Theresa MacLean, ND

Doctor of Naturopathic Medicine

185 Commercial Street, Suite 101

Berwick, Nova Scotia B0P 1E0

Date: _____

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (H): _____ Cell: _____

E-mail: _____

Age: _____ Date of Birth: _____

Occupation: _____ Past occupation: _____

Martial Status: _____ Number of children: _____

Family Physician: _____ Contact Number: _____

Emergency contact: _____ Contact Number: _____

Health Insurance: Y __ N __ Provider: _____ Policy: _____

Member ID: _____

What are your main health concerns:_____

_____

_____

MEDICAL HISTORY

Date of last physical exam: _____ Weight: _____ Height: _____

Energy level (scale 1-10, 10 highest): _____ Blood type: _____

Do you wake refreshed: Y __ N __ Do you smoke now? Y __ N __ Did you smoke in the past? Y__ N __

Do you drink alcohol? Y __ No __ Number of drinks per week? _____

Do you exercise? Y __ N __ Type of exercise and times per week: _____

_____

Allergies? (drugs, food, etc.) Y __ N __ List: _____

Do you have environmental sensitivities? List: _____

Current Medications: _____

Current vitamins and supplements: _____

Review of systems: Please circle any of the following conditions you have experienced.

Skin: rashes, hives, itching, dry skin, acne, eczema, night sweats, other: _____

Head: Headache, dizziness, head injury, migraine, other, _____

Ears: Discharge, earache, ringing, excessive wax, itching, decreased hearing, other: _____

Eyes: Glasses/contacts, impaired vision, double vision, redness, discharge, tearing, dryness. Cataracts, blurring,

Light sensitivity, blind spots, poor night vision, glaucoma, itching, other: _____

Nose and Sinus: Nose bleeds, obstructions, hay fever, allergies, frequent colds, nose/sinus injury, number of colds per year ( ), other: _____

Mouth and throat: Hoariness, dry mouth, sore throats, mouth sores, dental cavities, gum problems, loss of taste,

Other: _____

Neck: Stiffness, swollen glands, lumps, goiter, pain, other: _____

Respiratory: Wheezing, sputum, chest pain, pleurisy, asthma, difficult breathing, pneumonia, emphysema, bronchitis, cough, other: _____

Breasts: Lumps, tenderness, pain, other: _____

Cardiovascular: Heart disease, ankle swelling, murmurs, chest pain, high blood pressure, angina, palpitations, other:

_____

Gastronintestinal: Indigestion, heartburn, belching/gas, bloating, hiatal hernia, difficulty swallowing, change in appetite, jaundice, nausea, vomiting, hemorrhoids, diarrhea, constipation, rectal bleeding, number of bowel movements per day ( ), other: _____

Urinary: Pain on urination, increased frequency, blood in urine, bladder infection, kidney stones, inability to urinate, other: _____

Musculoskeletal: Joint pain or stiffness, muscle spas, or cramps, weakness, numbness/tingling, broken bones, arthritis, backache, other: _____

Peripheral Vascular: Cold hands, cold feet, varicose veins, deep leg pain, other: _____

Neurological: Fainting, loss of memory, seizures, loss of balance, paralysis, speech problems, muscle weakness, involuntary movements, other: _____

Endocrine: Thyroid disease, diabetes, hormone therapy, low blood pressure, other: _____

Lymph/Blood: Anemia, lymph node swelling, easy bruising, other: _____

Reproduction Female: regular menses, cycle length in days ( ), birth control method: _____
Age of first menstruation: ( ), menopause, if yes, what age ( ), menopause symptoms: _____
_____
number of pregnancies: ( ), number of miscarriages/abortions: ( ), sexually transmitted disease: _____
_____

Premenstrual syndrome: Depression, irritability, mood swings, cravings, breast tenderness, weight gain, increases appetite, other: _____

Reproduction Male: Prostate disease, sexual difficulties, history of sexually transmitted disease,
other: _____

Phycho/Social: Depression, mood swings, emotional/physical abuse, anxiety/nervousness, phobias, alcohol/drug problems, sleep problems, other: _____

Have you even had psychiatric/psychological counselling? _____

How content are you with your life (1 – 10, 10 very content)? _____

What would you like to change in your life: _____

Do you express your emotions easily? _____

Family History: cancer, heart disease, high blood pressure, diabetes, arthritis, osteoporosis, asthma, kidney disease, mental illness, thyroid disease, other: _____

Childhood disease: measles, rheumatic fever, diphtheria, mumps, chickenpox, polio, whooping cough, other:

_____

Have you had a bad reaction to a vaccination, explain if yes: _____

_____

Health History: Please list hospitalizations, surgeries, disease, major accidents, traumas, etc.

Age: _____
Age: _____
Age: _____
Age: _____
Age: _____
Age: _____

Is there anything else I need to know? _____

_____

_____

_____

_____

Type of Diet:

Breakfast: _____

_____

_____

Snacks: _____

Lunch: _____

_____

_____

Snack: _____

Supper: _____

_____

_____

Snack: _____

Privacy Policy and Informed Consent

Naturopathic Medicine is the treatment and prevention of disease by natural remedies. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. The naturopathic doctor will take a thorough history and preform a relevant physical exam. It is important that you inform you naturopathic doctor if any medical concerns and allergies, as well as any medications and supplements that you are taking.

Please advise the naturopathic doctor if you are pregnant, suspect you are pregnant, or are breast feeding. As a patient, you will receive information about your diagnosis and/or treatment, alternative courses of action, costs, expected benefits, risks, side effects, and in each case the medical intervention there can be health risks associated with Naturopathic Medicine. Some possible side effects could be an aggravation or pre-existing symptoms, an allergic reaction to supplements or herbs, and/or pain, bruising or fainting from acupuncture.

I understand that a confidential record will be kept of the health services provided to me. I understand that I may look at my medical record at any time and I can request a copy of my file for a fee. Only necessary information collected to assess your health and advise you of treatment options, to establish and maintain contact with you, for billing purposes and to comply with legal and regulatory requirements. We only share information with your written consent.

I understand that email or message communication privacy and security cannot be guaranteed. It is possible that unauthorized persons can intercept and misuse this information.

I understand that the results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to naturopathic care. I intent this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient name (please print): _____

Signature: _____

Signature of parent of guardian: _____

Date: _____

Signature of office staff: _____