

Centre for Natural Medicine Inc.

1218 Lorette Ave - Winnipeg, Manitoba - R3M 1W5

Phone: 488-6528 Fax: 452-7044

Due to the chemical sensitivity of some of our patients, we ask that you please refrain from wearing perfume/cologne when visiting our office. Thank you.

Name _____ Date _____
Age _____
Date of Birth ____/____/____
Gender: female _____ male _____
Address _____
City _____ Prov _____ Postal Code _____
Telephone# (home) _____ Parent/Guardian (Work) _____
Name of Parent/Guardian _____
How did you hear about this clinic? _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS

What are his/her most important health problems that he/she is seeking treatment for or is currently being treated for? List as many as you can in order of importance.

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

ALLERGIES

Is he/she hypersensitive or allergic to any of the following (please list):

Drugs? _____

Foods? _____

Environmentals? (pollen, dust, etc.) _____

CURRENT MEDICATIONS

Please list **any** prescription medications, over the counter medications, vitamins or other supplements he/she is taking:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Additional Comments: _____

Frequently Eaten Foods: _____

GENERAL

Weight: _____ lbs Weight 1 year ago: _____ lbs

Max. Weight / When : _____ Height: _____

When during the day is his/her energy the best? _____ Worst? _____

REVIEW OF SYSTEMS

Y = A condition he/she has now
 N = A condition he/she never had
 P = A condition he/she has had in the past but is not experiencing at this time.

PLEASE CIRCLE THE APPROPRIATE LETTER FOR THE FOLLOWING:

Mental/Emotional

Mood Swings	Y	N	P		Anxiety or nervousness	Y	N	P
Poor Concentration	Y	N	P		Memory Problems	Y	N	P

Endocrine

Hypothyroid	Y	N	P		Heat or cold intolerance	Y	N	P
Hypoglycemia	Y	N	P		Diabetes	Y	N	P
Fatigue	Y	N	P		Seasonal Depression	Y	N	P

Immune

Vaccinations	Y	N	P		Reactions to vaccinations	Y	N	P
Chronic infections	Y	N	P		Chronic swollen glands	Y	N	P
Slow Wound Healing	Y	N	P					

Skin

Rashes	Y	N	P		Eczema, Hives	Y	N	P
Acne, Boils	Y	N	P		Itching	Y	N	P

Head

Headaches	Y	N	P		Migraines	Y	N	P
Head Injury	Y	N	P					

Ears

Earaches	Y	N	P		Impaired Hearing	Y	N	P
Dizziness	Y	N	P		ringing in Ears	Y	N	P

Nose and Sinuses

Frequent colds	Y	N	P		nosebleeds	Y	N	P
Stuffiness	Y	N	P		Hayfever	Y	N	P
Sinus Problems	Y	N	P		Loss of Smell	Y	N	P

Y = A condition he/she has now
 N = A condition he/she never had
 P = A condition he/she has had in the past but is not experiencing at this time.

Mouth and Throat

Frequent sore throat Y N P

Sore tongue/lips

Y N P

Respiratory

Cough Y N P

Wheezing

Y N P

Asthma Y N P

Bronchitis

Y N P

Cardiovascular

Heart Disease Y N P

High/Low Blood Pressure

Y N P

Palpitations Y N P

Gastrointestinal

Heartburn Y N P

Belching or passing gas

Y N P

Change in thirst Y N P

Change in appetite

Y N P

Constipation Y N P

Diarrhea

Y N P

How many bowel movements a day? _____ Is this a change? _____

Urinary

Increased frequency Y N P

Frequency at night

Y N P

Frequent Infections Y N P

Musculoskeletal

Joint pain Y N P

Stiffness in joints

Y N P

Muscle spasms/ Y N P

Arthritis

Y N P

Cramps

HABITS

Does he/she exercise? Y N P

If yes, what kind and how often? _____

Average 8-10 hrs. sleep Y N P

Sleep well

Y N P

Awaken Rested Y N P

Any Major traumas

Y N P

History of abuse Y N P

Eat refined sugar

Y N P

Watch television Y N P

Read?

Y N P

How many hours? _____

How many hours? _____

Is there any information about the child's health that you would like to add?

I _____ (parent or legal guardian) **AGREE** to pay my full account at the time of each visit or treatment, including fees for appointments, services, cost of supplements and remedies, cost of laboratory tests, administrative fees, missed appointment fees as well as other applicable fees.

Patient's Full Name: _____
First Middle Last

Date of Consent: Day: _____ Month _____ Year: 20__

Signature of Patient (or Parent or Legal guardian)