HEALTHmatters
health store + wellness clinic

Dr. Han Ping Helen Cen, ND

ADULT CLIENT INFORMATION SHEET

Date of Initial Appointment: _____

Name: **Birthday:**

Address:

City: **Province:** **Postal Code:**

Home Phone: **Cell:** **Work:**

Email:

Appointment Notifications: We will advise you of your upcoming appointments 24 hours in advance.
Please circle which is the best way to contact you for notifications: Email Text Phone Call

Electronic Messages: Would you like to receive e-mails including monthly newsletters, promotions, upcoming classes and information from Health Matters? (Please circle one) YES NO
How did you hear about us? Facebook Google Referral In-Store Other_____

Sex:_____ Date of Birth:_____Age: _____Current weight: Height:_____

Who is filling out this form if not self? (Name and relationship):

Occupation: Marital Status: Number of Children:

Pregnant: Y N If yes, how many weeks: Breastfeeding: Y N

Emergency Contact Name: Phone Number: Relationship:

Name of Medical Doctor: Phone Number:

Have you received *naturopathic* care previously? Y N If yes, when?

Name of practitioner: For what reason?

Health Concerns

What are your main health concerns in order of importance to you?

Vitamins and Supplements

Please list all vitamin/mineral/herbal supplements you are currently taking: **Please bring in all supplements info (or photo) to initial visit**

Supplement (Including Brand)	Dosage	When did you begin supplement?

Medication

Please list all prescription and non-prescription medication you are currently taking: **Please bring in all medications to initial visit**

Please list all prescription medications you have taken in the past for longer than 6 months. Indicate how long you have taken each for:

Family History

Is there a history of any of the following in your family?
Please check and then list relationship of family member beside the condition.

	Alcoholism		Cataracts		Kidney Disease
	Allergies		Celiac		Learning Disability
	Arteriosclerosis		Colitis		Mental Disease
	Arthritis		Depression		Multiple Sclerosis
	Asthma		Diabetes		Schizophrenia
	Bed Wetting		Epilepsy		Tuberculosis
	Candida Albicans		Heart Disease		Yeast Infections
	Cancer		Hyperactivity		

Medical History

Please list any injuries and/or major surgery you have had and when they occurred.

Please list any major illnesses or diseases that you have or have had.

Vaccinations (please check)

	DPT (Diphtheria, Pertussis, Tetanus)		Flu Shot		MMR (Measles, Mumps, Rubella)
	Hepatitis A		Hepatitis B		Chicken Pox
	Polio		Other		

Did you experience any symptoms from them? If yes, please explain.

Diet

	Non Vegetarian		Vegetarian		Vegan
	For How Long?				
How many cups/bottles/glasses do you drink, on average, per day?					
	Coffee		Milk 2%		Fruit juice
	Tea		Skim milk		Soft drinks (diet)
	Water		Beer		Soft drinks (regular)
	Herbal tea		Wine		Vegetable juice
	Milk 1%		Liquor		Other

All allergies/intolerances/sensitivities:

Review of Symptoms

Please check any of the following that apply to you or write "P" beside the box if you have experienced any in the past.

General

	Fatigue		Night sweats		Sleep problems
	Change in appetite		Allergies		Hours of sleep per night
	Change in thirst		Heat or cold intolerance		Sudden drop in energy (time?)
	Bleed or bruise easily		Cancer		

Skin

	Rashes/hives/itching		Hair changes (colour/quantity)		Skin ulcers/skin cancer
	Eczema/psoriasis		Changes in skin color		Warts
	Nail changes (strength/shape)		Excess dryness/moistness		Recent moles
	Acne/boils				

Head, eyes, ears, nose, and throat

	Headache		Blurred/double vision		Ringing in the ears
	Problems with jaw joint/TMJ		Use of glasses		Poor hearing
	Head injury		_____Date of last eye exam		Sinus issues
	Migraines		Cataract		Frequent colds
	Dizziness		Floaters/blind spot		Mercury dental fillings
	Light-headedness		Earache/infection		Cold sore/ canker sore
	Eye pain		Excess ear wax		Swollen glands

Heart and circulation

	High blood pressure		Irregular heartbeat		Varicose veins
	High cholesterol		Palpitation/fluttering		Blood clots
	Heart disease		Chest pain		Cold hands and feet

Neurological

	Fainting/loss of consciousness		History of concussion		Twitching
	Seizures		Loss of sensation		Tremors
	Speech problems/slurring		Numbness/tingling		Memory problems

Endocrine

	Thyroid problems		Weight gain		Hormone replacement therapy
	Diabetes		Weight loss		

Musculoskeletal

	Joint pain / stiffness		Muscle weakness		Osteoporosis
	Sciatica		Muscle spasm / cramp		

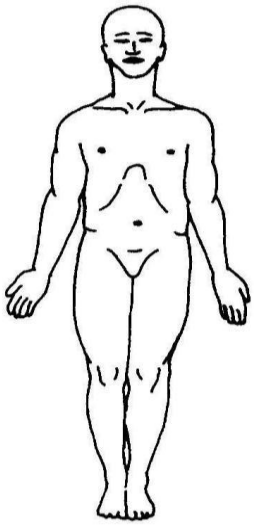
Urinary

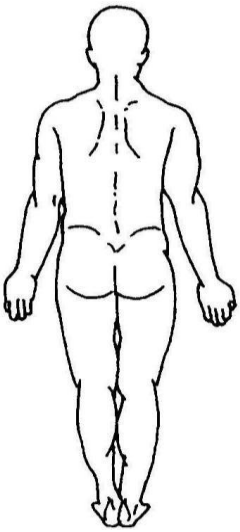
	Pain / burning while urinating		Urinary tract infections		Kidney problems
	Inability to hold urine		Blood in urine		Kidney stones/infection
	Urgency/hesitation				

Sexual Health

	Sexually active		Sexually transmitted infection		Contraception use

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed in color or texture (e.g. moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.





Thank you for taking the time to complete this form to your best knowledge.

Informed Consent

Please note that this form must be signed prior to your first appointment.

Naturopathic medicine is the treatment and prevention of diseases 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 clinician, Han Ping Helen Cen ND, will take a thorough case history, perform a physical examination, which can include a breast exam, and take blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

There are some slight potential risks associated 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 clinician of any allergies you may have.*
- *Pain, bruising or injury from venipuncture or acupuncture or parental therapy.*

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

The Naturopathic Doctor is trained to handle emergencies should the need arise.

I understand:

- *That naturopathic treatments and conventional treatments are not mutually exclusive and therefore I am free to seek or continue medical care from a qualified physician.*
- *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.*

CANCELLATION POLICY

Please note a no show appointment is a loss of income for our practitioners and delays our work. When you must cancel, please give us at least 24 hours notice. We are rarely able to fill a cancelled session unless we know at least 24 hours in advance. If you are unable to provide at least 24 hours notice when you cancel, a $25 cancellation fee will be applied.

_____ _____

Patient or Lawful Representative Signature *Date signed*

_____

Full Name Printed