



CONTACT INFORMATION

Last Name: _____ First Name: _____ Initial: _____

Date of Birth: _____ Age: _____

Sex: Male Female Ethnicity: _____

Occupation: _____

Marital Status: _____ No. of Dependents: _____

Address: _____ Apt. # _____

City: _____ Province: _____

Postal Code: _____ Email: _____

Telephone: (home) _____ (work) _____

Telephone: (cell) _____ (other) _____

Preferred form of contact for reminder/follow-up calls:

Home Work Email Other – Please specify _____

Emergency Contact Name: _____

Relation: _____ Telephone: _____

Name of Medical Doctor: _____

Address: _____

City: _____ Telephone: _____

How did you hear of pureBalance Wellness Centre? _____

Were you referred to us, if so by whom? _____



ACKNOWLEDGEMENT AND INFORMED CONSENT

I would like to take this opportunity to welcome you. This health clinic utilizes the principles of naturopathic medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means. I will conduct a detailed case history, conduct a physical exam and may utilize specific blood and/or urinary laboratory reports as part of the treatment work-up. Some treatments or procedures may include: nutrition, herbs, homeopathy, acupuncture, naturopathic manipulation, hydrotherapy, lifestyle counseling.

All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

As a patient of this clinic I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I also 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 unless so directed by myself or unless it is required by law. I also recognize the potential risks that include, but are not limited to: aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain, fainting or bruising from venipuncture or acupuncture, muscle strains and sprains from spinal manipulations, inconvenience of lifestyle changes.

In order to comply with the regulations as set out in the Personal Information Protection and Electronic Documents Act (PIPEDA), the following policy has been developed. All health care professionals are all trained in the appropriate uses and protection of your information.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial, or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

Full Name (please print): _____

Signature: _____ Date: _____

Witness _____ Date: _____

Print parent/guardian's name _____

Signature of parent/guardian _____



ADULT / CHILD INTAKE FORM

Please fill out this form to the best of your ability. It will help to assess your present health and will assist in facilitating the healing process.

Last Name: _____ First Name: _____ Initial: _____

Preferred Name: _____

Age: _____ Height: _____ Weight: _____

Max Weight: _____ When? _____

What are your chief concerns?

- 1.
- 2.
- 3.

Describe your general overall state of health at present in less than 5 words:

List all prescribed medications currently taken, and include dose, frequency, and how long you have been taking them.

- 1.
- 2.
- 3.

List any medication allergies (for example penicillin)

List all over the counter medications that you take (for example aspirin, Tums, Tylenol) and include dose and frequency.

How many courses of antibiotics have you been on in the last 5 years? _____

List all vitamins, minerals, herbal medicines, Asian medicines, or homeopathics you are currently taking and include dosage.

Do you use any recreational drugs? If yes, indicate type and frequency of usage.

What type of vaccinations have you received?

Have you ever experienced an adverse reaction to the above vaccinations?

Describe your general state of health as a child.

Describe your general state of health as a teenager. _____

Have any of your family members had any significant illness or health concerns?

Do you have siblings? _____ How many? _____

List any conditions that may apply to your siblings.

List any surgeries and/or hospitalizations.

List any severe accidents or injuries in the past.

What is a typical food/drink day for you?

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

Water:

Do you drink alcohol? If yes, what type, and how often?

Do you smoke? If yes, since when, and how many a day?

Do you exercise? _____ What type? _____

List your hobbies or interests.

What level of personal stress are you experiencing at the present moment?

minimal

average

considerable

unbearable

Top three main stressors in your life?

Please circle 'Y' if you are currently experiencing the condition. Please circle 'P' if you had the condition in the past. Write comments as necessary.

SKIN

Itching	Y	P	
Acne (pimples)	Y	P	
Bruises easily	Y	P	
Hives (allergy)	Y	P	
Eczema	Y	P	
Boils	Y	P	
Dryness	Y	P	
Rosacea	Y	P	
Night sweats	Y	P	
Skin cancer	Y	P	
Change in moles	Y	P	

HEAD

Headaches/migraines	Y	P	
Head injury	Y	P	
Dizziness	Y	P	
Loss of hair	Y	P	

EYES

Glasses/contact lenses	Y	P	
Eye pain	Y	P	
Tearing	Y	P	
Dryness	Y	P	
Double vision	Y	P	
Glaucoma	Y	P	
Cataracts	Y	P	
Blurring	Y	P	
Bothered by sun	Y	P	
Blind spot	Y	P	
Night/colour blindness	Y	P	

EARS

Impaired hearing	Y	P	
Earache	Y	P	
Discharge	Y	P	
Infections	Y	P	
Ringing in ears	Y	P	

NOSE

Frequent colds	Y	P	
Nose bleeds	Y	P	
Stuffiness	Y	P	
Hay fever	Y	P	
Sinus problems/infections	Y	P	

MOUTH AND THROAT

Frequent sore throats	Y	P	
Sore tongue/mouth	Y	P	
Gum problems	Y	P	
Hoarse voice	Y	P	
Loss of taste	Y	P	
Dry mouth	Y	P	

NECK

Pain or stiffness	Y	P	
Enlarged thyroid/glands	Y	P	

RESPIRATORY

Cough	Y	P	
Sputum	Y	P	
Wheezing	Y	P	
Asthma	Y	P	
Bronchitis	Y	P	
Difficulty breathing	Y	P	
Pain on breathing	Y	P	
Shortness of breath	Y	P	
Shortness of breath at night	Y	P	
Shortness of breath lying down	Y	P	

CARDIOVASCULAR

Heart disease	Y	P	
Angina	Y	P	
High blood pressure	Y	P	
Chest pain	Y	P	
Swelling in ankles	Y	P	
Palpitations, fluttering	Y	P	

GASTRO-INTESTINAL

Heartburn	Y	P	
Change in thirst/appetite	Y	P	
Nausea/vomiting	Y	P	
Bowel movements - how often?			
Blood in stool	Y	P	
Belching/passing gas	Y	P	
Jaundice (yellow skin)	Y	P	
Liver/gallbladder disease	Y	P	
Ulcer	Y	P	
Indigestion	Y	P	
Diarrhea/constipation	Y	P	
Hemorrhoids	Y	P	
Intestinal worms	Y	P	

URINARY

Pain on urination	Y	P	
Increased frequency	Y	P	
Inability to hold urine	Y	P	
Frequent urinary infections	Y	P	
Kidney stones	Y	P	
Blood in urine	Y	P	

MALE

Testicular masses/pain	Y	P	
Are you or have you been sexually active?	Yes	No	
Sexual difficulties	Y	P	
Venereal disease	Y	P	
Discharge or sores	Y	P	

FEMALE

Age menses began			
Average number of days of menses			
Average length of cycle			
Bleeding between periods	Y	P	
Irregular cycles	Y	P	
Pain during intercourse	Y	P	
Painful menses	Y	P	
PMS	Y	P	
Excessive flow	Y	P	
Last menstrual period (date)			
Last PAP (date)			
Vaginal discharge	Y	P	
Vaginal itching	Y	P	
Are you or have you been sexually active?	Yes	No	
Difficulty conceiving	Yes	No	
Birth control?	Yes	No	
What type?			
Number of pregnancies			
Number of live births			
Number of miscarriages			
Number of abortions			
Sexual difficulties	Y	P	
Veneral disease	Y	P	
Do you do self breast exams?			
Lumps/pain/discharge	Y	P	

MUSCULOSKELETAL

Joint pain or stiffness	Y	P	
Arthritis	Y	P	
Broken bones	Y	P	
Muscle spasms or cramps	Y	P	
Backache	Y	P	
Foot pain	Y	P	

PERIPHERAL VASCULAR

Deep leg pain	Y	P	
Cold hands/feet	Y	P	
Varicose veins	Y	P	
Extremity numbness/coldness/swelling	Y	P	

NEUROLOGICAL

Fainting	Y	P	
Seizures/convulsions	Y	P	
Paralysis	Y	P	
Loss of memory	Y	P	
Involuntary movement	Y	P	
Loss of balance	Y	P	
Speech problems	Y	P	

ENDOCRINE

Heat intolerance	Y	P	
Cold intolerance	Y	P	
Thyroid abnormalities	Y	P	
Excessive thirst/hunger/urination	Y	P	

ENDOCRINE (con't)

Excessive sweating	Y	P	
Diabetes	Y	P	
Hypoglycemia	Y	P	
Hormone therapy	Y	P	

BLOOD/LYMPHATIC

Anemia	Y	P	
Easy bleeding/bruising	Y	P	
Lymph node swelling	Y	P	

EMOTIONAL

Depression	Y	P	
Mood swings	Y	P	
Anxiety or nervousness or tension	Y	P	
Alcohol/Drug abuse	Y	P	
Insomnia	Y	P	

1. Why did you choose to come to this clinic?

2. What do you know about our approach?

3. What three expectations do you have from this visit to our clinic?

4. What long-term expectations do you have from working with our clinic?

5. What expectations do you have of me personally as your physician?

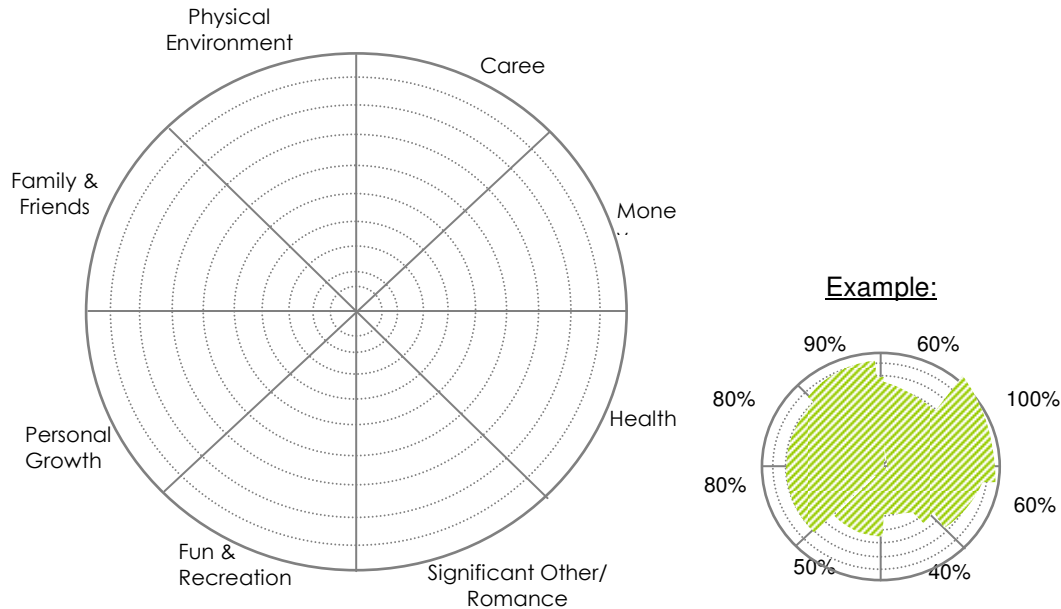
6. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you. For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



7. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

8. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

9. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

10. What do you LOVE to do?