living wellness centre

Health History Add-on

NAME Date

MAIN HEALTH CONCERN

Other concerns:

IMMUNIZATIONS

Did you receive general childhood vaccinations? ☐ Yes ☐ No

Check any other vaccines taken: ☐ Hepatitis A ☐ Hepatitis B ☐ Flu shot ☐ Others

ALLERGIES

Please list any allergies or sensitivities in the following categories.

Medications

Foods

Environmental/chemical

MEDICATIONS

Please check if you use any of the following.

☐ Alcohol ☐ Antacids ☐ Anti-inflammatories ☐ Caffeine ☐ Cortisone ☐ Laxatives
☐ Marijuana ☐ Pain relievers ☐ Sleeping pills ☐ Tranquilizers ☐ Other drugs

Were you ever on antibiotics for more than 1 month over the last 10 years? ☐ Yes ☐ No

Have you ever used probiotics (acidophilus) following antibiotic use? ☐ Yes ☐ No

FAMILY HISTORY

Please check if you have a family history of any of the following:

☐ Arthritis ☐ Asthma/allergies ☐ Cancer ☐ Depression ☐ Diabetes ☐ Drug/alcohol abuse
☐ Epilepsy ☐ High blood pressure ☐ High cholesterol ☐ Kidney disease ☐ Mental Illness ☐ Stroke
☐ I don't know my family history ☐ Other

SLEEP

Time you go to sleep Time you wake up

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

Do you wake well rested in the morning? ☐ Yes ☐ No

DIET

Do you follow any particular diet regimens or restrictions? ☐ Yes ☐ No

If yes, please specify:

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Naturopathic Declaration & Consent to Treatment

A Naturopathic Doctor (ND) will conduct a thorough case history and physical examination, and may utilize specific blood, urinary or other laboratory reports as part of your treatment work-up.

Statement of Acknowledgement

As a patient of Living Wellness Centre, I have read the information and understand that the form of medical care given is based on Naturopathic principles and practices. I recognize that even the gentlest therapies have potential complications in certain physiological conditions or in very young children or those on multiple medications.

The information I have provided is complete and inclusive of all heath concerns, including risk of pregnancy and all medications, including over-the-counter drugs.

The slight health risk of some Naturopathic treatments include but are not limited to: aggravation of pre-existing symptoms; allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and spasms.

I also recognize the following:

- Any treatment or advice provided to me as a patient of the clinic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another healthcare provider licensed to practice in British Columbia.
- I understand that a record of my visits will be kept. This record will be kept confidential and will not be released without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am aware that I am responsible for payment at the time services are rendered.
- I am aware that 48 hours notice must be given for cancellation of an appointment or a cancellation fee may be applied.
- I understand that the ND reserves the right to determine which cases fall outside his/her scope of practice, in which event the appropriate referral will be recommended.

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

Signature Date

Full Name

Naturopathic Physician Signature