a day..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eat two meals a day..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eat one meal a day..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cigarettes per day_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Marijuana Per day / Wk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Street drugs now / past..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hard drugs now / past..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during breast feeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism | | | |
| before pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during breast feeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Smoking | | | |
| before pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during breast feeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | | | |
| before pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during breast feeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | | | |
| before pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during breast feeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Prescribed drugs | | | |
| before pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during breast feeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Street drugs/narcotics | | | |
| before pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during breast feeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Communicable diseases | | | |
| before pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during breast feeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Personal Notes | | | |
| No parental history, I was adopted | <input type="checkbox"/> | | |
| Did not have a healthy childhood | <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 1, 2, 3 salads a day / a week

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
- 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 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 | |
|----------|-----------|--|--------------------------------|---------|
| () | 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. |
| | 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 | | | |
| | 64 | | | |
| | 65 | | | |
| | 66 | | | |
| | 67 | | | |
| | 68 | | | |
| | 69 | | | |
| | 70 | | | |
| | 71 | | | |
| | 72 | | | |

Please add another sheet

Due to the length of new appointments (120 Min). All New appointment require \$50 deposit to secure the appointment. It is refundable with a 48 Hrs. cancellation note.

| City | Choice ✓ | Code | Explanations (Listed time of visits and therapies are approximate) | Our fee schedule | Exclusion |
|-------------------|-------------|---|--|-----------------------|---|
| Toronto Clinic | | EX1-Adult | 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 are NOT included. | \$225.00 None Taxable | Remedies and blood work are NOT included in the first examination or any subsequent examination fee. |
| | | | All New appointment require \$50 deposit to secure the appointment. | \$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. Prescribed remedies are NOT included. | \$225.00 None Taxable | |
| | EX5 | Subsequent Examination is up to 30 Mins. To review major symptoms. Prescribed remedies are NOT included. | \$95.00 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 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 | |

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

Signature of Patient or Guardian (MUST)