Margaret Prange B.Sc., N.D.
519-885-1231

The following information is confidential and will only be released if you authorize me to do so.
Please bring this fully completed to your first visit.

NATUROPATHIC MEDICAL HISTORY

Personal Information

Name:_____ Date:_____

Address: _____
(Street, apartment number)

_____
(city, town) (province) (postal code)

Date of Birth (Y/D/M) _____ Current Age: _____

Home Phone: (____)_____ Ok to leave a message Yes NO

Work Phone: (____)_____ Ok to leave a message Yes NO

Cell Phone: (____)_____ OK to leave a message Yes NO

Email: _____

If you would like your reminders sent via email check here ☐

Occupation_____

Emergency Contact: _____

Relationship to you: _____ Phone (____)_____

Have you seen a Naturopathic Doctor before? Yes No

Name of Spouse (if applicable) _____

Number or Dependants (if applicable) _____

Medical History

Family Doctor: _____ Phone: (____)_____

Other Health Care Providers: Name:_____ Phone (___)_____

Name: _____ Phone (___)_____

Name: _____ Phone (____)_____

Permission to consult with your other health care providers? Yes NO

Present Health Concerns- Please list your most important health concerns. If possible, please list them in order of importance to you. For example, #1 is the most important and #5 is the least important.

1. **_____**
2. **_____**
3. **_____**
4. **_____**
5. **_____**

Know Food Allergies/ Intolerances: _____

_____

Know Environmental Allergies/ Insensitivities: _____

_____

Are you exposed to tobacco smoke? _____
Are you exposed to chemicals? _____

How would you describe your present level of personal stress?
Minimal_____ Average _____ Considerable _____ Unbearable _____

How many hours of sleep do you get on the average: _____

What do you do for exercise? _____

<u>Current prescription medications</u> (eg. Prozac, atenolol etc.) <u>non-prescription medications</u> (eg. Aspirin, Tylenol, ibuprofen etc) and/or <u>health supplements</u> (e. vitamins, minerals, herbs etc.) Please list the medications/supplements that you are currently taking with dosages on the lines below.

Name of Medication/ Supplement	Dose # of capsules, Milligrams etc.	Frequency times per day/ week/month	Duration how long have you been taking
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

<u>Medical Prodedures, hospitalizations and major injuries –</u> Please list previous medial procedures, surgeries and hospilizations on the lines below.

Approximate date/year	Surgery/hospitalization/prodedure/injuries
1._____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Every disease, serious illness, accident, physical or emotional trauma and drug leaves its mark and remain a weak point in our body's system. Homeopathic medicine takes into account details of the past and will work to eliminate these weak

points to strengthen your body. That is why it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken. In the lists below, please circle all major illnesses that you have experienced.

Measles (rubella)	**Colitis**	**Spleen Disease**	**Gonorrhea**
German Measles	**Irritable bowel syndrome**	**Gall Bladder disease**	**Chlamydia**
Chicken Pox	**Crohns Disease**	**Jaundice**	**Syphilis**
Mononucleosis	**Diverticulitis**	**Pancreatic Disease**	**HIV**
Mumps	**Hiatal Hernia**	**Hepatitis**	**Genital Herpes**
Scarlet Fever	**Constipation**	**Other liver Disease**	**Genital Warts**
Whooping Cough	**Hemorrhoids**	**Human Papillovirus**	**(HPV)**
Stomach/Duodenum Ulcers	**Polio**	**Reyes Syndrome**	**Appendicitis**
Typhoid	**Rheumatoid Arthritis**	**Kidney Problems**	**Miscarriage**
Cholera	**Osteoarthritis**	**Bladder Problems**	**Abortion**
Malaria	**Rheumatism**	**Diabetes**	**D and C**
Food Poisoning	**Back pain/ sciatica**	**Hypoglycemia**	**Uterine Prolapse**
Worms/parasites	**Fibromyalgia**	**Prostate Problems**	**Gestational Diabetes**
Diarrhea	**Gout**	**Eye Problems**	**Preeclampsia**
Dysentery			**Other pregnancy illness**
Acne, boils, impetigo	**Strep throat**	**Heart problems**	**PMS**
Carbuncles, ringworm	**Scarlet fever**	**Circulation problems**	**Fibrocystic breast disease**
Fungus, scabies, shingles	**Tonsillitis**	**High blood Pressure**	**Uterine Fibroids**
Poison Ivy	**Sinusitis**	**Low blood pressure**	**Endometriosis**
Keloids, psoriasis, warts	**Allergies (environmental)**	**Fainting**	**Ovarian Cysts**
Herpes Urticaria (skin allergy)	**Hay fever**	**Palpitations**	**Vaginitis (recurrent)**
Ulcers on any part of body	**Pneumonia**	**Anemia**	**Painful periods**
Bronchitis	**Pleurisy**	**Stroke**	**Skin cancer**
Tuberculosis	**Platelet Disorders**	**Bronchitis**	**Reynard's Disease**
Malnutrition	**Multiple sclerosis**	**Migraine headaches**	**Cushing's disease**
Pickets	**Lupus**	**Dizziness(vertigo)**	**Addison's Disease**
Osteoporosis	**Myasthenia Gravis**	**Numbness**	**Hypothyroid**
Hemochromatosis	**Cramps**	**Hyperthyroid**	**Wilson's disease**
Epilepsy	**Meningitis**	**Cancer (specify type)**	**Chronic fatigue**
Eating Disorder	**Environmental Illness**	**Schizophrenia**	**Candida**
Bipolar disease	**Clinical depression**	**Suicidal tendencies**	**Other:**

Family History

Please put an "L" for living and a "D" for deceased. Age is present age or age at the time of death.

Relationship	L/D	Age	Disease Suffered/ Cause of death
Paternal Grandfather	____	_____	_____
Paternal Grandmother	____	_____	_____
Maternal Grandfather	____	_____	_____
Maternal Grandmother	____	_____	_____
Father	_____	_____	_____
Mother	_____	_____	_____
Brother/Sister 1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

<u>Thank you</u> for taking the time to fill out this questionnaire!

Consent of Treatment/ Office Policy

In order to clarify our positions as health care practitioners, and to make the office run smoothly, we ask for you co-operation in signing this statement of acknowledgement.

1. That you understand that the practitioner in this clinic is a Naturopathic doctor and not a Medical doctor: that we used non-invasive, natural methods of assessment and treatment of disease.
2. That you understand that the methods utilized in this clinic have proven clinical foundations yet may not be accepted practice by standard (allopathic) medicine.
3. That you understand that treatment and or referral to other health care practitioners is based upon the assessment of you health revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation.
4. That you understand that the practitioner reserves the right to determine which cases fall outside of their scope of practice, in which event an appropriate referral will be recommended.
5. That you are accepting or rejecting this care of you own free will.
6. That you understand that the ultimate responsibility of your health care is your own, and that we are here to support you in this. We reserve the right to discontinue our services where it is apparent that your expectations and what we provide are not in agreement.
7. That you understand that fees are payable at the time of the appointment by the patient or guardian. OHIP does not cover naturopathic services. Payment can be made by cash, personal cheque, and debit, Visa or MasterCard.
8. That you understand that if it is necessary for you to change an appointment, to give a minimum of 48 hours notice, otherwise a service charge of the full visit fee will be assigned to those not abiding to this policy.
9. That you understand the importance of arriving on time for your appointment. No extensions of appointments or alterations in fees will be granted.\

I, _____ have read, understood and acknowledged the about statements.

Signature: _____

Date: _____