Touchstone Naturopathic Centre
Nutritional Consultation Intake Form

Please note that this office is an allergy free zone. Please do not wear any scented products, as many of our patients as well as staff members are chemically sensitive. These include lotions, cologne, perfume, hair spray, and also applies to products made with natural essential oils.

As well, please DO NOT bring any highly allergenic foods, e.g. <u>peanuts,</u> into the office.

To provide you with the best possible nutritional advice, it is important for the nutritionist to have a thorough understanding of your health concerns and of the physical, mental, and emotional factors that impact your health, as well as a thorough understanding of your past and current eating habits. Please take the time to carefully and thoroughly complete this health history questionnaire.

Patient Profile

Date: _____

Name: _____ Age___ Date of Birth: _____ Sex: _____
Last Name / Given Name(s) Month/Day/Year

Address: _____ City: _____ Postal Code: _____

Contact in case of Emergency: _____

Home tel #: _____ Other tel #: _____

How did you hear about our clinic? _____

Home tel #: _____ Work tel #: _____

Cell #: _____ E-mail: _____

Occupation: _____ Employer: _____

Emergency contact: _____ Tel #: _____

Relationship to you: _____

Name of family doctor: _____

Address: _____

What other health care are you presently receiving? _____

How did you hear about our clinic? _____

PRIMARY HEALTH CONCERNS

Please list your most important health concerns, in order of importance to you.

1. _____ 2. _____

3. _____ 4. _____

What goals do you have for your health care at this time? (symptom relief, achieving optimal health)

PRIOR TREATMENTS AND RESPONSE
Regarding your primary health concerns, please list all former treatments you have used, both conventional and alternative, and the degree of effectiveness of each treatment.

CURRENT MEDICATIONS AND SUPPLEMENTS
Please list any prescription medications (including hormonal drugs and birth control pills), over-the-counter medications, and nutritional or herbal supplements that you are currently using (including liquids, ointments, suppositories, etc.):

Medication / Supplement	Dosage	Medication / Supplement	**Dosage**

Do you have any medical devices / prosthetics / implants (specify): _____

When was the last time you consulted a doctor and for what reason? _____

When was your last complete physical exam: _____

When was your most recent lab/blood work performed? _____

Please indicate how often you use or consume the following:

	Frequency (per day, month, or week)		Frequency (per day, month, or week)
Cigarettes		Alcohol	
Pain medication		Recreational drugs	
Antibiotics		Diet pills	
Antacids		Laxatives	
Coffee		Tea	

ALLERGIES: List any allergies/sensitivities you have to:

Drugs: _____

Foods: _____

Environmental/Other: _____

What happens (symptoms) when you have an allergy attack? _____

CHILDHOOD HEALTH

Health as a child (please X): Good _____ Fair _____ Poor _____

What childhood illnesses have you had?

Rubella ____ Measles ____ Mumps ____ Chickenpox ____ Whooping cough ____
Polio ____ Roseola ____ Asthma ____ Scarlet fever ____ Rheumatic fever ____

Other: _____

IMMUNIZATION HISTORY

Please indicate which vaccines you have received:

DTP (diphtheria, pertussis, tetanus) ____ Polio ____ Tetanus; when? _____

MMR (measles, mumps, rubella) ____ Hepatitis A ____ Hepatitis B _____

Influenza ____ Other: _____

Any adverse reactions? _____

DIETARY HISTORY

Please list in details everything you typically eat for breakfast, lunch and dinner on an average day (include also a typical weekend day). If you have recently changed your eating habits, please indicate "current" or "past" next to food items. Please include all snacks, fruits, vegetables, and any drinks. Be honest with yourself when you answer – the information is only helpful if you are honest.

Breakfasts: _____

_____

_____

_____

_____

Lunches: _____

_____

_____

_____

Dinners: _____

_____

_____

_____

Snacks: _____

_____

_____

Do you have any favorite foods or foods that you crave often? _____

_____

_____

_____

List any foods that you react adversely to (or know you are allergic to): _____

_____

_____

_____

Do you have any foods that you dislike and would never consider to eat? Please include any Religious dietary restrictions. _____

_____

_____

_____

_____

FAMILY HISTORY:

	Father	Mother	Brothers	Sisters	Spouse	Child	Other
Age (if living)							
Age (at death)							
Cause of Death							
Health (**G=good, P=poor**)							
Check those applicable:							
Alcoholism							
Anemia							
Arthritis							
Asthma / hayfever / hives							
Bleeding tendency							
Cancer							
Colitis							
Diabetes							
Epilepsy							
Glaucoma							
Heart disease							
High blood pressure							
Kidney disease							
Mental illness							
Migraines							
STD's							
Stroke							
Tuberculosis							
Other							

DIET AND LIFESTYLE

How much sleep do you average a day? _____ Do you: sleep well? _____ Wake rested? _____
How many meals do you eat in a day? _____ How much liquid do you consume a day? _____
Do you follow any particular diet regimens or restrictions? _____

_____

Are you satisfied with your diet? _____
Do you exercise regularly? _____ If yes, what do you do? How often? _____
How would you describe the emotional climate of your home? _____

_____

How stressful is work or other aspects of your life? _____
How well do you handle stress? _____
What do you do in your spare time? What are your hobbies? _____

ENVIRONMENT

Where do you live? Apartment _____ House _____ Type of heating used? _____
How old is your home? _____ How long have you lived there? _____
Have you done any home renovations recently? _____
Who do you live with? _____
Are you frequently exposed to animals? _____
Are you frequently exposed to toxins, chemicals, or hazards (work, home,hobbies, etc.)? _____
Please describe _____
Have you traveled outside of Canada in the past year? If yes, where? _____

Review of Systems

Daily or Frequent	Sometimes or Occasional	Past		Daily or Frequent	Sometimes or Occasional	Past	
			GENERAL				**EARS**
❑	❑	❑	Fatigue, lack of energy	❑	❑	❑	Impaired hearing
❑	❑	❑	Fever, chills	❑	❑	❑	Discharge or wax
❑	❑	❑	Difficulty falling asleep	❑	❑	❑	Earaches
❑	❑	❑	Disturbed sleep	❑	❑	❑	Frequent ear infections
❑	❑	❑	Vivid dreams	❑	❑	❑	Ringing in the ears
❑	❑	❑	Frequent infections				**NOSE / SINUSES**
❑	❑	❑	Recent weight gain/loss of: _____	❑	❑	❑	Frequent colds
❑	❑	❑	Height _____	❑	❑	❑	Discharge
❑	❑	❑	Weight _____	❑	❑	❑	Sneezing
❑	❑	❑	Weight 1 year ago _____	❑	❑	❑	Stuffiness
❑	❑	❑	Maximum weight _____When? ____	❑	❑	❑	Nosebleeds
			SKIN / HAIR / NAILS	❑	❑	❑	Sinusitis
❑	❑	❑	Dryness/Cracking	❑	❑	❑	Polyps
❑	❑	❑	Itching; where? _____	❑	❑	❑	Loss of smell
❑	❑	❑	Rashes				**EYES**
❑	❑	❑	Eczema, hives	❑	❑	❑	Poor eyesight (near or far)
❑	❑	❑	Acne	❑	❑	❑	Use of corrective glasses/contacts
❑	❑	❑	Boils	❑	❑	❑	Eye pain
❑	❑	❑	Warts, moles, cysts (circle); any change in size/color recently? _____	❑	❑	❑	Tearing or dryness (circle)
❑	❑	❑	Psoriasis	❑	❑	❑	Redness
❑	❑	❑	Dandruff	❑	❑	❑	Itching
❑	❑	❑	Areas of pigmented/depigmented skin	❑	❑	❑	Blurred vision
❑	❑	❑	Weak, brittle nails	❑	❑	❑	Sensitive to light
❑	❑	❑	Ridges, pits, or spots on nails	❑	❑	❑	Cataracts
❑	❑	❑	Fungal infection of nails	❑	❑	❑	Glaucoma
❑	❑	❑	Loss of hair; where? _____	❑	❑	❑	Frequent conjunctivitis/styes
❑	❑	❑	Increased facial or body hair	❑	❑	❑	Spots in front of eyes
❑	❑	❑	Wounds slow to heal	❑	❑	❑	Dark circles under eyes
			HEAD / NEUROLOGIC				**MOUTH / THROAT**
❑	❑	❑	Headaches	❑	❑	❑	Frequent sore throat
❑	❑	❑	Migraines	❑	❑	❑	Hoarseness, loss of voice
❑	❑	❑	Pain in jaw	❑	❑	❑	Phlegm
❑	❑	❑	Dizziness	❑	❑	❑	Drainage to back of throat
❑	❑	❑	Seizures or convulsions	❑	❑	❑	Cold sores
❑	❑	❑	Fainting spells	❑	❑	❑	Canker sores
❑	❑	❑	Difficulty with concentrating or maintaining attention	❑	❑	❑	Swollen / tender / bleeding tongue or gums
❑	❑	❑	Poor memory, loss of memory	❑	❑	❑	Dental cavities / root canal
❑	❑	❑	Learning difficulties, dyslexia	❑	❑	❑	Sensitivity to hot/cold
❑	❑	❑	Involuntary movement	❑	❑	❑	Grinding teeth

NECK

- ❑ ❑ ❑ Lumps
- ❑ ❑ ❑ Swollen lymph nodes
- ❑ ❑ ❑ Pain or stiffness

RESPIRATORY

- ❑ ❑ ❑ Cough
- ❑ ❑ ❑ Phlegm (between colds); color: _____
- ❑ ❑ ❑ Spitting up blood
- ❑ ❑ ❑ Wheezing
- ❑ ❑ ❑ Shortness of breath
- ❑ ❑ ❑ Difficulty breathing: with exertion
- ❑ ❑ ❑ " " lying down
- ❑ ❑ ❑ " " during sleep
- ❑ ❑ ❑ Asthma
- ❑ ❑ ❑ Bronchitis
- ❑ ❑ ❑ Pneumonia
- ❑ ❑ ❑ Emphysema

CARDIOVASCULAR

- ❑ ❑ ❑ Heart disease
- ❑ ❑ ❑ Pain in chest
- ❑ ❑ ❑ Irregular heart beat
- ❑ ❑ ❑ Palpitations
- ❑ ❑ ❑ Murmurs
- ❑ ❑ ❑ High blood pressure
- ❑ ❑ ❑ High cholesterol or triglycerides
- ❑ ❑ ❑ Rheumatic fever

GASTROINTESTINAL

- ❑ ❑ ❑ Lack of appetite
- ❑ ❑ ❑ Difficulty swallowing
- ❑ ❑ ❑ Indigestion
- ❑ ❑ ❑ Heartburn
- ❑ ❑ ❑ Belching or passing gas
- ❑ ❑ ❑ Bloating after eating
- ❑ ❑ ❑ Nausea
- ❑ ❑ ❑ Vomiting
- ❑ ❑ ❑ Vomiting blood
- ❑ ❑ ❑ Ulcer
- ❑ ❑ ❑ Abdominal pain
- ❑ ❑ ❑ Constipation
- ❑ ❑ ❑ Diarrhea or loose stools
- ❑ ❑ ❑ Loss of bowel control
- ❑ ❑ ❑ Hemorrhoids
- ❑ ❑ ❑ Rectal bleeding
- ❑ ❑ ❑ Anal itching
- ❑ ❑ ❑ Liver disease or Gall bladder disease
- ❑ ❑ ❑ Bowel movements; how often?_____
- ❑ ❑ ❑ Stool floats or breaks up in water
- ❑ ❑ ❑ Malodorous or smelly gas / stools
- ❑ ❑ ❑ Black or tarry stools
- ❑ ❑ ❑ Color of stools: _____

URINARY

- ❑ ❑ ❑ Pain or burning on urination
- ❑ ❑ ❑ Increased frequency
- ❑ ❑ ❑ Urinate large amount of clear liquid
- ❑ ❑ ❑ Dark or concentrated urine
- ❑ ❑ ❑ Frequency at night; get up at night ____ times to urinate
- ❑ ❑ ❑ Unable to hold urine or incontinence
- ❑ ❑ ❑ Difficulty passing urine, dribbling
- ❑ ❑ ❑ Frequent infections
- ❑ ❑ ❑ Kidney stones
- ❑ ❑ ❑ Blood in urine

MUSCULOSKELETAL

- ❑ ❑ ❑ Arthritis
- ❑ ❑ ❑ Back pain
- ❑ ❑ ❑ Pain / swelling / limited motion in joint or muscle; Where? _____
- ❑ ❑ ❑ Joint pain which moves from one area to another
- ❑ ❑ ❑ Muscle cramps or spasms

CIRCULATION

- ❑ ❑ ❑ Cold hands/feet
- ❑ ❑ ❑ Varicose veins
- ❑ ❑ ❑ Deep leg pain
- ❑ ❑ ❑ Leg cramps
- ❑ ❑ ❑ Numbness, tingling, coldness, or swelling in extremities (circle)
- ❑ ❑ ❑ Leg ulcer
- ❑ ❑ ❑ Pain in leg with walking

BLOOD / LYMPHATIC

- ❑ ❑ ❑ Anemia
- ❑ ❑ ❑ Easy bleeding or bruising
- ❑ ❑ ❑ Slow healing of wounds
- ❑ ❑ ❑ Lymph node swelling

ENDOCRINE

- ❑ ❑ ❑ Heat or cold intolerance (circle)
- ❑ ❑ ❑ Increased thirst
- ❑ ❑ ❑ Increased hunger
- ❑ ❑ ❑ Increased sweating
- ❑ ❑ ❑ Night sweats
- ❑ ❑ ❑ Hot flashes, flushing of skin
- ❑ ❑ ❑ Diabetes
- ❑ ❑ ❑ Thyroid condition
- ❑ ❑ ❑ Hypoglycemia

MALE REPRODUCTIVE

- ❑ ❑ ❑ Swelling, lumps, pain in testicles
- ❑ ❑ ❑ Discharge or growth on penis
- ❑ ❑ ❑ Difficulty with erection or ejaculation
- ❑ ❑ ❑ Lack of sex drive
- ❑ ❑ ❑ Infertility
- ❑ ❑ ❑ Venereal disease
- ❑ ❑ ❑ Problems with prostate gland
- ❑ ❑ ❑ Hernia
- ❑ ❑ ❑ Are you sexually active?

			FEMALE REPRODUCTIVE				FEMALE REPRODUCTIVE
			Age of first period: _____	❑	❑	❑	Pain during intercourse
			Length of period: _____	❑	❑	❑	Lack of sexual arousal
			Length of cycle: _____	❑	❑	❑	Breast pain or tenderness
❑	❑	❑	Bleeding between periods	❑	❑	❑	Breast lumps
❑	❑	❑	Irregular cycles	❑	❑	❑	Nipple discharge
❑	❑	❑	Painful menses	❑	❑	❑	Do you do self breast exams?
❑	❑	❑	Heavy menstrual flow	❑	❑	❑	Number of pregnancies _____
❑	❑	❑	Menstrual clots	❑	❑	❑	Number of live births _____
			Last menstrual period _____	❑	❑	❑	Number of miscarriages _____
			Last PAP smear _____	❑	❑	❑	Number of abortions _____
❑	❑	❑	Premenstrual syndrome	❑	❑	❑	Difficulty conceiving
❑	❑	❑	Cramping before periods	❑	❑	❑	Are you sexually active?
❑	❑	❑	Food craving before periods	❑	❑	❑	Birth control; type _____
❑	❑	❑	Mood swings before periods				**EMOTIONAL**
❑	❑	❑	Bloating before periods	❑	❑	❑	Anxiety, nervousness
❑	❑	❑	Fatigue before periods	❑	❑	❑	Irritability, restlessness
❑	❑	❑	Migraines with or before periods	❑	❑	❑	Depression
❑	❑	❑	Mood swings or depressed moods before periods	❑	❑	❑	Mood swings
❑	❑	❑	Vaginal itching/burning	❑	❑	❑	Experience indifference
❑	❑	❑	Vaginal discharge	❑	❑	❑	Alcohol/drug abuse
❑	❑	❑	Yeast infections	❑	❑	❑	Stress, tension
❑	❑	❑	Venereal disease	❑	❑	❑	Mood swings
❑	❑	❑	Pelvic pain	❑	❑	❑	Experience indifference
❑	❑	❑	Ovarian disease	❑	❑	❑	Alcohol/drug abuse
❑	❑	❑	Uterine fibroids	❑	❑	❑	Stress, tension

Is there anything else you would like us to know?

_____

_____

_____

_____

_____

_____

_____

Thank you for your time and co-operation.

Touchstone Naturopathic Centre

Consent for Personal Information:

I, the undersigned, understand that to provide me/the patient with the goods and services of naturopathic medicine, Touchstone Naturopathic Centre will collect some personal information about me/the patient (e.g. name, telephone numbers, address, age, gender, etc.).

I have reviewed (or been offered to review) the Privacy Policy of Touchstone Naturopathic Centre about the collection, use and disclosure of personal information, steps taken to protect the information, and my right to review my/the patient's personal information. I understand how the Privacy Policy applies to me/the patient. I have been given a chance to ask questions that I have about the Privacy Policy, and they have been answered to my satisfaction.

I authorize Touchstone Naturopathic Centre to contact me (periodically) for the following purposes – including but not limited to:

- notices or reminder calls of upcoming appointments/treatments **(*please note:* reminder calls are offered as a courtesy when time permits).** It is my responsibility to maintain a schedule of appointments and to contact Touchstone Naturopathic Centre if changes and/or cancellations are required. If I am not contacted, this does not imply that my appointment has been cancelled or changed. **(Please refer to the Schedule of Fees for more detail on late/cancellation fees).**
- newsletters and other information mailings from this Centre
- notice of promotions and special offers from this Centre
- updates/mailings by electronic mail. (This approach is not currently recommended, and it is advised that you do not reply to any electronic mail communications from this Centre until such time that you are advised that encryption software is in use).

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

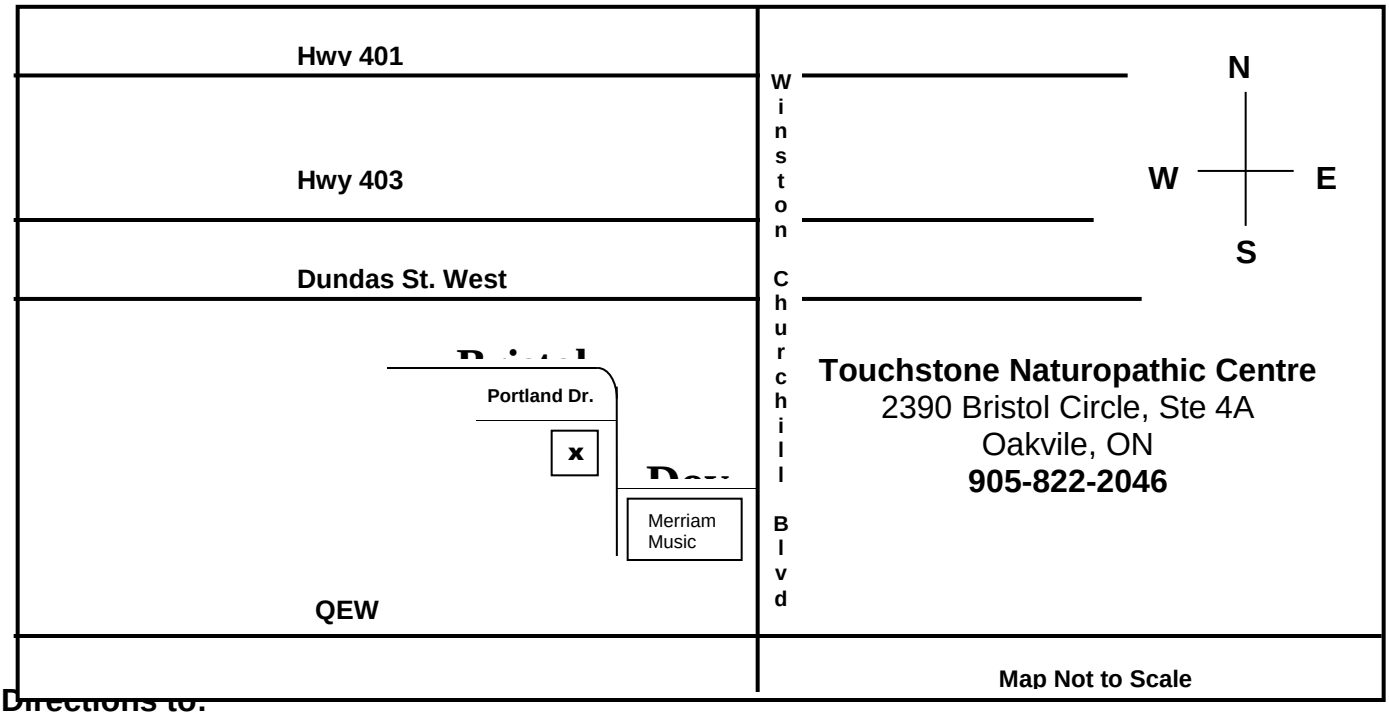
I agree to Touchstone Naturopathic Centre collecting, using and disclosing personal information about me/the patient as set out in Touchstone Naturopathic Centre's Privacy Policy and as outlined above.

_____
Patient Name If Minor

_____ _____
Patient/Guardian Signature Date

_____ _____
Printed Name Relationship To Minor

Please be aware that if you wish to change your informed consent at any time, you may ask for a form entitled, Change to Informed Consent.



Directions to:

Touchstone Naturopathic Centre 2390 Bristol Circle Ste 4A, Oakville, ON L6H 6M5

We are in the office complex that the Sunset Grill sign is on

From Toronto, via QEW:

- **Westbound** QEW – exit at Winston Churchill Blvd. **(north)**
- turn **right** onto Winston Churchill Blvd
- turn **left** onto Dover Gate at (stop light) (Merriam Music Store is on this street)
- turn **right** at stop sign onto Bristol Circle
- turn l**eft** onto Portland Dr. and **left** into parking lot

From Toronto via 401/403:

- **Westbound** 401/403 – exit at Winston Churchill Blvd. **(south)**
- continue **south** past Dundas St.
- turn **right** onto Dover Gate (stop Light) (Merriam Music Store is on this street)
- turn **right at stop sign** onto Bristol Circle
- turn l**eft** onto Portland Dr. and left into parking lot

From Hamilton/Burlington/Oakville via QEW:

- **Eastbound** QEW - exit at Winston Churchill Blvd. **(north)**
- turn **left** onto Winston Churchill Blvd
- turn **left** onto Dover Gate at (stop light) (Merriam Music Store is on this street)
- turn **right** at stop sign onto Bristol Circle
- turn l**eft** onto Portland Dr. and **left** into parking lot

From London/Kitchener/Waterloo/Guelph via 401/403:

- **Eastbound** 401/403 – exit at Winston Churchill Blvd. **(south)**
- continue **south** past Dundas St.
- turn **right** onto DoverGate (stop Light) (Merriam Music Store is on this street)
- turn **right at stop sign** onto Bristol Circle
- turn l**eft** onto Portland Dr. and left into parking lot