

Complete Balance Health Centre
 2896 Bloor Street West
 Toronto, ON, M8X 1B5
 (416) 769-1163



First Name				Last Name			
Address				City		Postal Code	
DOB				Age:			
H Telephone		Cell		W Telephone			
Email							

Physician: _____ **Address:** _____ **Phone:** _____

Occupation _____

How did you hear about us? Friend Internet Phone Book Sign
 Other: _____

Height: _____ **Weight:** _____

Have you received the following services before?

- | | |
|--|--|
| <input type="checkbox"/> massage therapy | <input type="checkbox"/> foot care |
| <input type="checkbox"/> chiropractic | <input type="checkbox"/> orthotics |
| <input type="checkbox"/> naturopathy | <input type="checkbox"/> psychotherapy |

NATUROPATHIC NEW PATIENT FORM

Dear Client:

Our ability to draw effective conclusions about your present state of health and how to improve it, depends to a significant extent on your ability to respond thoughtfully and accurately to both these written questionnaires and those posed during your consultations. We are the only ones who will review your forms. Thank you for your time in advance and we look forward to working together to achieve your health goals.

Mary-Ellen Kelly, N.D. and Soo-Jung Han, N.D.

What are your main health concerns at this time?	Date symptoms started
1) _____	/ _____
2) _____	/ _____
3) _____	/ _____

Naturopathic Intake Form

Please list any medications you are taking:

Please list any vitamin or herbal supplements you are taking:

Have you had Naturopathic care in the past? YES/NO

If yes, please explain how your needs were *not* met in the past:

Please list any medical conditions or abnormal lab results that you have had in the past:

Any hospitalizations or surgeries?:

Any environmental or food allergies?:

How many hours do you sleep? _____

Is it interrupted? YES/NO

If interrupted, for what reason(s) _____

How often do you move your bowels? {please circle}

Every 2 days, every day, 2 x's daily, 3 x's daily, or ___ x's a week.

Do you smoke? YES/NO _____/day

Do you drink alcohol? YES/NO _____/day _____/week

Do you drink coffee YES/NO _____/day _____/week

Caffeinated tea? YES/NO _____/day _____/week

Do you drink soda pop? YES/NO _____/day _____/week

Do you drink water? YES/NO _____/day

Do you exercise? YES/NO How often? _____ Type? _____

Do you meditate or pray? YES/NO How often? _____

What do you feel is the cause of your current health concerns?

Naturopathic Intake Form

Health Appraisal Questionnaire

0= Never	1= Mild or Occasional	2= Moderate	3= Severe or Frequent	
Burping	0	1	2	3
Fullness for extended time after meals	0	1	2	3
Bloating	0	1	2	3
Poor Appetite	0	1	2	3
Stomach upsets easily	0	1	2	3
History of constipation	0	1	2	3
Abdominal cramps	0	1	2	3
Indigestion after eating	0	1	2	3
Fatigue after eating	0	1	2	3
Lower bowel gas	0	1	2	3
Heartburn	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Roughage and fiber causes constipation	0	1	2	3
Mucous in stools	0	1	2	3
Stool poorly formed	0	1	2	3
Three or more large bowel movements daily	0	1	2	3
Foul smelling stool	0	1	2	3
Dry, flaky skin and/or dry brittle hair	0	1	2	3
Pain on the left side under rib cage	0	1	2	3
Pain on the right side under rib cage	0	1	2	3
Acne	0	1	2	3
Intolerance to greasy foods	0	1	2	3
Antacid use	0	1	2	3
Sudden, acute indigestion	0	1	2	3
Relief of symptoms by carbonated beverages	0	1	2	3
Black stool when not taking iron supplements	0	1	2	3
Bladder and kidney infections	0	1	2	3
Bad breath	0	1	2	3
Body odour	0	1	2	3
Big toe painful	0	1	2	3
Trouble waking up in the morning	0	1	2	3
Depressed, apathetic	0	1	2	3
Low sex drive	0	1	2	3
Sugar causes irritability and mood swings	0	1	2	3

Naturopathic Intake Form

Sensitive to exhaust fumes, smog, petrochemicals, perfume	0	1	2	3
Dizziness when standing suddenly	0	1	2	3
Crave sweets	0	1	2	3
Headaches relieved by eating sweets or alcohol	0	1	2	3
Feel shaky or jittery	0	1	2	3
Irritable if a meal is missed	0	1	2	3
Wake up in middle of night craving sweets	0	1	2	3
Need to drink coffee to get started	0	1	2	3
Poor memory, forgetfulness	0	1	2	3
Poor concentration	0	1	2	3
Night sweats	0	1	2	3
Increased thirst	0	1	2	3
Lowered resistance to infection	0	1	2	3
Family history of diabetes	0	1	2	3
Frequent urination	0	1	2	3
History of antibiotic use	Yes		No	
Thinning or loss of outside portion of eyebrow	Yes		No	
Smoker	Present			Past
High cholesterol	Present			Past
<i>MALES ONLY</i>				
Pain or burning while urinating	0	1	2	3
Wake up to urinate at night	0	1	2	3
Dripping after urination	0	1	2	3
Difficulty attaining and/or maintaining an erection	0	1	2	3

Naturopathic Intake Form

Mary-Ellen Kelly, B.P.E., N.D., D.O.H.S.

Soo-Jung Han, B.Sc., N.D.

DOCTOR OF NATUROPATHIC MEDICINE

2896 Bloor Street West 📍 Toronto, Ontario 📍 M8X 1B5 📞 416-766-7227

DECLARATION AND CONSENT TO TREATMENT

This is to acknowledge that I understand that:

- 1) Any treatment or advice provided to me as a client of Mary-Ellen Kelly or Soo-Jung Han, Doctors of Naturopathic Medicine is not mutually exclusive from any treatment or advice that I may now be receiving or may receive in the future from another licensed health care provider.
- 2) I am at liberty to seek or continue medical care from a medical doctor or other health care provider licensed to practice in Ontario.
- 3) The practitioners in this health care centre are Naturopathic or Chiropractic Doctors and are not medical doctors.
- 4) Treatments are non-invasive, natural methods, which have a proven clinical foundation, yet may not be accepted practice by standard allopathic medicine.
- 5) I have received an explanation of the treatment and/or services that I will receive at this office and hereby authorize and consent to treatment by Mary-Ellen Kelly, N.D. or Soo-Jung Han, N.D.
- 6) The ultimate responsibility for my health is my own and the clinic is here to support me in this. The clinic reserves the right to discontinue services should my expectations and what is provided be found to be incongruous.
- 7) I agree to pay my full account at the time of each visit or treatment, including fee for services, cost of supplements, cost of laboratory tests and other fees.
- 8) 24 - hour notice is required for appointment cancellation, otherwise a \$ 30.00 fee applies. No shows will be charged the full visit fee.
- 9) With my prior consent, I agree to sharing of my medical information on as an needed basis between Mary-Ellen Kelly, N.D. and Soo-Jung Han, N.D. who may confer to provide the best possible treatment.

Dated this _____ day of _____, 20 _____.

Client's Signature: _____

Print Client's Name: _____