Appointment:

Location: 102 –A Kent Street

NATUROPATHIC DECLARATION AND CONSENT TO TREATMENT

Patient Name: _____

This is to acknowledge that I have been informed and that I understand that:

- Any treatment or advice provided to me as a patient of the Clinic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from any other licensed healthcare provider.
- I am at liberty to seek or continue medical care from a medical doctor or other healthcare provider licensed to practice in P.E.I.
- I am aware that PEI Medicare covers no part of my treatment or testing and that I am solely responsible for payment.
- Payment is to be made at the time of treatment.

I HEREBY AUTHORIZE AND CONSENT TO TREATMENT BY GRETCHEN MACLEAN, N.D.

Patient Signature: _____

Dated this_____day of _____ 2006

How did you hear about us?

Advertisement Word of Mouth Walk-by Referral

Other: _____

Dear Patient: Could you please record all food and beverages consumed for one day and bring to the consultation. Thanks- Gretchen

Naturopathic Intake

Name:_____ Date of Birth:_____

Address:_____

_____ Postal Code:_____

Phone (H):_____ (W)_____

Occupation:_____ Employer:_____

Sex: M/F Marital Status:_____ # of Children_____

Contact person in case of an emergency:_____ Tel. #_____
Do you have an extended health care plan that covers Naturopathic services? Y/ N
Have you had previous Naturopathic Services? Y/ N When? _____
Have you had previous Chiropractic Services? Y/ N When ?_____
Date of last medical visit:_____ Reason for visit:_____
Family physician:_____

- Past injuries traumatic events: _____ When? _____
  _____
- Past surgeries/hospitilizations: _____ When? _____
- Past vaccinations _____ Any reactions? _____
- Last prescription for antibiotics: _____ Reason: _____
- Please list all allergies (if any): _____
- Please list all currently used medications: _____
  _____
  _____
- Supplements: _____
  _____
  _____
- What kind of physical activity do you do? _____
  _____
- Are there any conditions after which you haven't been totally well again? _____
  _____
- My primary purpose for seeking Naturopathic service is: _____
  _____

Please list in order of priority the areas in which you would like improvement.

1. _____
2. _____
3. _____

FAMILY HEALTH HISTORY

Indicate below which of the following ailments, or any other ailments, have affected your relatives:

Alcoholism Allergies Alzheimer's Arthritis	Asthma *Cancer Depression Diabetes	Epilepsy Gonnorrhoea Gout Hay Fever	Heart Disease Hypertension Kidney Disease Mental Illness	Paralysis Pneumonia Skin disease Digestive Disorders	Syphilis Thyroid Disorder Tuberculosis

RELATIVE	AGE if alive	AGE at death	AILMENTS
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

* Please specity type of cancer (primary source)_____

_____

_____

Indicate which, if any, of the following conditions you have ever had:

Abscesses	_____	Gonorrhea	_____	Pleurisy	_____
ADD /ADHD	_____	Gout	_____	Pneumonia	_____
Alcoholism	_____	Hay Fever	_____	Premenstrual	
Allergies	_____	Heart Disease	_____	Syndrome	_____
Anemia	_____	Hepatitis	_____	Prostatis	_____
Arthritis	_____	HIV	_____	Rheumatic fever	_____
Asthma	_____	Infertility	_____	Scarlet Fever	_____
Cancer	_____	Influenza	_____	Sexual abuse	_____
Cankers	_____	IBS	_____	Sinusitis	_____
Chicken pox	_____	Kidney Disease	_____	Stroke	_____
Chlamydia	_____	Leukemia	_____	Strep Throat	_____
Cold Sores	_____	Low/High Blood		Syphilis	_____
Crohn's / Colitis	_____	Pressure	_____	Thyroid Disease	_____
Depression	_____	Lyme Disease	_____	Tonsillitis	_____
Diabetes	_____	Malaria	_____	Tuberculosis	_____
Emphysema	_____	Measles	_____	Typhoid Fever	_____
Endometriosis	_____	Miscarriage	_____	Uterine fibroids	_____
Epilepsy	_____	Mononucleosis	_____	Venereal Wart	_____
Fibrocystic Breasts	_____	MS	_____	Warts	_____
Frequent colds	_____	Mumps	_____	Whooping cough	_____
Fungal infections	_____	Parasites	_____	Worms	_____
Gallstones	_____	Peritonitis	_____	Yeast infections	_____
Genital Herpes	_____	Pelvis Inflammatory Disease	_____		

Any other conditions? _____

Is there any condition from which you have not fully recovered? Yes _____ No _____

If yes, provide details:_____

_____

_____

_____

_____

REVIEW OF SYMPTOMS

Please circle "Y" if you have the condition now and "P" if you have had it in the past (persistently)

SKIN:

Rashes	Y	P
Hives	Y	P
Acne	Y	P
Boils	Y	P
Eczema	Y	P
Psoriasis	Y	P
Dry skin	Y	P
Itching	Y	P
Lumps	Y	P
Night sweats	Y	P

How often_____

Other_____

_____

MOUTH & THROAT:

Hoarseness	Y	P
Gum problems	Y	P
Dental fillings	Y	P
Sores	Y	P
Mouth dryness	Y	P
Sore throats	Y	P
Lost taste	Y	P

Other_____

_____

RESPIRATORY:

Wheezing	Y	P
Cough	Y	P
Breath short	Y	P
Difficult breath	Y	P
Chest pain	Y	P
Bloody sputum	Y	P
Emphysema	Y	P
Asthma	Y	P
Breath Painful	Y	P
Bronchitis	Y	P
Pneumonia	Y	P
Pleurisy	Y	P

Last chest ray_____

Last TB test_____

Other_____

_____

GASTROINTESTINAL:

Heartburn	Y	P
Difficult swallow	Y	P
Thirst changes	Y	P
Appetite changes	Y	P
Nausea	Y	P
Indigestion	Y	P
Gas/belching	Y	P
Constipation	Y	P
Rectal bleeding	Y	P
Hemorrhoids	Y	P
Jaundice	Y	P
Hernias	Y	P
Diarrhea	Y	P

No. BM/day _____

HEAD:

Headache	Y	P
Migraine	Y	P
Dizziness	Y	P
Injuries	Y	P

Other_____

_____

NECK:

Pain	Y	P
Swollen glands	Y	P
Lumps	Y	P
Goitre	Y	P
Stiffness	Y	P

Other_____

_____

NOSE AND SINUSES:

Bleeding	Y	P
Stuffiness	Y	P
Hayfever	Y	P
Injury	Y	P
Colds	Y	P
Allergies	Y	P
Obstructions	Y	P
Sinus problems	Y	P

Other_____

_____

CARDIOVASCULAR:

Heart disease	Y	P
Angina	Y	P
High blood pressure	Y	P
Murmurs	Y	P
Chest pain	Y	P
Palpitations	Y	P
Ankle swelling	Y	P
Rheumatic fever	Y	P

Last ECG test_____

Other_____

_____

URINARY:

Pain urinating	Y	P
More frequent	Y	P
Reduced flow	Y	P
Kidney stones	Y	P
Blood in urine	Y	P
Infections	Y	P
Incontinence	Y	P

Other_____

_____

EYES:

Impaired vision	Y	P
Pain	Y	P
Redness	Y	P
Double vision	Y	P
Cataracts	Y	P
Light sensitive	Y	P
Discharge	Y	P
Tearing	Y	P
Dryness	Y	P
Itching	Y	P
Blurring	Y	P
Glaucoma	Y	P
Blind spot(s)	Y	P
Contact lenses	Y	P

Other_____

_____

EARS:

Discharge	Y	P
Itching	Y	P
Excess wax	Y	P
Infections	Y	P
Ringing	Y	P
Earache	Y	P
Hearing loss	Y	P

Other_____

_____

BREASTS:

Lumps	Y	P
Tenderness	Y	P
Self examine?	Y	P

Other_____

_____

PERIPHERAL VASCULAR:

Cold hands/feet	Y	P
Deep leg pain	Y	P
Varicose veins	Y	P
Thrombophlebitis	Y	P

Other_____

_____

MUSCULOSKELETAL:

Joint pain	Y	P
Arthritis	Y	P
Broken bones	Y	P
Numbness	Y	P
Tingling	Y	P
Muscle spasms	Y	P
Weakness	Y	P
Backache	Y	P

Other_____

FEMALES:

Age of first menses_____

Menopause symptoms

Age_____

Type of birth control_____

How long?_____

Vaginal discharge	Y	P
Vaginal itching	Y	P
Decreased sexual desire	Y	P

Other_____

_____

MENSES:

Cycle regular YES NO

Length of cycle _____

Bleeding between periods	Y	P
Painful menses	Y	P
Excessive flow	Y	P

No. of pregnancies_____

Age_____

No. of miscarriages_____

No. of abortions_____

PMS SYMPTOMS:

Depression	Y	P
Irritability	Y	P
Bloating	Y	P
Increased appetite	Y	P
Weight gain	Y	P
Breast tenderness	Y	P

Other_____

REPRODUCTIVE:

Sexual difficulties	Y	P
Venereal disease	Y	P

MALE:

Prostate symptoms	Y	P
Impotence	Y	P
Testicular masses	Y	P
Hernia	Y	P
Urgency of urination	Y	P
Incomplete urination/ Dribbling	Y	P
Decreased sexual desire	Y	P

BLOOD/LYMPHATICS:

Anemia	Y	P
Swollen lymphs	Y	P
Easy bleeding	Y	P
Bruising	Y	P
Transfusions	Y	P
Clotting	Y	P

Other_____

_____

ENDOCRINE:

Thyroid problems	Y	P
Diabetes	Y	P
Hypoglycemia	Y	P
Hormone therapy	Y	P

Other_____

_____

NEUROLOGICAL:

Fainting	Y	P
Seizures	Y	P
Convulsions	Y	P
Paralysis	Y	P
Muscle weakness	Y	P
Memory loss	Y	P
Involuntary movements	Y	P
Loss of balance	Y	P
Speech problems	Y	P

Other_____

_____

PSYCHO/SOCIAL:

Depression	Y	P
Tension	Y	P
Mood swings	Y	P
Phobias	Y	P
Sleep problems	Y	P
Anxiety	Y	P
Nervousness	Y	P
Alcohol or drug abuse	Y	P

Other_____

_____

ADRENAL:

Fatigue, apathy	Y	P
Allergies	Y	P
Delayed wound healing	Y	P
Low blood pressure	Y	P
Dizziness when Standing up	Y	P
Frequent urination	Y	P
Muscular weakness	Y	P
Nervousness	Y	P
Low back pain	Y	P
Ringing in the ears	Y	P

THYROID:

Loss of hair	Y	P
Weight gain	Y	P
Dry skin	Y	P
Loss of outer part of Eyebrows	Y	P
Menstrual disorders	Y	P
Stubborn constipation	Y	P
Goiter	Y	P
Low or high blood Cholesterol	Y	P
Feeling very cold	Y	P

LIVER:

Anemia	Y	P
Hypertension	Y	P
Elevated blood Cholesterol	Y	P
Low energy before eating	Y	P
Decreased drug or Alcohol tolerance	Y	P
Premenstrual tension	Y	P
Endometriosis	Y	P
Heavy menses	Y	P
Frequent headaches	Y	P
Skin problems	Y	P
Constipation	Y	P
Gall bladder problems	Y	P
Chronic muscle tension	Y	P
Eye problems	Y	P
Difficulty digesting Fatty foods	Y	P

PANCREAS:

Food allergies	Y	P
Blood sugar Abnormalities	Y	P
Maldigestion	Y	P
Undigested food in stool	Y	P
Bowel gas	Y	P
Stool floats	Y	P

PARATHYROID:

Osteoporosis	Y	P
Joint pain	Y	P
Gum/tooth disease	Y	P
Kidney stones	Y	P
Ridged fingernails	Y	P

Indicate which, if any, of the following medications you are currently taking: ✓

antiinflammatories/cortison	_____	heart medications	_____
antacids	_____	laxatives	_____
antibiotic	_____	lithium	_____
antidiabetic/insulin	_____	oral contraceptives	_____
antidepressants	_____	radiation	_____
antifungal	_____	relaxants/sleeping pills	_____
aspirin/tylenol	_____	thyroid	_____
chemotherapy	_____	recreational drugs	_____
hormones	_____	ulcer medications	_____
high blood pressure	_____	other (specify)	_____
			_____

Indicate which, if any, of the following items you eat, drink or use: ✓

alcohol	_____	herbal teas	_____
aluminum pans	_____	luncheon meats	_____
candy	_____	margarine	_____
carbonated beverages	_____	microwave	_____
chew tobacco	_____	minerals	_____
cigarettes	_____	refined sugars	_____
coffee	_____	saccharine (sweet & low)	_____
distilled water	_____	spring water	_____
fast foods	_____	tea	_____
fried foods	_____	vitamins	_____

Indicate which, if any, of the following apply to you: ✓

Diet often	_____	Under excessive stress	_____
Do not exercise regularly	_____	Exposed to chemicals at work	_____
Salt food without tasting	_____	Exposed to cigarette smoke	_____

How much do you drink of the following items on a daily basis:

Beer	_____	Milk (2%)	_____
Coffee	_____	Soft Drinks (diet)	_____
Fruit juice	_____	Soft Drinks (reg.)	_____
Herbal tea	_____	Tea	_____
Liquor	_____	Water	_____
Milk (skim)	_____	Wine	_____

How often would you have an alcoholic beverage? _____

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

a. _____

_____

b. _____

_____

c. _____

_____

d. _____

_____

e. _____

_____

Are you currently working with a professional counselor, psychologist, social worker, or other therapist? Please provide details: _____

_____

Have you had naturopathic treatment before? Please provide details: _____

_____

_____

_____

_____

_____

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_____

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_____

_____

_____