Detailed Annual Screening and Wellness Check Up

Please help us provide you with a complete and thorough evaluation by completing this questionnaire fully.

Your information is kept private and confidential as per the Ontario Privacy Act

Name: _____ Birthday: _____/_____/_____ Age: ___
(Full Name) mm dd yyyy

Address:_____

City: _____ Province: _____ Postal Code: _____

Home Phone #:_____ Work Phone #:_____

Cellular Phone #:_____ Email: _____

(Optional) Preferred Pronoun _____ (Optional) Gender ID _____

Note: As a courtesy, we do email or text reminders for appointments, and sometimes let our patients know of important clinic updates via email. This occurs infrequently. It is important that we can reach you this way. It is your right to opt out if you wish.

How did you find out about us? Personal Referral Professional referral Google/website Walking by
Other _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Marital Status: □ Single □ Common-Law □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____ Occupation: _____

Your Health Care Team:

Medical Doctor: _____ Phone #: _____

Specialist/Other: _____ Phone #: _____

Date of last physical exam (approx.): _____

Date of last screening bloodwork (approx.): _____

Main reasons for office visit; your health goals

_____

_____

_____

_____

Medications and Supplements

List all **current** medications and dose (prescribed or over the counter):

Medication	Dose and frequency	Since When	Adverse Effects?

List all supplements you are currently taking and dosages: (vitamins, minerals, enzymes, homeopathic, herbs, etc.)

Supplement, Brand	Dose and frequency	Since When

Your Medical History

Do you have any anaphylactic allergies?
_____

Do you have any allergies to: medications, environmental substances (airborne, dust, pollens animals, chemicals) or foods? What kind of reactions to you experience?
_____
_____

Please list all major hospitalizations: Year, Surgery/ Illness/ Injury & Outcome
_____
_____
_____

Please list any pre-existing diagnoses or health concerns:
_____
_____
_____
_____

Your weight today: _____ Height: _____

Do you consider yourself: □ Underweight □ Overweight □ Just Right

Rate your current energy level from 1 to 10 with 10 being the most energy you've had.
1 2 3 4 5 6 7 8 9 10

In your estimation, how physically fit are you (please circle)?

□ Unfit □ Below Average □ Average □ Above Average □ Very Fit

What do you do for exercise? How many times per week? How many minutes/hours?
_____

Nutrition/Hydration/Substances

Any foods that you avoid and why? _____

Are following a diet style? (Keto, Paleo, vegetarian, vegan, other – please list)
_____

How many: Cups of water per day? _____

Alcoholic beverages/week (Please answer honestly)? _____

Caffeine: Cups of coffee per day ___ Cups of caffeinated tea per day ___ cans of pop per day ___

Notes: _____

Do you smoke? Y or N If "yes" how much per day? _____ Please list past use; how much smoked daily for how long, and number of years quit: _____

Medical Review

Please check the conditions you have had or continue to experience: **Specify (p) Past or (c) Current.**

□Abuse
□Alcoholism
□Allergies
□Alzheimer's
□Angina
□Hay Fever
□Alzheimer's
□Anemia
□Anxiety
□Arthritis
□Appendicitis
□Asthma
□Atypical Pap
□Auto Immune Disease
□Bronchitis
□Cancer
□Cardiovascular Disease
□Carpal Tunnel
□Chicken Pox
□Cholesterol Elevated
□Circulatory Problems
□Colitis
□Crohn's Disease
□Dementia
□Depression
□Diabetes
□Diverticular Disease
□Drug Addiction
□Eating Disorder
□Emphysema
□Environmental Sensitivity
□Epilepsy
□Eyes, Ears, Nose, Throat Problems
□Gallstones
□Genetic Disorder
□Glaucoma
□Goiter
□Gout
□Heart Attack
□Heart Valve Problem
□Hepatitis A B C
□Herpes: Oral/ Genital
□HIV
□Hypertension
□Infection- Chronic
□Irritable Bowel Syndrome
□Kidney or Bladder Disease
□Learning Disability
□Liver Disease
□Malaria
□Measles
□Mental Illness _____
□Migraines
□Mononucleosis
□Mumps
□Neurological Problems
□Osteopenia
□Osteoporosis
□Pacemaker
□Paralysis
□Parasites
□Parkinson's
□Pleurisy
□Pneumonia
□Prostatitis
□Rheumatic Fever
□Scarlet Fever
□Seasonal Affective Disorder
□Sleep Apnea
□STD
□Stent
□Stroke
□Thyroid Issues
□Tuberculosis
□Ulcer
□Urinary Tract Infections
□Varicose Veins
□Whoop
□Other _____

Family Medical History (Also indicate *which family member*)

□Arthritis
□Autoimmune Disease _____
□Asthma
□Alzheimer's Disease
□Bleeding Problems
□ Cancer (Type)_____ _____ _____
□Cardiovascular disease
□Cholesterol elevated
□Dementia
□Diabetes
□Eating Disorders
□Epilepsy
□Hay Fever, Allergies
□Heart Attack
□Heart Murmur
□High Blood Pressure
□Kidney Problems
□Mental Health Issues _____
□Obesity
□Osteoporosis
□Parkinson's Disease
□Stroke
□Substance Abuse (What?) _____
□Thyroid Problems
□Tuberculosis
□Other _____

Systems Review: Please check all *Current* Symptoms

□Recurrent Infections
□Swollen Lymph Nodes
□Sweating at night
□Sweat Easily
□Excessive Thirst
□Thirst but No Desire to Drink
□Excessive Appetite
□Recent Change in Appetite
□Fatigue
□Poor Sleep
□Edema (Water Retention)
□Underweight
□Overweight
□Heat Intolerance
□Cold Intolerance
□Other _____

Cardiovascular
□Blood Clots
□Fainting
□Chest pain
□Heart Palpitations
□Cold Hands/Feet
□Difficulty Breathing
□Irregular Heartbeat
□Swelling in Hands/Feet
□Other _____

Musculoskeletal
□Neck Ache/Pain
□Back Ache/Pain
□Muscle Pains
□Joint Pain
□Stiffness
□Muscle Weakness
□Orthotics
□Hernia
Other _____

Behavioral
□Nervousness
□Anxiety
□Depression
□Easily Stressed
□Overwhelm
□Moody
□Aggressive/Bad Temper
□Panic Attacks
□Fear
□High Pressure Job
□Other _____

Gastrointestinal
□Nausea
□Vomiting
□Gas/Bloating
□Bad Breath
□Constipation
□Use Laxatives
□Diarrhea
□Change in Bowel Habits
□Pain or Cramps
□Sensitive Abdomen
□Indigestion/Heartburn
□Belching
□Rectal Pain
□Bloody Stools
□Mucus in Stools
□Hemorrhoids
□Black Stools
□Other _____

Respiratory
□Coughing Blood
□Coughing Phlegm/Mucus
□Tight Chest
□Shortness of Breath
□Sinus Problems
□Postnasal Drip
□Wheezing
□Difficulty Breathing When Lying Down
□Recurrent/Persistent Cough/Cold
Other _____

Neurological
□Numbness/Tingling
□Twitching
□Tremors
□Loss of Balance/Coordination
□Nerve Damage
□Vertigo
□Other _____

Skin
□Bleed or Bruise Easily
□Rashes
□Itching
□Eczema
□Dry Skin/Scalp
□Oily Skin/Scalp
□Loss of Hair
□Dandruff
□Ulcerations
□Pimples/Acne
□Hives
□Fungal Infection
□Recent Moles
□Change in Colour of Mole
□Other _____

Head, Eyes, Ears, Nose, Throat
□Dizziness
□Concussions
□Headaches
□Ringing in Ears
□Hearing Aid
□Poor Hearing
□Draining/Discharge from Ear
□Teeth Problems
□Bleeding Gums
□Dentures
□Sores on Lips or Tongue
□Dry Mouth
□Grinding Teeth
□Dry Throat/Hoarseness
□Jaw Clicks
□Spots in Eyes/Floaters
□Wear Glasses/Contacts
□Color Blindness
□Eye Pain
□Cataracts
□Night Blindness, Difficulty
□Blurry Vison
□Nose Bleeds
□Snoring
□Sinus Problems
□Mucus in Nose and Throat
□Other _____

Genito-Urinary
□Pain on Urination
□Unable to Hold Urine
□Urgency to Urinate
□Frequent Urination
□Wake up to Urinate
□Blood in Urine
□Dribbling Urination
□Kidney Stones
□Impotency
□Other _____

Sexual Orientation (Optional)
□Lesbian
□Gay
□Bisexual
□Transgender
□Queer
□Asexual
□Hetero

Male
□Discharge from Penis
□Pain in Testicles
□Lump in Testicles
□Prostate Abnormalities
□Vasectomy
□Change in Sex Drive
□Infertility
□Varicocele
Other _____

Female
□Vaginal Itching or Burning
□Vaginal Discharge
□Cervical Dysplasia
□Painful Menstrual Periods
□Lumps in Breast
□Discharge from Nipple
□Pain with Intercourse
□PCOS
□Bleeding Between Periods
□Fibroids
□Endometriosis
□Hysterectomy Full/Partial
□Ovarian Cysts
□PMS
□Perimenopausal
□Menopausal
□Midcycle Pains
□Irregular Cycles
□Recent Change in Cycle
□Infertility
□Insufficient Lactation
□Tendency to Miscarry
□Tubal Ligation
□Change in Sex Drive
Low or High
□Other _____

Last Pap Date: _____

Methods of Birth Control:
_____
_____

Last Mammogram/Thermogram:
_____

Menstruation:
Last Menstrual Period Date:
_____

Cycle Length (e.g. 28 days)
_____

# of days of bleeding: _____

PMS/Menstrual Symptoms
□Mood Changes (Anger, Irritable, Sad, Sensitive
□Cravings
□Water Retention
□Cramping
□Breast Tenderness
□Back Pain
□Diarrhea/constipation
□Difficulty sleeping
□Fatigue
□To Hot/To Cold
□Headaches, Migraines
□Acne/Pimple Flare
□Other _____

Flow
□Clots
□Heavy: #Pads/Day _____
□Scanty
□Dark Red
□Bright Red
□Better Pressure
□Worse Pressure
□Better Heat
□Other _____

Birth Control Pill History of Use: # of years? _____
What ages? _____
Tolerance to it? Good bad

Hormone Replacement Therapy? Y or N
How long? _____

Number of Pregnancies_____
Number of Live Births_____
Number of Miscarriages _____
Number or Abortions_____

Thank-you for completing this form thoroughly, so that we can do our best to help you!

Consent To VCIM Wellness Series: Physical Exam and Lab Review

Overview:

The process for the VCIM Wellness Series will be reviewed with you in office by Tammy Grime, ND or Sarah Bowler, ND prior to assessment. Please review this consent form in advance of your appointment. Please ask your Naturopathic Doctor (ND) at the time of your visit if you have any questions. Please sign this consent form in advance if you are comfortable with this process.

Naturopathic medicine is the treatment and prevention of diseases by natural means and by addressing the root causes of physiological disturbance. Naturopathic doctors usually assess the whole person with a complete intake, physical exam and appropriate tests to do this, so it must be clear that this wellness series does not provide complete Naturopathic Care.

Aims:

The aim of this visit series is to provide a physical exam and standard lab tests to screen for any abnormalities, obvious disease processes or areas that could use improvement. Time will be spent in the second visit to discuss the results of the physical exam and the blood tests. Discussion will include but not limited to:

- Normal and abnormal findings from the physical exam
- What was evaluated in the physical exam and what are the limitations of such an exam
- In-range, out-of-range lab results, and what they might mean
- Context relating to your stated personal medical history and family history
- What are “ideal” lab results to aim for
- When to re-evaluate
- Further steps, including referrals
- We will provide you a copy of your lab results

Consent:

I _____ (patient name) understand that:

- I may be paying out of pocket for the labs. I will be provided with the requisition form upon payment and completion of the physical exam component and will complete the bloodwork at a LifeLabs location of my choosing. It is my responsibility to ensure I complete this process in advance of my second visit to ensure results are available.
- I must be fasting for at least 8 hours before completing my blood tests
- The information gathered will be for screening purposes only, and is not intended to be a substitute for a full naturopathic intake and no treatments will be given during these visits.
- Should abnormal results show up, you may be suggested to follow up with your family doctor or a walk-in clinic (since ND’s are restricted in what follow-up testing, we can provide), be directed to get repeat testing at a specified time, or be encouraged to pursue naturopathic care or referral to other healthcare providers.
- We will not provide diagnoses based on your results
- We will not provide advice on medications; please continue to take all medications as previously prescribed
- We may make very basic supplement recommendations, depending on your results, but only for simple nutrients that can treat deficiencies noted, or specific risks assessed (for example iron to correct iron deficiency). It must be understood that any suggestions given after the results are general, based on your PE and labs, and not based on a naturopathic evaluation or full understanding of your medical case.
- I understand that the ND will answer any questions I have to the best of her ability.
- I accept full responsibility for any fees incurred during care and treatment.
- I understand that charges are to be paid at the time of the visit unless previous arrangements have been made prior to my scheduled appointment.
- I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Risks:

- I understand that the exam will be as comprehensive as we are able, and the results will provide a good snapshot of your health, but we cannot guarantee that nothing is missed. This is not a substitute for medical care.
- I understand that results are not guaranteed.

Privacy:

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my record at any time and can request a copy of it by paying the appropriate fee.

Cancellation Policy:

I understand that the Cancellation policy requires me to cancel and/or reschedule a booked appointment 24 hours prior to a given, scheduled appointment. Cancellations with less than 24 hours 'notice will incur a charge of 50% of the scheduled office visit fee that must be paid prior to the next visit.

In Office Wait Times

We try our very best to keep appointments running on time which can be difficult in a health care setting. At times there are unexpected complexities, urgencies and needs that can affect the scheduling. **Our longest wait time is 30 minutes.**

Please don't hesitate to call to see if we are running on time. We also ask that you be on time and adjust for traffic, transit delays and parking ahead of your visit time so that we use your visit time well.

Email Policy

Medical advice and care cannot be provided by email; it is not a safe or effective way to provide care. It is also very difficult to schedule appointments over email. Please call the office directly for any concerns, for prescription clarifications and appointment scheduling.

We do very much want to know how you are doing and any concerns you may have – alas we cannot address such concerns by email.

Signatures:

I intend this consent form to cover the entire course of treatment

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have read and understand all this form, including the risks, alternatives for treatment, and the Village Centre for Integrative Medicine office policies.

Name (Print): _____ Signature: _____ Date: _____