



Naturopathic Medicine

Welcome to DOWNTOWN INTEGRATIVE HEALTH GROUP and thank you for the opportunity to help you with your health. To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly.

PERSONAL INFORMATION

Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Phone: Home _____ Business _____ Cell _____

E-mail _____ Alberta Health Card Number _____ - _____

Date of Birth (D/M/Y) _____ Age _____ Male [] Female []

Occupation _____ Employer _____

Contact Person _____ Their phone number _____

Do you have extended health care benefits? Yes No With whom? _____

Is this a Workers Compensation Board injury? Yes No

Are your injuries related to a Motor Vehicle Accident? Yes No

We appreciate those who refer their friends and family to our office. Please let us know who referred you to our care. Name
_____ Relationship to you _____

If you weren't referred, how did you hear about us? M.D. Website Sign Phone Book

Other _____

**Although our office does not direct bill third party insurance coverage, we do encourage our patients to check their benefit package regarding their coverage for the following services: chiropractic, naturopathy, TCM, acupuncture, massage therapy, orthotics, exercise therapy. We will issue you receipts that you can submit for reimbursement.*

CURRENT HEALTH CONCERNS

What are the most important health concerns for which you are seeking treatment from us or are receiving elsewhere?

List in order of importance to you.

1. _____

2. _____

3. _____

What do you hope to gain from your treatment here? Check all that apply:

Pain reduction Return of function Guidance for future prevention Other: _____

Health Providers *Who else have you seen regarding your health and when was your last visit?*

- | | |
|---|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Naturopathic Doctor |
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Acupuncturist |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Homeopath |
| <input type="checkbox"/> Traditional Chinese Medical Practitioner | <input type="checkbox"/> other |

Last Visit _____ Name of your Medical Doctor: _____

Please list any prescription and non- prescription medications, vitamins and other supplements, the dosage and reason for using them.

1. _____
2. _____
3. _____
4. _____

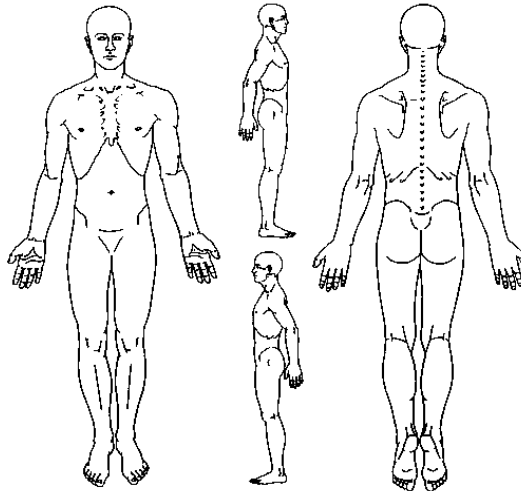
Please list any serious illnesses, surgeries, auto or sports injuries or broken bones
_____ when _____

Have you reached full recovery? **Y N**
_____ when _____

Have you reached full recovery? **Y N**
_____ when _____

Have you reached full recovery? **Y N**
_____ when _____

On the diagram(s) below, please circle the area(s) that applies most to where you experience symptoms or feel pain.



Use these letters to describe the pain: **S** sharp **D** dull **A** achy **H** hot **C** cold **N** numb **T** tingling **DB** deep and boring **TW** twisting **V** variable

How bad is the pain at its **LOWEST** and **HIGHEST** (no pain) 0-1-2-3-4-5-6-7-8-9-10 (worst pain ever)

When and how did it start? _____



HEALTH LIFE STYLE INFORMATION

Your health is influenced by many factors. Your answers to the following questions are important and will be kept totally confidential.

Weight : _____ Weight 1 year ago: _____ Max weight: _____ Height : _____ Blood type:
O A AB B Don't know

Rate your energy level: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Rate your quality of sleep: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Rate your stress level: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Do you currently wear orthotics? Yes No Do you wear a dental splint? Yes No

What are your primary physical activities?

1. _____
2. _____
3. _____

How would you describe your job? physically demanding with heavy lifting variety of sitting, standing and walking mostly sitting boring satisfying in transition

Do you smoke? Yes No How many per day? _____ How many years? _____

Chew tobacco? Yes No How many per day? _____ How many years? _____

Have you ever tried to stop? Yes No

Do you drink alcohol? Yes No How often? daily weekly infrequently

Do you use recreational drugs? Yes No How often? daily weekly infrequently

How often do you eat out per week? less than 3 between 4 and 8 over 9

What would you say about your diet? needs significant improvement ok for now very healthy

Do you drink coffee? Yes No How many cups/day? _____

Have you any diet preferences or restrictions? vegetarian celiac other: _____

Please list any drug, food, and environmental allergies or sensitivities.

Have you now or in the past had mercury dental fillings? Yes No Yes, but they're removed

Have you any surgical implants or piercing (medical or cosmetic)? Yes No

Please be specific: _____

Have you been vaccinated? Yes No Any adverse reactions? Yes No

How many times have you been on antibiotics in the past two years? _____

Do you have a history of drug or alcohol abuse? Yes No



WOMEN'S HEALTH

Is there a chance you could be pregnant? **Yes** **No**

Number of previous pregnancies _____ Number of miscarriages/abortions _____

Have you ever used birth control? **Yes** **No** What type? _____ How long? _____

How many days do you bleed? _____ How long between your periods (onset to onset)? _____

Do you experience: Heavy flow Light flow Clotting Bleeding between periods

Cramping Pain during intercourse Low sex drive

Do you have pre-menstrual symptoms (PMS)? **Yes** **No**

Pain or cramping Mood Swings Bloating and/or water retention Headaches Breast tenderness

Cravings Other: _____

Have your periods stopped (menopause)? **Yes** **No** When? _____

Date of last bone density test _____ normal osteopenia osteoporosis

Date of last Pap test _____ normal abnormal

Do you perform monthly self-breast exams? **Yes** **No**

When was your last professional breast exam? _____

Do you have regular mammograms? **Yes** **No**

MEN'S HEALTH

Do you have any of the following?

Hernia Testicular mass and or pain Discharge or sores Impotence or erectile dysfunction Low sex drive Prostate condition

Do you perform self-testicular exams? **Yes** **No**

Year of last prostate exam? _____

Are there any other significant events that you believe have impacted your health?

Naturopathy Informed Consent To Treatment

Dr. Trudy Strasser, ND, Rac

First Name: _____ Last Name: _____

Naturopathic Medicine is separate and distinct from medical doctors and is not covered under AHC. Therefore, I take sole responsibility for my consent to follow the advice and treatment suggested by Dr. T. Strasser.

1. I authorize Dr. T. Strasser to perform the following procedure(s) and treatment as needed: - Naturopathy, Homeopathy, Acupuncture, Hydrotherapy, Nutritional Counseling, Detoxification, Herbs, Physical and Psychological Therapy, IV Therapy, Biopuncture, Neurotherapy, Prolotherapy or alternate treatment that the doctor considers advisable in the opinion, judgement and conclusion of the aforementioned doctor.
2. The nature and purpose of the treatment, possible methods of treatment, alternate methods of treatment, the risks involved and the complications will be fully explained to me by the above named doctor and or assistants.
3. It is my responsibility to comply with therapies for drugs, surgery, chemotherapy, radiation, etc. as prescribed by the medical profession.
4. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

Note: *medical records will not be released without your written consent.*

No refunds on services, NSF checks subject to bank fees, 24-hour cancellation notice or \$25 fee may apply.

I certify that I have read and fully understand the above consent to treatment and that the explanations therein referred to be in fact made to me and that this form was completed prior to treatment.

Signature of Patient: _____ Date: _____

Witness: _____ Date: _____

Note: when the patient is a minor or otherwise incompetent to give consent, the consent of a parent or guardian must be obtained.

Signature of Parent or Guardian:

Name of Signatory (Please Print)

Date:

Relationship of person signing for patient