Complete Balance Health Centre
2862 Lakeshore Blvd W - 2nd Floor
Etobicoke, ON, M8V 1H9
(416) 769-1163

First Name				**Last Name**			
Address				**City**		**Postal Code**	
DOB / Age				**Occupation**			
H Telephone		**Cell**			**W Telephone**		
Email							

Physician: _____ **Address:** _____ **Phone:** _____
Employer: _____ **Hours per week** _____
How did you hear about us? ☐ **Friend** ☐ **Internet** ☐**Signage Other:** _____
Name of Guardian if Applicable: _____
Emergency Contact: _____ **Relation:** _____ **Phone:** _____
Height: _____ **Weight:** _____

Have you received the following services before?

☐ massage therapy ☐ naturopathy ☐ orthotics
☐ chiropractic ☐ foot care ☐ psychotherapy

Lifestyle:
Special Interest:_____ Sports:_____
Hobbies:_____ Number of Hours per Week: _____

☐ Coffee ☐No ☐Yes _____ cups/day
☐ Tea ☐No ☐Yes _____ cups/day
☐ Cigarettes ☐No ☐Yes _____ x/day
☐ Alcohol ☐No ☐Yes _____ x/week
☐ Exercise ☐No ☐Yes _____ x/week
☐ Recreational drugs ☐No ☐Yes _____ x/week

What type of exercise:_____
_____
Do you have trouble falling sleep? ☐No ☐Yes
Staying asleep? ☐No ☐Yes
Do you wake up feeling rested? ☐No ☐Yes
How many hours do you sleep a night? _____

Do you have any dietary restrictions? e.g. religious, vegetarian/vegan, etc.

_____

What do you usually eat on a typical day? (foods and drinks)

_____

_____

_____

What level of energy are you currently experiencing on average during a day? _____ /10. (1=lowest; 10=highest)

Primary Health Concerns

1. Please describe your primary concern(s) for seeking health care. Include when the symptoms began.

2. If you have seen other practitioners for these concerns, indicate the results of these evaluations/treatments.

3. What habits, activities or attitudes do you consider to have contributed to any of your concerns?

Health Goals

List your current health goals in order of importance.

1. _____

2. _____

3. _____

Any foreseeable obstacles that will get in the way of following a treatment plan in order to achieve results?

_____

_____

_____

What is your level of commitment to improving your health? _____ out of 10. (1=lowest; 10=highest)

Medical History

1. **Please check all illnesses or diagnosis you have had in the past along with the date.**

Illness	Year
● AIDS/Positive HIV	_____
● Addiction (drug/alcohol)	_____
● Allergies	_____
● Anemia	_____
● Arthritis	_____
● Asthma	_____
● Cancer	_____
● Colitis	_____
● Convulsions/Seizures	_____
● Crohn's disease or Inflammatory bowel disease	_____
● Depression	_____
● Diabetes	_____
● Digestive disease	_____
● Eating Disorder	_____
● Eczema/Psoriasis	_____
● Emphysema	_____
● Endometriosis/Fibroid	_____
● Heart Disease	_____
● Heart Murmur	_____
● Herpes/Shingles	_____
● Hepatitis	_____
● High Blood Pressure	_____

Illness	Year
● High Cholesterol	_____
● Kidney/Bladder Disease	_____
● Lupus	_____
● Mental Illness	_____
● Migraine Headaches	_____
● Mononucleosis	_____
● Pap test, abnormal	_____
● Pneumonia	_____
● Polio	_____
● Rheumatic Fever	_____
● Scleroderma	_____
● Sinus problems	_____
● STD	_____
● Stomach/Duodenal Ulcer	_____
● Stroke	_____
● Thyroid condition	_____
● Tuberculosis	_____
● Ulcer	_____
● Urinary Tract Infections	_____
● Vaginitis	_____
● Other _____	_____

2. **Family Illnesses:**

Illness	Relationship	Illness	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Please list **all** prescribed and over-the-counter medications, vitamins, minerals, herbs, and homeopathic remedies, which you are **presently** using. You must include the dose, brand, and ingredients particularly for the natural supplements.

Medications	**Natural Supplements**
_____	_____
_____	_____
_____	_____
_____	_____

5. Any specialized tests or recent laboratory work that you have had (xray, MRI, CT scan, ECG, colonoscopy, mammogram, blood work etc.)

_____
_____
_____

6. Please list any hospitalizations, surgeries, or injuries. Please include the reason, date, and the outcome.

_____
_____

7. Allergies / Intolerances? □ Yes □ No

Yes, list any allergies to foods, drugs, inhalants, environment or other substances:

_____

8. Do you have children? If so, please list their names and current ages:

9. Last menstrual date: _____ Last PAP date: _____

History of birth control pill: If yes, include approximate start and end date: _____

Naturopathic Medicine Informed Consent

Naturopathic medicine is the treatment and prevention of diseases by natural means. Both modalities assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. **Please note**: **Your initial appointment may ONLY be for one of these modalities, however, future treatment may involve integration of the two. You are NOT required to consent to both, and you have the option to decline either treatment on the next page where a blank space is provided.**

Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. A number of different approaches are used. Diet and nutritional supplements, botanical medicine, hands-on therapy, oriental medicine and acupuncture, homeopathy, and lifestyle counseling are recommended and combined when indicated.

- **Individual Diets and Nutritional Supplements** are recommended to address deficiencies, treat disease processes and promote health.
- **Botanical Medicine** is the use of herbal teas, tinctures, capsules and other forms of herbal preparations.
- **Physical Medicine** refers to the use of hands-on techniques for the purpose of treating musculoskeletal and neurological problems.
- **Traditional Chinese Medicine** includes acupuncture, as well as the use of Chinese-based botanical formulas and dietary changes to balance body functions. Acupuncture refers to the insertion of sterilized needles through the skin at specific points on the surface of the body. Dietary advice is based on Traditional Chinese medical theory.
- **Homeopathy** is a form of medicine based on the law of similars - that is the use of minute doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal or mineral origin are used to stimulate the body's ability to heal itself.
- **Lifestyle** is considered relevant to most health problems. Risk factors will be identified and recommendations made to help you optimize your physical, mental and emotional environment.

Even the gentlest therapies have their complications, especially in certain physiological conditions such as pregnancy and lactation, or in very young children. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform your Naturopathic Doctor of any disease process that you are suffering from, as well as any medications (prescription and over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant or you are breast-feeding, advise your Naturopathic Doctor immediately.

There are some health risks to treatment by Naturopathic Medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms;
- Allergic reactions to supplements or herbs;
- Pain, bruising or injury from acupuncture;
- Fainting or puncturing of an organ with acupuncture needles.

I, _____ (print name), understand that a record will be kept of the health services provided to me. I understand that I may look at my record at any time and can request a copy of it. My record will be kept confidential and will not be released to others unless so directed by myself or my representative, or unless it is required by law, or for the purpose of fulfilling the regulatory body's mandate. I understand that if I am undergoing care with other practitioners at Complete Balance Health Centre information from my record may be shared and/or discussed between practitioners to coordinate optimal care, unless otherwise advised.

I have read the above information and with this knowledge, I voluntarily consent to the diagnostic and treatment procedures mentioned above, except for: (please list exceptions)

_____

Please read the following and check/initial in the space provided:

1. ____I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent unless required by law.
2. I understand that the Naturopathic Doctor will answer my questions to the best of her ability. I understand that results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all the risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions on the back)
3. I understand that I am at liberty to seek or continue to seek medical care from other health care providers who are qualified to practice in Ontario.
4. I understand that my credit card details will be stored for processing payments. Payment processing partners have been very carefully chosen.
5. I understand that fees and supplements are to be paid for at the time of consultation.
6. I understand that I will be **charged in 50%** for any missed appointments, unless I have advised the office of a cancellation no **less than forty-eight (48) hours**. Cancellations will not be accepted on weekends.
7. I am aware that the fees for naturopathic treatment are not covered by OHIP and that it is my responsibility to confirm whether any company that provides me with private health insurance will reimburse me for the cost of such naturopathic treatments.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Date: _____

Patient Name (please print): _____

Signature of Patient (or Guardian): _____

Signature of Naturopathic Doctor: _____