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NATUROPATHIC CLINIC

Welcome to your journey towards health!
Please fill out the following form in as much detail as possible to help me best understand you and your health needs. If there is any other information you would like to provide, please do so on the back of the form.

Today's Date: ______________________________

Context of Care Review		
As a naturopathic doctor, I believe comprehensive and effective healthcare is only possible when a physician has a complete understanding of the patient on a phyiscal, mental, and emotional level. The responses you provide to the following questions will assist me in understanding your health care needs and goals. Your time, thoughtfulness and honesty in completing this form is appreciated, and will provide me with great insight in order to help you feel better, sooner!		
Have you been to a naturopathic doctor before? ❑ Yes ❑ No Dietician? ❑ Yes ❑ No Acupuncterist? ❑ Yes ❑ No		
Patient Information		
Name:		
Age:	DOB: _____ / _____ / _____ (day, month, year)	Sex: ❑ Male ❑ Female ❑ Other
Height:	Weight:	
Marital Status:	Occupation:	
Contact Information		
Home Address:		
City:	Postal Code:	
Home Phone:	Cell Phone:	Work Phone:
May we leave voicemails at the above phone numbers? If so, please select which ones. No confidential information is left on voicemails. ❑ Home ❑ Cell ❑ Work		
Email Address:		
Would you like to recieve our newsletter for news, events, and special offers? (sent once a month or less) ❑ Yes ❑ No	Preferred method of contact: ❑ Phone ❑ Email	
Emergency Contact Information		
Primary Contact:	Relationship:	
Phone number(s) for emergency contact:		

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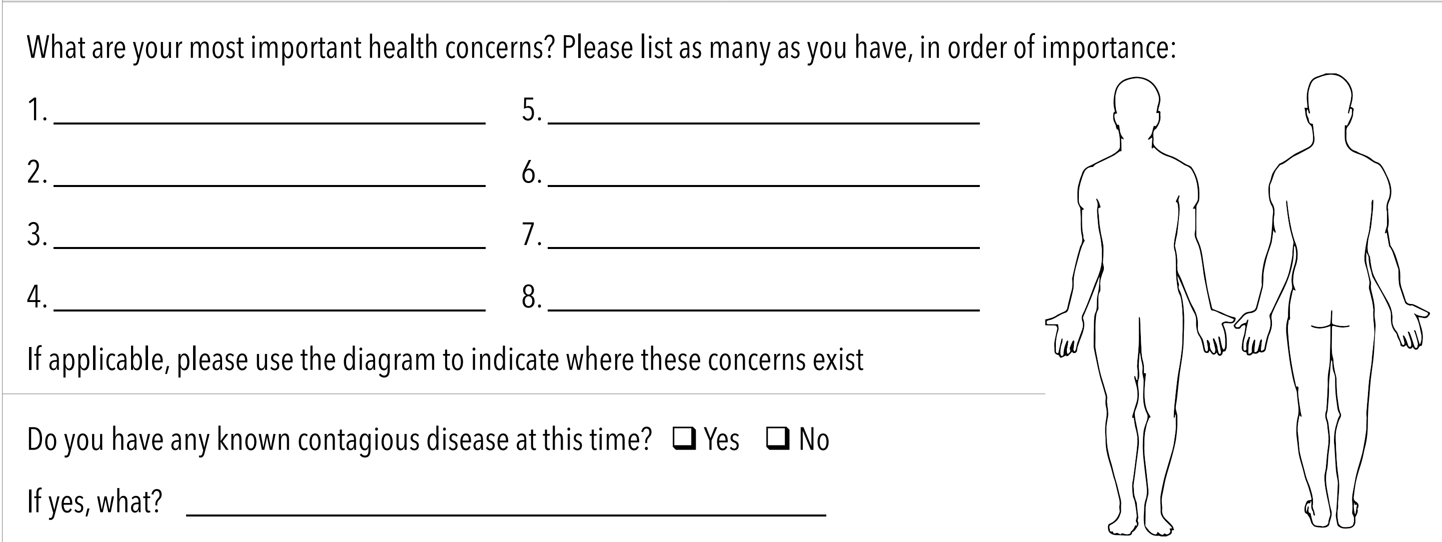
Other Healthcare Providers

Name of Doctor:	Telephone #:	
Are you currently under their care? ❑ Yes ❑ No	Date of last visit:	Date of last physical:
Name of Doctor:	Telephone #:	
Are you currently under their care? ❑ Yes ❑ No	Date of last visit:	Date of last physical:

May we contact these practitioners to share your treatment plan? ❑ Yes ❑ No

Health Concerns

What are your most important health concerns? Please list as many as you have, in order of importance:



1. ______________________________ 5. ______________________________
2. ______________________________ 6. ______________________________
3. ______________________________ 7. ______________________________
4. ______________________________ 8. ______________________________

If applicable, please use the diagram to indicate where these concerns exist

Do you have any known contagious disease at this time? ❑ Yes ❑ No

If yes, what? ____

Do you get regular SCREENING tests (Pap, Blood Tests, Colonoscopy, etc.) done by another doctor? ❑ Yes ❑ No

Please list any diagnoses you have received (presently or in the past), who diagnosed the condition, and any relevant dates (even if just an estimation):

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Medications & Supplements

Please list all current medications, dose, and how long you have been taking it.

	Medication Name	Dose	How Often	For How Long	Reason
1.					
2.					
3.					
4.					
5.					

Please list all current supplements (include brand if known), dose, and how long you have been taking it:

	Supplement Name	Dose	How Often	For How Long	Reason
1.					
2.					
3.					
4.					
5.					

Allergies & Sensitivities (please list)

Expectations

What 3 expectations do you have for your first visit?

1. ______________________________
2. ______________________________
3. ______________________________

What is your longterm goal of treatment?

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Personal Health Habits

Do you drink water? ❑ Yes ❑ No How many cups per day? ___________

Do you smoke? ❑ Yes ❑ No How long ago did you start? _________ # of cigarettes per day _________

Did you smoke before? ❑ Yes ❑ No For how long? ____________________ # of cigarettes per day _________

Do you drink alcohol? ❑ Yes ❑ No What type? ______________________ How frequently? ______________

Do you drink coffee? ❑ Yes ❑ No How many cups per day? ___________

Do you take recreational drugs? ❑ Yes ❑ No What type? _______________ How frequently? ______________

How often do you exercise? ❑ 5-7 days/week ❑ 3-4 days/week ❑ 1-2 days/week ❑ rarely Length? ______________

What do you do for exercise/movement? ____

How many hours do you sleep at night? _____ Do you wake up feeling rested? ❑ Yes ❑ No Do you nap? ❑ Yes ❑ No

Do you wake in the night? ❑ Yes ❑ No For any particular reason? ________________ At any particular time? _____

Do you dream frequently? ❑ Yes ❑ No Do you remember your dreams? ❑ Yes ❑ No

Do you have trouble falling asleep? ❑ Yes ❑ No Do you have trouble staying asleep? ❑ Yes ❑ No

Have you in the past or do you currently take any of the following medications?

❑ Aspirin ❑ Laxatives ❑ Antacids ❑ Diet pills ❑ Birth control pills/HRT

Social Health

Please rate the following on a satisfaction scale of 0-10, 10 being the most satisfied:

Energy: ____________ Sleep: ____________ Mood: ____________

On a scale of 1-10 (10 being unbearable), what level of personal stress are you experiencing right now?

What is your main stressor?

❑ Financial ❑ Job related ❑ Marriage ❑ Health
❑ Interpersonal ❑ Spiritual ❑ Family ❑ Unfulfilled expectations

What do you love to do?

What behaviours or lifestyle habits do you engage in regularly that you believe do not support and/or benefit your health?

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Family History

Does anyone in your family have a history of any of the following? Please check and indicate who.

Y = Yourself M = Mother F = Father GM = Grandmother GF = Grandfather S = Sister B = Brother C = Child

- ___ Alcohol abuse
- ___ Allergies
- ___ Anemia
- ___ Anxiety
- ___ Asthma
- ___ Arthritis
- ___ Back, muscle, joint pain
- ___ Bladder/urinary problems
- ___ Cancer
- ___ Candida
- ___ Chicken pox
- ___ Depression
- ___ Diabetes
- ___ Eczema
- ___ Epilepsy
- ___ Female reproductive problems
- ___ Gallstones
- ___ Gout
- ___ Gum/teeth problems
- ___ Hay fever
- ___ Heart attack
- ___ Heart problems
- ___ High blood pressure
- ___ High cholesterol
- ___ Hives
- ___ Kidney problems
- ___ Liver problems
- ___ Malaria
- ___ Measles
- ___ Mononucleosis
- ___ Mumps
- ___ Overweight
- ___ Pleurisy
- ___ Pneumonia
- ___ Psychological problems
- ___ Rubella
- ___ Sinusitis
- ___ Skin problems
- ___ Stroke
- ___ Suicidality
- ___ Thyroid problems
- ___ Tuberculosis
- ___ Ulcers
- ___ Venereal disease

Other:

____

What is your family heritage? ________________________________

Athletic History

Please list all sports and activities you were and/or are involved in (including # of years played and level of competitiveness and if you are currently still involved in this activity):

Bone breaks (location, type, sideness, approximate year(s)):

Concussions (# and approximate year(s)):

Other injuries (location, type, sideness, approximate year(s)):

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Review of Systems

Please check the box if you recently (R) had the symptoms, and/or have had the symptoms in the past (P). Leave blank otherwise.

HEAD / EENT
- Headaches/migraines R__ P__
- Dizziness R__ P__
- Double vision R__ P__
- Glaucoma R__ P__
- Cataracts R__ P__
- Changes in vision R__ P__
- Eyes bothered by light R__ P__
- Contacts/glasses R__ P__
- Blurring/seeing spots R__ P__
- Impaired hearing R__ P__
- Ear infection R__ P__
- Ringing in ear R__ P__
- Frequent nosebleeds R__ P__
- Hay fever R__ P__
- Sinus problems R__ P__
- Loss of smell R__ P__
- Frequent sore throat R__ P__
- Hoarseness of voice R__ P__
- Mouth/lip/tongue sores R__ P__
- Mercury fittings R__ P__
- Neck stiffness R__ P__
- Swollen glands in neck R__ P__
- Goiter R__ P__

RESPIRATORY
- Chronic cough R__ P__
- Excess phlegm/mucus R__ P__
- Frequent colds R__ P__
- Asthma/wheezing R__ P__
- Difficulty breathing R__ P__
- Coughing up blood R__ P__
- Chest pain R__ P__
- Bronchitis/COPD R__ P__
- Pneumonia R__ P__
- Tuberculosis R__ P__
- Emphysema R__ P__
- Date of last chest x-ray: ____________________

CARDIOVASCULAR
- Heart disease R__ P__
- High blood pressure R__ P__
- Stroke R__ P__
- Arrhythmia R__ P__
- Chest pain/Angina R__ P__
- Rheumatic fever R__ P__
- Palpitations R__ P__
- Easy bruising/bleeding R__ P__
- Date of last ECG: ____________________

PERIPHERAL VASCULAR
- Cold hands/feet R__ P__
- Deep leg pain R__ P__
- Extreme numbness R__ P__
- Swelling in ankles R__ P__
- Extremity ulcers R__ P__
- Phlebitis R__ P__

GASTROINTESTINAL
- Frequent nausea R__ P__
- Frequent vomiting R__ P__
- Vomiting blood R__ P__
- Hernia R__ P__
- Ulcers R__ P__
- Heartburn R__ P__
- Jaundice R__ P__
- Hepatitis R__ P__
- Difficulty swallowing R__ P__
- Food allergy/sensitivity R__ P__
- Indigestion/bloating R__ P__
- Excess burping/gas R__ P__
- Change in appetite R__ P__
- Change in thirst R__ P__
- Appendicitis R__ P__
- Gallbladder issues R__ P__
- Hemorrhoids R__ P__
- Blood in stool R__ P__
- Diarrhea R__ P__
- Constipation R__ P__
- Change in bowls mvmts R__ P__
- # of bowel movements per day: ____________________

ENDOCRINE
- Excess thirst R__ P__
- Excess hunger R__ P__
- Excess urination R__ P__
- Excess sweating R__ P__
- Thyroid issues R__ P__
- Diabetes R__ P__
- Hypoglycemia R__ P__
- Hormone therapy R__ P__
- Excess fatigue R__ P__
- Poor concentration R__ P__
- Hair loss R__ P__
- Brittle nails R__ P__
- Sensitivity to heat R__ P__
- Sensitivity to cold R__ P__

SKIN & NAILS
- Eczema R__ P__
- Psoriasis R__ P__
- Acne R__ P__
- Hives R__ P__
- Dry skin R__ P__
- New/changing moles R__ P__
- Change in nails R__ P__

URINARY
- Pain during urination R__ P__
- Urgency R__ P__
- Hesitancy R__ P__
- Increased frequency R__ P__
- Increased freq. at night R__ P__
- Decreased frequency R__ P__
- Inability to hold urine R__ P__
- Blood in urine R__ P__
- Freq. bladder infections R__ P__
- Kidney infections R__ P__

MUSCULOSKELETAL
- Joint pain/stiffness R__ P__
- Arthritis R__ P__
- Joint swelling R__ P__
- Muscle weakness R__ P__
- Muscle spasms/cramps R__ P__
- Sciatica R__ P__

NEUROLOGICAL
- Fainting R__ P__
- Numbness/tingling R__ P__
- Seizures/convulsions R__ P__
- Paralysis R__ P__
- Muscle weakness R__ P__
- Involuntary movement R__ P__
- Changes in coordination R__ P__
- Loss of balance R__ P__
- Loss of/poor memory R__ P__
- Speech problems R__ P__
- Hallucinations R__ P__
- Head injury R__ P__

BREAST
- Breast lumps R__ P__
- Breast pain R__ P__
- Nipple discharge R__ P__
- Fibrous breasts R__ P__
- Do you self exam? Y__ N__
- Date of last breast exam: ____________________

SEXUAL HEALTH
- Change in sex drive R__ P__
- Infections/STIs R__ P__
- HIV/AIDS R__ P__
- Pain with intercourse R__ P__
- Sexually active? Y__ N__

MALE
- Hernias R__ P__
- Testicular masses R__ P__
- Testicular pain R__ P__
- Prostate issues R__ P__
- Discharge/sores R__ P__
- Erectile dysfunction R__ P__
- Premature ejaculation R__ P__
- Last PSA score: __________
- Date of last prostate exam: ____________________

FEMALE
- Irregular cycles R__ P__
- Spotting R__ P__
- Clots R__ P__
- Excessive flow R__ P__
- Vaginal discharge R__ P__
- Yeast infection R__ P__
- Type of birth control: __________
- Duration of cycle: __________
- Duration of flow: __________
- Age of 1st menses: __________
- # of pregnancies: __________
- # of live births: __________
- # of miscarriages: __________
- # of abortions: __________
- Date of last PAP: __________
- Endometriosis R__ P__
- Ovarian cysts R__ P__
- Cervical dysplasia R__ P__
- Difficulty conceiving R__ P__
- Age of menopause: __________

MENTAL/EMOTIONAL
- Depression R__ P__
- Anxiety/nervousness R__ P__
- Mood swings R__ P__
- Phobias R__ P__
- Insomnia R__ P__
- Drug/alcohol abuse R__ P__
- Suicidal R__ P__
- Schizophrenia R__ P__
- Bipolar disorder R__ P__

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Consent to Treatment of Naturopathic Medicine

This form must be signed prior to your first appointment.

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Dr. Janna Levanto, ND will take a thorough case history, perform a focused physical examination and complete laboratory testing, if necessary.

It is very important that you inform Dr. Janna Levanto, ND immediately of any disease process that you are suffering from and any medications/over the counter medications that you are taking. Please advise Dr. Janna Levanto, ND immediately if: you are pregnant, suspect you are pregnant or are breast-feeding.

There are some slight health risks associated with treatment by naturopathic medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reaction to supplements or herbs
- Pain, bruising or injury from venipuncture, acupuncture or parenteral therapy
- Fainting or puncturing of an organ with acupuncture needles
- Muscle strains and sprains, disc injuries from spinal manipulation
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened prior to manipulating the neck.

I understand:

- A medical record will be kept of the health services provided to me. This record will be kept in strictest confidentiality and will not be released to others unless law requires it or I give my written consent. I realize in rare instances courts may subpoena my medical records, which means that my records will have to be released.
- Dr. Janna Levanto, ND will have to report me in the following instances: when I am in imminent danger of harming myself or others, when there is reasonable suspicion that I am neglecting and/or emotionally, physically or sexually abusing a minor, and if I engage in sexual relations with any of my healthcare providers.
- I may access my medical records at any time and can request a copy by paying the appropriate fee.
- Dr. Janna Levanto, ND does not guarantee treatment results. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and potential complications. I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list, if any):

  ____

I recognize that this consent form covers the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
I have read this statement and agree to work within its guidelines, including the limits of confidentiality.

Patient Name (please print): ______________________________ Witness: ______________________________

Signature of Patient or Patient's Guardian: ______________________________ Date: __________________

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Patient Consent for Collection, Use and Disclosure of Personal Information

This form must be signed prior to your first appointment.

Privacy and protecting your personal information is an important part and consideration of my practice as a naturopathic doctor. This privacy policy outlines what I do to ensure that:

- Only necessary information is collected about you;
- I only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols (this includes cloud-based electronic medical records that are housed within Canada and are compliant with such legislation and privacy protocols);
- Privacy protocols comply with privacy legislation and standards of naturopathic doctor's regulatory body

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To assess your health concerns, provide health care and advise you of treatment options;
- To establish and maintain contact with you;
- To remind you of upcoming appointments;
- To efficiently follow-up with you for treatment;
- To complete claims for insurance purposes;
- To invoice for goods and services;
- To process credit card payments;
- To collect unpaid accounts and follow up on billing, as required;
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others;
- To be used for educational and research purposes (this includes case summaries and reports, photographs, lab results and other pertinent medical information). Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances.

Patient Consent

I, ____ have reviewed the above information that explains how Dr. Janna Levanto, ND will use my personal information and the steps that are taken to protect my information.

I agree that Dr. Janna Levanto, ND can collect, use and disclose personal information about my case as set out above regarding privacy policies.

Patient Signature: ________________________________

Witness Signature: ________________________________

Date: ________________________________

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Visit Billing Procedures Are As Follows

Naturopathic Services

Service	Fee
Initial Visit - 75 minutes	$220
Follow up - 60 min	$165
Follow up - 45 min	$135
Follow up - 30 min	$110
Follow up - 15 min	$65

Please be advised that 50% of the fee for missed appointments, without a 24-hour cancellation notice, will be applied to your account. Thank you for respecting our time.