***Dr. Nicole Shortt*, B.Sc. N.D.**
Naturopathic Doctor
Telephone: 250.545.0103

Balance Natural Health Clinic
3105 36th Avenue
Vernon, B.C., V1T 2V7

Patient Information Today's Date:_____

Name: _____
------- (First) --------- (Middle) ---------- ------- (Last) --------

Birthdate: _____ Age: _____ BC Care Card #: _____
(month/day/year)

Address: _____
(Number) (Street) (Apt #) (City) (Province) (Postal Code)

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ E-mail: _____

If above is a child:
Mothers Name: _____ Phone #_____

Fathers Name: _____ Phone #_____

Extended Benefits (3rd Party Coverage) : _____ Pacific Blue Cross _____ Green Shield

Policy # _____ ID#_____

*(Sign Here) X*_____
(Assignment of Payment & Consent to Release Personal Information to Insurance Provider)

Emergency Contact:

Name: _____ Relationship to you: _____

Home Phone #: _____ Alternate Phone #:_____

How did you hear about us? _____

Have you ever seen a naturopathic doctor before? Y / N
If yes, name of previous naturopath: _____

Please list other healthcare practitioners: (e.g. MD, chiropractor, RMT, counselor, etc.)

1) _____

2) _____

3) _____

Personal Information

Height: _____ Weight:_____Occupation: _____

Relationship Status: Single In a Relationship Live-in partner Married Separated Divorced Widowed

Partner's/Spouse's name: _____

# of children: _____ Children's ages: _____

Current Health Concerns:
Please list your major health concerns in order of importance:

1) _____
2) _____
3) _____
4) _____

Please list any past injuries, major illnesses, surgeries or hospitalizations:

1) _____
2) _____
3) _____
4) _____

Please list current medications and natural health products, their dose, and how long you've been taking:

1) _____
2) _____
3) _____
4) _____
5) _____

How committed are you to implementing changes to your lifestyle?
{Rate 0% to 100%: 0 = not committed to 100= fully committed} _____

What habits/lifestyle choices do you have that you feel are helpful to your health and wellness?

_____

What habits/lifestyle choices do you have that you feel are harmful to your health and wellness?

_____

Please list the 5 most significant/stressful events in your life, from the most recent to the most distant. Are you aware of any of these events continuing to impact your life?

_____

_____

_____

_____

_____

Review of Systems

Please check all that apply, whether you have currently [C] or have had in the past [P]:

Skin/Hair/Nails	C	P		C	P
Redness/Rashes/Hives/Itching			Hair changes (colour/shine/loss/growth)		
Eczema/Psoriasis/Shingles/Acne			Nail changes (shape/strength/thickness)		
Easy bruising			Temperature changes/Night sweats		
Excessive dryness/moisture			Skin ulcers/Skin cancer		
Colour changes/mole changes					

Head/Neurologic	C	P		C	P
Headache			Seizure/Convulsions/Epilepsy		
Head Injury			Numbness/Tingling		
TMJ problems/Teeth grinding			Speech problems/slurring		
Dizziness/Fainting/Loss of balance			Involuntary movement		
Stroke/Aneurysm/Transient Ischemic Attacks			Paralysis		

Eye	C	P		C	P
Glasses/Contacts			Excess tearing/Dryness/Redness		
Impaired vision/Double vision/Blurring			Floaters/Blind spots		
Eye pain/Itching/Discharge			Glaucoma/Cataracts		

Ear	C	P		C	P
Impaired hearing/Hearing aid/Ear tubes			Ruptured ear drum		
Ringing/Tinnitus			Excess ear wax/discharge		
Earache/Infection					

Nose/Sinus	C	P		C	P
Frequent colds/Stuffiness			Nose bleeds		
Sinus problems/Chronic congestion			Sensitive to smells		
Allergies/Hay fever			Change in ability to taste		

Mouth/Throat/Neck	C	P		C	P
Gum problems /bleeding			Frequent sore throat /Hoarseness		
Cold sores /Canker sores			Lumps /swollen nodes in neck		
Sore or dry tongue /mouth			Thyroid problems/Goiter		
Cavities /Fillings			Neck pain /Stiffness		
Type of fillings:			How often do you brush & floss?		

Respiratory	C	P		C	P
Cough /Wheezing			Pleurisy		
Sputum /Mucus			Tuberculosis		
Spitting /coughing up blood			Tuberculin Test		
Pain /difficulty breathing /Shortness of breath			Do you/Have you smoked?		
Shortness of breath at night /Sleep apnea			How long: How many:		
Asthma			Chest X-ray		
Emphysema			Date of last chest x-ray:		

Cardiovascular	C	P		C	P
Heart Disease /Coronary Artery Disease			Rheumatic fever		
Angina /Chest pain			Blue extremities		
High blood pressure			Swelling in ankles		
High blood cholesterol			Varicose veins		
Heart murmur/irregular heart beat/palpitations/fluttering			Pacemaker		
Myocardial Infarct /Heart attack					

Breast	C	P		C	P
Lumps /puckering of skin			Nipple discharge / changes		
Pain /tenderness			Implants /reduction /surgery		
Have you ever breastfed?			Do you perform self-exams? Howoften?		
Any problems with breastfeeding?			Family history of breast cancer?		

Gastrointestinal	C	P		C	P
Heartburn /Acid reflux			Diarrhea /Constipation		
Belching /Passing gas			Rectal bleeding /Hemorrhoids		
Offensive breath /Bad taste in mouth			Blood /mucus /undigested food in stool		
Trouble swallowing			Liver disease /hepatitis		
Changes in appetite /thirst			Gall bladder disease /stones /removal		
Bloating /Abdominal pain			Jaundice /Yellow skin		
Nausea/Vomiting			Black tarry stool		
Vomiting blood			Hernia		
Ulcers			Food allergies /sensitivities		
Indigestion					

Urinary	C	P		C	P
Pain /Pressure/ Blood with urination			Inability to hold urine /incontinence		
Urgency /Hesitation			Frequent urinary infections		
Increased frequency day or night			Kidney stones /infections		

Male Reproductive	C	P		C	P
Testicular masses /pain			Discharge /Sores		
Prostate problems /BPH /Prostatitis			Sexually Transmitted Infections		
Date of last prostate exam:			Problems with sperm /conceiving		
Are you sexually active?			Birth Control? Type used:		

Female Reproductive

Age menses began:			Average number of days bleeding:		
Length of cycle (# of days from first day of period to day before next period):					
Bleeding between periods	C	P	Irregular cycles	C	P
Heavy flow	C	P	Painful periods	C	P
PMS	C	P	Endometriosis	C	P
Ovarian cysts	C	P	Uterine cysts /Fibroids	C	P
Sexually Transmitted Infections	C	P	Pain/difficulty during intercourse	C	P
Number of pregnancies:			Number of miscarriages/abortions:		
Number of live births:			Difficulties conceiving	C	P
Yeast / Candida infections	C	P	Abnormal pap / Cervical dysplasia	C	P
Vaginal discharge / itching /redness	C	P	Date of last pap	C	P
Birth control	C	P	Type of birth control used:		
Menopause	C	P	Age at menopause:		
Hot flashes / Night sweats	C	P	Vaginal atrophy /dryness	C	P
Decreased / Loss of libido	C	P	Hormonal therapy for menopause	C	P
Are you sexually active?					

Musculoskeletal	C	P		C	P
Joint pain /stiffness/swelling /Arthritis			Broken bones/fractures		
Muscle weakness /spasms /cramps			Back pain		
Sciatica			Have you had a bone density test?		

Endocrine	C	P		C	P
Sensitive to heat / cold			Diabetes		
Thyroid problems			Hypoglycemia (Low blood sugar)		
Excessive thirst / hunger			Hormone / Steroid therapy		
Excessive urination / sweating					

Blood/Lymphatic	C	P		C	P
Anemia			Easy bleeding / bruising		
Past transfusions			Lymph node swelling		
Hemophilia / Clotting problems			Blood type:		

Allergies	C	P		C	P
Drug Sensitivity			Reaction to vaccine		
Pease list allergies:					

Mental/Emotional	C	P		C	P
Depression			Mood swings		
Sleeping difficulties / Insomnia			Phobias		
Anxiety / Nervousness			Excessive stress		
Substance abuse			Treatment for substance abuse		
Thoughts of suicide / Attempts					

Family Medical History

Has anyone in your family (siblings/parents/grandparents) had the following conditions?	√	Which family member?	Age
Heart disease / High blood pressure			
Asthma / Allergies			
Diabetes / Blood sugar problems			
Cancer (breast, colon, skin, prostate, lung, etc.)			
Psychiatric (depression, anxiety, addiction, etc.)			
Kidney problems			
Hormonal problems (thyroid, pituitary, estrogen, etc.)			
Congenital / Developmental problems			
Neurological problems (MS, Parkinson's, Alzheimer's, etc.)			
Arthritis			
Digestive (Crohn's, gall bladder, IBS, Celiac, colitis, etc)			
Other			

Please indicate your consumption of the following:

	High	Moderate	Low	None
Salt				
Sugar				
Caffeine				
Tobacco				
Alcohol				
Recreational Drugs				
Water				
Exercise				

Please use this space to add anything else you think would be helpful in forming your treatment plan:

_____

_____

_____

_____

Balance
NATURAL HEALTH CLINIC

Dr. Nicole Shortt, N.D.
Naturopathic Physician

Acknowledgment and Consent: Please read, sign and deliver. Thank you.

Naturopathic Medicine: Naturopathic doctors provide primary and complementary health care by focusing on the scientific use of natural therapies to support and stimulate healing processes.

Naturopathic doctors use standard medical diagnostic tools (physical exam, fitness testing, health history and imaging studies, etc.) Therapies used in naturopathic practice are:

*Botanical Medicine *Clinical Nutrition
*Homeopathic Medicine *Lifestyle/Fitness Counseling
*Eastern Medicine/Acupuncture *Physical Therapeutic Procedures/Bowen Technique

A confidential record will be kept of your health consults and will not be released without your consent unless directed by law. I permit Dr. Shortt to use her discretion in consulting with other professionals (who are also bound by provincial privacy laws) regarding my health in order to provide me with optimal medical care. (You may look at your file at any time and can request a copy by paying a minimal fee.)

I voluntarily consent to the diagnostic and therapeutic procedures mentioned above. I understand that there are health risks involved with Naturopathic Medicine services and I hereby release Dr. Shortt, N.D. and Balance Natural Health Clinic (its employees and owners) from any claims, demands and causes of action arising from my voluntary participation in these services.

I understand that failure to follow Naturopathic prescriptions could undermine the expected results. Naturopathic Doctors reserve the right to determine which cases fall outside his/her scope of practice, in which event an appropriate referral will be made.

I allow communication via Email as it saves resources and response times. Dr. Shortt makes every attempt to prevent computer/internet criminal activity. I understand the inherent risk involved with computer and internet use and release Dr. Shortt from any liability.

All fees for services and supplements are payable at the time of the appointment. There is a fee for completing insurance forms, letter writing, and telephone consultations greater than 5 minutes. Please give 24 hour notice for appointment cancellations as per the following cancellation policy form.

I have read and understand the above statements. I intend this consent form to cover the entire course of treatment. I am free to withdraw my consent and/ or terminate my treatment at any time.

Date_____

Signature of Patient (or Guardian) _____

Please print name_____

By providing my email address I consent to being added to the clinic list for newsletters, and understand I can unsubscribe at any time.
Email address for newsletters_____

Cancellation/ No Show Policy

Balance
NATURAL HEALTH CLINIC

Missed Appointments

When you book an appointment with us, that time is set aside for you - and ONLY you. Please understand thatmissed appointments prevent us from working with other clients.

Our Cancellation Policy

You may sometimes need to cancel your appointment with us, so we have tried to make our cancellation policy as simple as possible.

If you provide us with:

- **At least 24 hours' notice** – there is no charge for cancelling your appointment
- **Less than 24 hours' notice** – there will be a $50 charge for the missed appointment ($45 for counselling appointments)
- **Less than 3 hours' notice OR you simply don't show up** – we consider this a "no-show" and you are expected to pay 100% of the fee for the missed appointment ($45 for counselling appointments)

If you do not reach us, please leave a message on our voice-mail system. Note that with Monday appointments we will need to hear from you the Friday before as the receptionists do not check voicemail on the weekend and it won't be heard until Monday at 9 am.

Note: We recognize that there are circumstances that are out of your control (sudden illness, family emergencies, etc.) and so your healthcare provider may make an exception to the above policies on those rare occasions. You will need to speak to your service provider directly for an exception.

I understand the above policy and agree to pay for missed appointments and for cancellations with less than 24 hours' notice.

Signature: _____ Date: _____

_____

Signature of parent or guardian if client is under 19 years of age