Linda Shih Naturopathic
Healing. Wellness. Life.

Holly Chiropractic & Wellness
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General Information

Date:		
Dr./Mr./Mrs./Ms. (*circle one*) Last Name:		First Name:
Date of Birth:___/____/____ (dd/mm/yy) Gender: M___F____ Occupation: _____________________		

Email Address:		
Address:	City:	Prov:
Postal Code:		
Tel#:	Cell#:	Work #:
Where would you like us to leave you a message?		
Emergency contact:	Tel#:	Relation:
How did you hear about our clinic?		
Whom may we thank for referring you (if applicable)?		

Family Doctor:		Tel#:
Other health care providers:	Occupation	Tel#:
Other health care providers:	Occupation	Tel#:
Other health care providers:	Occupation	Tel#:

Current Medical Information

Please list your health concerns you want to address

PRIORITY	HEALTH CONCERN	DURATION OF CONDITION

Are they getting better, worse or staying the same?:
____

Do you have any of the following: (circle Yes or No)

Cancer/Tumor	Yes/No	Circulatory problems	Yes/No	Headaches	Yes/No
Seizures	Yes/No	High Blood pressure	Yes/No	Dizziness	Yes/No
Kidney problems	Yes/No	Skin/Hair problems	Yes/No	Fever	Yes/No
Allergies	Yes/No	Respiratory problems	Yes/No	Night pain	Yes/No
Digestive problems	Yes/No	Fractures	Yes/No	Night sweat	Yes/No
Arch Support	Yes/No	Back support	Yes/No	Osteoporosis	Yes/No
Diabetes	Yes/No	Pain	Yes/No	Blood borne illness	Yes/No

Immunizations

Check any immunizations you have had

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis B
☐ Tetanus booster; when?	☐ "Flu"	☐ Hepatitis A
☐ MMR (measles, mumps, rubella)	☐ Polio	☐ Smallpox

Other_______________

Have you had any operations/surgeries? If so describe _____________________________________

Have you had X-Ray taken? What are the results ____

What are the most significant measures which you have taken to date, to improve your state of health?

____

____

____

Have you ever had Naturopathic care in the past?
Where did you receive care?:
When?:
By Whom?:
For What?:

If you have allergies or medical conditions please list:____

____

____

Current Medications: Please list all prescribed/over the counter medications that you are currently taking.

NAME/BRAND	DOSE	FOR WHAT CONDITION?	SINCE WHEN?

How many times have you been treated with antibiotics? ___________________________

Natural Health Products: Please list all supplements, botanicals, homeopathics etc that you are currently taking

NAME/BRAND	DOSE	FOR WHAT CONDITION?	SINCE WHEN?

Lifestyle

Do you ingest or use the following:

	FORM	FREQUENCY	AMOUNT
Alcohol			
Tobacco			
Caffeine			
Recreational Drugs			

Do you exercise? If so, what do you do for exercise, how much, how often?______________________________

____

Environment

HOBBIES:
Do you have exposure to: • Smoke?: • Animals?: • Toxins or hazards?:

List your sources of stress:

Family History

List your family history:

Use this list as a reference: Heart disease; hypertension (high blood pressure); diabetes/blood sugar problems; asthma; allergies; kidney problems (stones etc.); digestive problems (Crohn's, Ulcerative colitis, Celiac's, IBS, lactose intolerance, etc); Neurological problems (MS, Parkinson's, Alzheimer's); Arthritis; Hormonal problems (thyroid, pituitary, estrogen, testosterone, cortisol, etc.); Congenital (birth) defects/developmental; Psychiatric problems (depression, anxiety, addiction, etc); cancer; other

FAMILY MEMBER	AGE IF ALIVE	AGE AT DEATH	AILMENTS
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Children			
Siblings			

For Women Only

Are you (possibly) pregnant? Yes/No
What contraception do you use (if any):
Date onset of last menstruation (MM/DD/YYYY):
Length of periods:
Length of cycle:
Number of pregnancies:
Number of children:

Describe your periods if applicable (pain, breast tenderness, clotting, headaches, emotional symptoms etc.):

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____

____

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Informed consent to Naturopathic Treatment

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors (NDs) assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non invasive techniques are generally used in order to stimulate the body's inherent healing capacity. NDs use a variety of therapeutic approaches, either alone or in combination. These include nutritional and lifestyle counseling, nutritional supplementation, Asian medicine and acupuncture, botanical medicine, homeopathy and physical medicine.

Your ND will take a thorough case history and physical examination as required by the licensing board. It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your ND immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

There are some rare health risks associated with treatment by naturopathic medicine:

These include but are not limited to:

- Some patients experience allergic reactions to certain supplements and herbs. Please advise your ND of any allergies you may have.
- Even the gentlest therapies may have complication in certain physiological conditions such as pregnancy, lactation, in patients who are very young or old, or in people taking medications. In addition, some therapies must be used with caution in certain diseases including but not limited to diabetes, lung, hear, liver or kidney disease.
- Pain, bruising, or injury from injections or acupuncture.
- Fainting, or puncturing of an organ with acupuncture needles.
- Muscle strains and sprains from soft tissue work. There is also risk of disc injuries from spinal manipulation. There is also a small potential for stroke in neck manipulation.
- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms.

I declare that I have received a full and complete explanation of the treatment or services that I may receive at Holly Meadows Chiropractic Clinic by the Naturopathic Doctor, and hereby authorize and consent to treatment to her. I intend this consent to apply to all my present and future naturopathic care.

I also understand that I am fully responsible for the relevant fees for all naturopathic services, lab tests and products.

By signing, I acknowledge that I have read and understood the risks of naturopathic medicine. Also I acknowledge that I am responsible for all fees associated with the naturopathic services and remedies.

____

Signature of Patient

____

Name of Patient printed

____

Date Signed