Naturopathic and Allergy Clinic

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Complimentary consultation

Form 101 **Version JAN 2021**

Dear Patient: This form was specifically designed by our **Naturopathic Doctor, the clinic director Fateh Srajeldin ND,** to help our medical team understand the reasons behind your current condition. This form is confidential and will not be shared or discussed with any establishment outside our office.

✳**Please make sure to answer all questions that have the mark (✳), Thank you.**

Personal Information

✳Last name: _____ ✳First name: _____ .

✳Date of birth: ____ MM. DD. YY. _____ Sex: ❑ Male, ❑ Female, Height: _____ Weight: _____ .

✳My Occupation is: _____ My employer is: _____ .

✳I have been unwell for: _____ Yrs., Physician's name who treated me: _____ .

I was treated by a ❑ Medical Dr., ❑ Chiropractor, ❑ Naturopath, ❑ Psychiatrist, ❑ Hospital, ❑ Homeopath,

Was treatment terminated? : ❑ Yes, ❑ No, Did treatment achieve its goal % (explain): _____ .

_____ .

✳I was treated for: _____ .

✳**Currently**, I am suffering from the following symptoms and need treatments for.:_____ .

_____ .

_____ .

_____ .

✳Home address: _____ . Apt. _____ City _____ . Prov. _____ P C _____ .

✳Phone number ( ): _____ ✳Email: _____ @ _____ .

Do you, your partner or (If a child) do the parents have an extended health insurance at work ❑ Yes, ❑ No.?

Name of Insurance company: _____ .

✳Who referred you to this clinic : _____ .

❑ Office sign, ❑ Our Website, ❑ Surfing the Net, ❑ Office Pamphlet, ❑ TV Interview, ❑ Word of mouth.

Please check the system that has your symptoms

- ❑ Allergy symptoms
  - ❑ Seasonal
  - ❑ Year round
- ❑ Respiratory symptoms
- ❑ Muscle/bone/joints issues
- ❑ Digestive symptoms
- ❑ Oral symptoms
- ❑ Throat symptoms
- ❑ Nasal symptoms
- ❑ Scalp & hair symptoms
- ❑ Ear issues
- ❑ Eyes issues
- ❑ Head related issues
- ❑ Heart symptoms
- ❑ Skin symptoms _____ .
- ❑ Fatigue issue
- ❑ Sleep issues
- ❑ Endocrine glands sx
- ❑ Genital / urinary symptoms
- ❑ Nervous system symptoms
- ❑ Malignancies _____ .
- ❑ Female issues
- ❑ Male issues
- ❑ Past surgeries _____ .
- ❑ Any form of cannabis _____ .
- ❑ List medications taken now
- ❑ Exposure to COVID-19
- ❑ COVID-19 Vaccination .
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
  - ❑ _____ .
- ❑ Daily Dietary habits
  - ❑ Tea per (Day / Wk): ____ .
  - ❑ Water per (Day / Wk): ____ .
  - ❑ Milk per (Day / Wk): ____ .
  - ❑ Cheese per (Day / Wk): ____ .
  - ❑ Yogurt per (Day / Wk): ____ .
  - ❑ Ice Cream per (Day / Wk): ____ .
  - ❑ Cola per (Day / Wk): ____ .
  - ❑ Coffee per (Day / Wk): ____ .
  - ❑ Beer per (Day / Wk): ____ .
  - ❑ Wine per (Day / Wk): ____ .
  - ❑ Cigarettes, per (Day / Wk): ____ .
  - ❑ Chocolate, per (Day / Wk): ____ .
  - ❑ Nutella, per (Day / Wk): ____ .
  - ❑ Peanut per (Day / Wk): ____ .
  - ❑ Whey, per (Day / Wk): ____ .

Naturopathic Doctors and all other regulated health practitioners are required by the Ontario Ministry of Health & Long-Term Care to screen every patient attending an in-person appointment. If you answer "yes" to any of the following questions, we cannot see you for an in-person appointment and you must get tested for COVID-19.

- Do you have or recently developed any of the following symptoms?
  - Fever ❒ Yes ❒ No
  - New onset of cough ❒ Yes ❒ No
  - Worsening chronic cough ❒ Yes ❒ No
  - Shortness of breath ❒ Yes ❒ No
  - Difficulty breathing ❒ Yes ❒ No
  - Sore throat ❒ Yes ❒ No
  - Difficulty swallowing ❒ Yes ❒ No
  - Decrease or loss of sense of taste or smell ❒ Yes ❒ No
  - Chills ❒ Yes ❒ No
  - Headaches ❒ Yes ❒ No
  - Unexplained fatigue/muscle aches ❒ Yes ❒ No
  - Nausea/vomiting diarrhea, abdominal pain ❒ Yes ❒ No
  - Pink eye (conjunctivitis) ❒ Yes ❒ No
  - Runny nose or nasal congestion ❒ Yes ❒ No
  - Have you travelled outside Canada in the last 14 days? ❒ Yes ❒ No
  - Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? ❒ Yes ❒ No

_____

Signature of Patient + Accompanied Persons or Guardian (MUST)