CAM
670 Taunton Rd. E, Unit B4B
Whitby, Ontario
(T) 905.655.7100
(F) 905.655.7155

CCIM
12 Main St. N
Markham, Ontario
(T) 905.471.9355
(F) 905.471.4348

Name: _____ Date: _____
Date of Birth: _____ (M/D/Y)
Address: _____
E-mail: _____
Telephone #: (H) (___) _____- _____ (W) (___) _____- _____(C) (___) _____- _____
Emergency Contact: _____
Phone #: (____) _____ - _____ Relation: _____
How did you hear about our clinic? _____
If you answered "friend" or "doctor" above, please provider their name:
_____
Have you registered on our website (www.advancedmedicine.ca)? Y/N
We strongly encourage you to visit www.functionalmedicine.org
for a better understanding of what to expect
Do you have health care insurance? Y/N Coverage/ Year: _____
Other health care providers you are seeing:
1. _____ 2._____ 3._____
(___) _____- _____ (___) _____- _____ (___) ____- _____

What are your health concerns, in order of importance:
1. _____
2. _____
3. _____
4. _____

Please list the medical conditions you have been diagnosed with:
1. _____
2. _____
3. _____
4. _____

Medical History

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approx. dates: **SEE TIMELINE** (separate document).

What types of therapies have you tried for these problem(s) or to improve your health overall:
__ diet modification __ fasting __ vitamins/minerals __ herbs __ homeopathy ___ chiropractic __ acupuncture __drugs
other _____

Do you experience any of these general symptoms EVERY DAY?

__debilitating fatigue	__shortness of breath	__insomnia	___constipation
__depression	__panic attacks	__nausea	__fecal incontinence
__disinterest in sex	___headaches	__vomiting	__urinary incontinence
__disinterest in eating	___dizziness	__diarrhea	__low grade fever
__bleeding	___discharge	__itching/rash	__chronic pain/inflammation

Laboratory procedures performed (e.g stool analysis, blood and urine chemistries, hair analysis):
_____
_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):
1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g changes in job, work, residence or finances, legal problems):
_____
_____

Do you consider yourself: __underweight __overweight __just right _____your weight today

Do you have any allergies (medicines, environmental, etc.)?
_____
_____

Please list all current medications (prescription, over the counter, vitamins, herbs, homeopathics, etc.):

_____
_____

How many times have you been treated with antibiotics? _____
Do you frequently use any of the following?
Aspirin/ Laxatives/ Antacids/ Diet Pills/ Birth Control Pills/ Impants/ Injections
Alcohol- How much per day? _____How much per week?
_____
Tobacco- Form? _____ How often? _____
Caffeine- Form? _____ How often? _____
Recreational drugs? _____

<u>Diet</u>
Do you have any food allergies, intolerances or dietary restrictions? Y/N
If yes, please list:
_____
_____
_____

What are your current dietary habits?

_____
_____
_____

<u>Environment</u>
Occupation: _____
Hobbies: _____
Have you been, or are you currently exposed to toxins or hazardous materials?
(Tobacco smoke, solvents, pesticides, heavy metals, work, home, hobbies, etc)

_____
_____

How is the emotional climate of your work and home environments?

_____
_____

How much do you work in a given week? _____

Any other lifestyle habits we should be aware of?

_____
_____
_____

Energy _____
Mood _____
Sleep _____ (# of hours)

Please list your short term health goals:
1. _____
2. _____
3. _____

Please list your long term health goals:
1. _____
2. _____
3. _____

How important is your health to you? (1-5; 1 being not really, 5 being optimal health and wellness) _____

How aggressive would you like your treatment plan?
3- Dramatic improvement as quickly as possible
2- Improvement within 3 months
1- Slow & steady improvement over 6 months to a year

Is there anything else that you feel is important, but has not been covered?

_____

_____

_____

PLEASE COMPLETE THIS FORM AND RETURN TO CLINIC RECEPTION

****Please note there will be a $40.00 charge for any appointments cancelled less than 24hours out****

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Date of last GYN exam _____

Mammogram ❑ + ❑ −

PAP ❑ + ❑ −

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

Age of first period _____

Date - last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

- ❑ Surgical menopause
- ❑ Menopause

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

- ❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

- ❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

- ❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

- ❑ Water: #glasses/d _____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk - #days/wk _____
- ❑ Run, jog, other aerobic - #days/wk _____
- ❑ Weight lift - #days/wk _____
- ❑ Stretch - #days/wk _____
- ❑ Other _____

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

❑ Skip meals - which ones _____

_____

- ❑ One meal/day
- ❑ Two meals/day
- ❑ Three meals/day
- ❑ Graze (small frequent meals)
- ❑ Generally eat on the run
- ❑ Eat constantly whether hungry or not

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs
- ❑ Homeopathy
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (Ensure)

Others _____

_____

I Would Like To:

ENERGY - VITALITY

- ❑ Feel more vital
- ❑ Have more energy
- ❑ Have more endurance
- ❑ Be less tired after lunch
- ❑ Sleep better
- ❑ Be free of pain
- ❑ Get less colds and flu
- ❑ Get rid of allergies
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives and stool softeners
- ❑ Improve sex drive

BODY COMPOSITION

- ❑ Loose weight
- ❑ Burn more body fat
- ❑ Be stronger
- ❑ Have better muscle tone
- ❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ❑ Learn how to reduce stress
- ❑ Think more clearly and be more-focused
- ❑ Improve memory
- ❑ Be less depressed
- ❑ Be less moody
- ❑ Be less indecisive
- ❑ Feel more motivated

LIFE ENRICHMENT

- ❑ Reduce my risk of degenerative disease
- ❑ Slow down accelerated aging
- ❑ Maintain a healthier life longer
- ❑ Change from a "treating-illness" orientation to creating a wellness lifestyle

7/00. Rev 1/03. Rev 3/06

MET1392

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PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part the Centre for Advanced Medicine, while providing you with quality Naturopathic Care. We understand the importance of protection your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate protection of your information.

Our privacy policy outlines what (CAM) is doing to ensure that:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy- Naturopathy.

HOW OUR CLINIC COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

CAM understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how CAM is using and disclosing your information.

The clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health care providers
- To allow us to efficiently follow up for treatment, care and billing
- To complete claims for insurance purposes
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others.

By signing this Patient Consent form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

PATIENT CONSENT

I have reviewed the above information that explains how your Clinic will use my personal information, and the steps your Clinic is taking to protect my information. I agree that CAM can collect, use, and disclose personal information about _____ as set out above in the information about CAM's privacy policies.

_____ _____ _____

Signature Print Name Date

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CENTRE FOR ADVANCED MEDICINE

CCIM
12 Main St. N
Markham, Ontario
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(F) 905.471.4348

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional, and spiritual aspects of the individual. Gentle, non invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your health care providers at the CAM will take a thorough case history, perform a physical examination, including a breast exam and take blood and urine samples.

It is very important that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from and any medications/ over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately: if you are pregnant, suspect you pregnant or you are breast-feeding.

As a patient you will receive information about your diagnosis and/ or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/ or treatment acted upon.

There is some slight health risks associate with treatment by Naturopathic Medicine.

These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have
- Pain, bruising or injury from venipuncture or acupuncture or parental therapy
- Fainting or puncturing of an organ with acupuncture needles
- Muscle strains and sprains, disc injuries from spinal manipulation
- The staff are trained to handle emergencies should the need arise

I understand

- The clinic does not guarantee treatment results
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have
- I am free to withdraw my consent and to discontinue treatment at any time

Patient Name: (Please Print) _____

Signature of Patient or Guardian: _____ Date: _____