



## Centre de Santé Harmonie Harmony Health Centre

### ***Hello and Welcome!***

Thank you for choosing Harmony Health Centre. Before your scheduled appointment, please carefully read and fill out this form. Please note that the diet diary on the last page will take *5 days* to complete. We know your time is valuable and bringing your completed information forms with you will maximize the amount of time we can spend discussing your case.

Naturopathy is a holistic and preventive approach. This means that we assess the whole person, taking into consideration the physical, mental, emotional, and spiritual aspects of the individual with the ultimate goal of identifying and eliminating the underlying causes of illness. Gentle, non-invasive techniques are used in order to stimulate the body's inherent healing capacity. These include a number of different modalities such as the following:

- ***Nutritional Support*** and dietary recommendations are integral to ensuring that the body has the needed building blocks to sustain and aid healing.
- ***Lifestyle Counseling*** addresses the link between concerns and concerns of well-being, lifestyle, events, thoughts and emotions and provides recommendations such as breathing and relaxation techniques or coping strategies.
- ***Botanical Medicine*** using herbal teas, tinctures or capsules for addressing specific concerns and aiding the body in recovering from injury or disease.
- ***Nutritional Supplementation*** to address deficiencies, assist the body in eliminating toxins, etc.
- ***Homeopathy*** is an energy-based system that stimulates the healing process in the body on all levels.
- ***Hydrotherapy*** is the use of water as an accessible and effective form of stimulating healing.

Most private health insurance companies cover naturopathy; please check with your provider to determine the amount that is covered under your policy. If you have coverage, you are responsible for billing your own insurance company - We will provide you with all the information necessary to send your claim for reimbursement.

Note that the clinic is ***scant free*** to respect those clients with allergies or sensitivities.

If you are unable to keep your scheduled appointment time please give us a 24hour notice so that we may reschedule your visit. If not, a \$50 cancellation fee will be charged.

***Remember to bring copies of any recent lab work or medical records as well as any supplements or medications you are currently taking.***

We look forward to supporting you on your journey to greater wellbeing

**Name** \_\_\_\_\_ **Date of appointment** \_\_\_\_\_  
First name Last name dd / mm / yyyy

**Date of birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Sex** M F  
dd / mm / yyyy

**Address** \_\_\_\_\_  
Street Apt#

City Province Postal Code

**Phone** \_\_\_\_\_  
Home Work Cell phone

\_\_\_\_\_ Email

**Emergency contact** \_\_\_\_\_  
First name Last name Relation

\_\_\_\_\_ Day Phone Evening Phone

How did you hear about the centre? \_\_\_\_\_

**Occupation** \_\_\_\_\_ Full time Part time

**Marital Status** Single Married Common Law Divorced Widowed Other \_\_\_\_\_

Please list your health concerns in order of importance, including how long they have been present

- 1- \_\_\_\_\_
- 2- \_\_\_\_\_
- 3- \_\_\_\_\_
- 4- \_\_\_\_\_
- 5- \_\_\_\_\_

How would you describe your general state of health? Excellent Good Fair Poor Very poor

**PERSONAL HISTORY**

Please list any hospitalizations, surgeries, X-Rays, or imaging scans you have received in the past.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any injuries or traumas you have received in the past.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all current prescription medications, over the counter medications, vitamins or other supplements you are taking.

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Please list all past prescription medications.

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How many times have you received antibiotic treatments in your lifetime?    Never    1-5    6-10    11-15    16-20    21+  
When was the last time you received an antibiotic treatment? \_\_\_\_\_

Which of the following conditions have you had? (Circle all that apply)

- |                      |                     |                        |                    |
|----------------------|---------------------|------------------------|--------------------|
| Abscesses            | Eczema              | Leukemia               | Scarlet Fever      |
| Acne                 | Emphysema           | Liver Disease          | Schizophrenia      |
| ADHD                 | Epilepsy            | Malaria                | Strep Throat       |
| Alcoholism           | Gall stones         | Measles                | Sinusitis          |
| Allergies _____      | Gonorrhoea          | Mononucleosis          | Stroke             |
| Anemia               | Gout                | Mood Disorder          | Syphilis           |
| Anxiety              | Hay Fever           | Mumps                  | Thalassemia        |
| Arthritis            | Heart Disease       | Parasites              | Thyroid Disease    |
| Asthma               | Heart Murmur        | Pelvic Inflammatory Dz | Tonsilitis         |
| Bronchitis           | Hemochromatosis     | Peritonitis            | Tuberculosis       |
| Cancer _____         | Hepatitis           | Pleurisy               | Typhoid            |
| Chicken Pox          | Herpes Genitalia    | PMS                    | Ulcerative Colitis |
| Coagulation Disorder | High Blood Pressure | Pneumonia              | Ulcers             |
| Crohn's Disease      | High Cholesterol    | Prostatitis            | Venereal Warts     |
| Cold Sores           | Hypoglycemia        | Psoriasis              | Whooping Cough     |
| Depression           | Irritable Bowel     | Rheumatic Fever        | Worms              |
| Diabetes             | Kidney Disease      | Rubella                | Yellow Fever       |

Other \_\_\_\_\_

Please indicate what vaccinations you have received (Circle all that apply):

- |                                      |                               |                 |
|--------------------------------------|-------------------------------|-----------------|
| Chicken Pox                          | Hepatitis A                   | Small Pox       |
| DPT (Diphtheria, Pertussis, Tetanus) | Hepatitis B                   | Tetanus booster |
| Flu                                  | MMR (Measles, Mumps, Rubella) |                 |
| Haemophilus influenza                | Polio                         |                 |

Other \_\_\_\_\_

What is the date of your last physical exam? \_\_\_\_\_

What is your overall energy?    Low - 1    2    3    4    5    6    7    8    9    10 - High

Is this a change from this time last year?    Y    N

Height? \_\_\_\_\_    Weight? \_\_\_\_\_

Has your weight changed in the last year?    Lost    Gained    No Change    How many pounds? \_\_\_\_\_

Do you have any mercury fillings?    Y    N    How many? \_\_\_\_\_

Do you smoke? Y N Previously \_\_\_\_\_ How many? \_\_\_\_\_  
 Are you sexually active? Y N Type of protection used: \_\_\_\_\_  
 Do you have children? Y N How many? \_\_\_\_\_  
 Have you ever had problems with fertility? \_\_\_\_\_

**Women only:**

Age of first menstrual period \_\_\_\_\_ Date of last menstrual period \_\_\_\_\_  
 Length of cycle (i.e. 28 days) \_\_\_\_\_ Days you menstruate (i.e. 5 days) \_\_\_\_\_  
 Bleeding between periods? Y N Is your cycle regular? Y N  
 Please circle if applicable: Cramps Abnormal vaginal discharge Pain during sexual activity Excessive flow  
 Have you had a yeast infection? Y N Have you had a Sexually Transmitted Infection? Y N  
 Are you currently pregnant? Y N Number of pregnancies \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_ Number of abortions \_\_\_\_\_  
 Date of last PAP smear \_\_\_\_\_ Date of last mammogram \_\_\_\_\_  
 Do you perform regular self-breast exams? Y N Please circle if applicable: Lumps Tenderness Discharge  
 Have you ever used the birth control pill? Y N For How long? \_\_\_\_\_ Any side effects? \_\_\_\_\_

**Men only:**

Date of last prostate exam \_\_\_\_\_  
 Do you have a history of (circle if applicable):  
 Hernia Testicular Mass Sexual Difficulty Enlarged Prostate  
 Penile Discharge Genital Sores Urinary Difficulties Sexually Transmitted Infections

**FAMILY HEALTH HISTORY**

Which of the following have affected your family members? Which family member?  
 Include parents (M or F), siblings (S or B), grandparents (MGF, MGM, PGF, PGM), aunts (A), and uncles (U)

|                     |                           |                          |
|---------------------|---------------------------|--------------------------|
| Acne _____          | Epilepsy _____            | Osteoporosis _____       |
| Alcoholism _____    | Gallstones _____          | Pneumonia _____          |
| Allergies _____     | Glaucoma _____            | Psoriasis _____          |
| Alzheimer's _____   | Gout _____                | Rheumatic Fever _____    |
| Arthritis _____     | Hay Fever _____           | Sickle Cell Anemia _____ |
| Asthma _____        | Heart Disease _____       | Strep Throat _____       |
| Bronchitis _____    | High Blood Pressure _____ | Stroke _____             |
| Cancer _____        | High Cholesterol _____    | Thyroid Disease _____    |
| Depression _____    | Hepatitis _____           | Tuberculosis _____       |
| Diabetes _____      | Kidney Disease _____      | Venereal Disease _____   |
| Easy Bleeding _____ | Liver Disease _____       |                          |
| Eczema _____        | Mental Illness _____      |                          |
| Emphysema _____     | Multiple Sclerosis _____  |                          |

Other \_\_\_\_\_  I do not know my family history

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**DIET**

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How many meals on average do you have a day? \_\_\_\_\_ Who prepares your food? \_\_\_\_\_

How much coffee do you drink on average?    None    1/week    2/week    3+/week    1/day    2/day    3+/day

How do you feel after drinking coffee?    No effect    Hands shaking    Heart racing    Light-headed feeling    Other \_\_\_\_\_

How much alcohol do you drink on average?    None    1-2/month    1-2/week    3-4/week    5+/week  
1-2/day    3-4/day    5+/day

What type of alcohol do you drink? \_\_\_\_\_

Do you tend to be thirsty?    Y    N    How much water do you drink each day? \_\_\_\_\_

Do you have any food allergies or sensitivities? (Please list)  
\_\_\_\_\_  
\_\_\_\_\_

What foods do you crave? Do you have any reactions to these foods?  
\_\_\_\_\_  
\_\_\_\_\_

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**PSYCHOSOCIAL**

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How often do you exercise?    Never    1-2/month    3-4/month    1/week    2/week    3/week    4/week    5+/week

Has your frequency of exercise changed recently?    Y    N    How? \_\_\_\_\_

What type/s of exercise do you do? \_\_\_\_\_

Do you enjoy exercising? If not, why not? \_\_\_\_\_

How would you describe the emotional climate of your home?  
\_\_\_\_\_  
\_\_\_\_\_

How stressful is your work or other aspects of your life? How do you handle this stress?  
\_\_\_\_\_  
\_\_\_\_\_

List the three most significant, stressful experiences in your life from the most recent to the most distant.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your interests or hobbies? \_\_\_\_\_

What long-term goals and expectations do you have with regards to working with me?  
\_\_\_\_\_

Is there anything else you would like me to know at this time?  
\_\_\_\_\_

**REVIEW OF SYSTEMS**

*Please check off any symptoms you currently experience (C) or have had in the past (P)*

**GENERAL**

Fatigue \_\_\_\_\_  
Night Sweats \_\_\_\_\_  
Diminished libido \_\_\_\_\_

**SKIN**

Rashes \_\_\_\_\_  
Inflammation \_\_\_\_\_  
Infection \_\_\_\_\_  
Growths \_\_\_\_\_  
Changes in hair/nails \_\_\_\_\_

**HEAD**

Headache \_\_\_\_\_  
Head Injury \_\_\_\_\_

**EYES**

Impaired Vision \_\_\_\_\_  
Eye Pain \_\_\_\_\_  
Tearing or dryness \_\_\_\_\_  
Double Vision \_\_\_\_\_

**EARS**

Impaired Hearing \_\_\_\_\_  
Ringing \_\_\_\_\_  
Dizziness \_\_\_\_\_

**NOSE and SINUSES**

Frequent Colds \_\_\_\_\_  
Nose Bleeds \_\_\_\_\_  
Stuffiness \_\_\_\_\_  
Sinus Problems \_\_\_\_\_  
Post Nasal Drip \_\_\_\_\_

**MOUTH and THROAT**

Frequent Sore Throat \_\_\_\_\_  
Sore Tongue \_\_\_\_\_  
Sores in mouth/on lips \_\_\_\_\_  
Gum Problems \_\_\_\_\_  
Hoarseness \_\_\_\_\_  
Dental Problems \_\_\_\_\_

**NECK**

Swollen Glands \_\_\_\_\_  
Pain or Stiffness \_\_\_\_\_

**BLOOD**

Anemia \_\_\_\_\_  
Easy bleeding/bruising \_\_\_\_\_

**HEART**

Heart Disease \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_  
Rheumatic Fever \_\_\_\_\_  
Chest Pain \_\_\_\_\_

Swelling Ankles \_\_\_\_\_  
Palpitations/fluttering \_\_\_\_\_

**RESPIRATORY**

Cough \_\_\_\_\_  
Spitting up Blood \_\_\_\_\_  
Wheezing \_\_\_\_\_  
Difficulty Breathing \_\_\_\_\_  
Pain on Breathing \_\_\_\_\_  
Shortness of Breath \_\_\_\_\_  
Positive TB test ever Y N

**DIGESTION**

Trouble Swallowing \_\_\_\_\_  
Heartburn \_\_\_\_\_  
Stomach Pain \_\_\_\_\_  
Nausea / Vomiting \_\_\_\_\_  
Bowels Move: Daily More Less  
Blood in Stools \_\_\_\_\_  
Belching or Gas \_\_\_\_\_  
Abdominal bloating \_\_\_\_\_  
Hemorrhoids \_\_\_\_\_

**URINARY**

Pain on Urination \_\_\_\_\_  
Increase Frequency \_\_\_\_\_  
Inability to Hold Urine \_\_\_\_\_  
Bladder Infections \_\_\_\_\_

**CIRCULATION**

Deep Leg Pain \_\_\_\_\_  
Cold Hands/Feet \_\_\_\_\_  
Varicose Veins \_\_\_\_\_

**NEUROLOGIC**

Fainting \_\_\_\_\_  
Seizures \_\_\_\_\_  
Paralysis \_\_\_\_\_  
Muscle Weakness \_\_\_\_\_  
Loss of Memory \_\_\_\_\_

**EMOTIONAL ISSUES**

Apathy \_\_\_\_\_  
Depression \_\_\_\_\_  
Sadness \_\_\_\_\_  
Mood Swings \_\_\_\_\_  
Anxiety or Nervousness \_\_\_\_\_  
Tension \_\_\_\_\_  
Fears or Phobias \_\_\_\_\_  
Anger or Rage \_\_\_\_\_  
Irritability \_\_\_\_\_

Other \_\_\_\_\_

**DIET DIARY**

The purpose of this daily record is to help you keep close watch over what you are eating, and help you to discover which, if any, foods or beverages may be causing or contributing to your symptoms. Use this as a tool for yourself to become more in tune with your dietary habits. It is very important that the information you record in this diary be as accurate and as correct as possible. The more honest you are, the more you will learn about yourself and the easier it will be to identify issues.

- 1- The following is to be done for 5 days in a row.
- 2- Write down everything you eat or drink, including water, snacks, alcoholic beverages, soft drinks, coffee and so on.
- 3- List the contents found inside mixed dishes and foods. It is not enough to write down "a turkey sandwich". You should also write down the kind of bread, spread, dressing (i.e. turkey sandwich – whole wheat bread, butter, mustard).
- 4- Whenever you make an entry in your diary, ask yourself: "Have I given myself and my licensed Naturopath enough information about what is in this food?"

| Day 1  |  |
|--|--|
| Breakfast  |  |
| Lunch  |  |
| Dinner   |  |
| Snack  |  |
| Digestive, urinary, skin complaints, other (i.e. Pain) |  |
| Overall mood and energy                                |  |

| Day 2  |  |
|--|--|
| Breakfast  |  |
| Lunch  |  |
| Dinner   |  |
| Snack  |  |
| Digestive, urinary, skin complaints, other (i.e. Pain) |  |
| Overall mood and energy                                |  |

| Day 3  |  |
|--|--|
| Breakfast  |  |
| Lunch  |  |
| Dinner   |  |
| Snack  |  |
| Digestive, urinary, skin complaints, other (i.e. Pain) |  |
| Overall mood and energy                                |  |

| Day 4  |  |
|--|--|
| Breakfast  |  |
| Lunch  |  |
| Dinner   |  |
| Snack  |  |
| Digestive, urinary, skin complaints, other (i.e. Pain) |  |
| Overall mood and energy                                |  |

| Day 5  |  |
|--|--|
| Breakfast  |  |
| Lunch  |  |
| Dinner   |  |
| Snack  |  |
| Digestive, urinary, skin complaints, other (i.e. Pain) |  |
| Overall mood and energy                                |  |





## INFORMED CONSENT

We would like to take this opportunity to welcome you to the Harmony Health Centre.

### Statement of Acknowledgement

Printed name \_\_\_\_\_

As a patient of this clinic I understand that the form of medical care is based on Naturopathic principles and practices. I recognize that even the gentlest therapies potentially have their complications and hence the information provided is complete and inclusive of all medical history including all prescription medications, over the counter drugs and supplements. The slight health risks of some Naturopathic protocols include, but are not limited to aggravation of pre-existing symptoms, and allergic reaction to supplements or herbs.

I also confirm that I have the ability to accept or reject this care of my own free will and choice. I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

*Please wait for your appointment to sign this form.*

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS