

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		
<p>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 physical, 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!</p>		
Have you been to a naturopathic doctor before?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dietician?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Acupuncturist?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Information		
Name: _____		
Age: _____	DOB: ____/____/____ day month year	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Height: _____		Weight: _____
Marital Status: _____		Occupation: _____
Contact Information		
Home Address: _____		
City: _____		Postal Code: _____
Home Phone: _____	Cell Phone: _____	Work Phone: _____
<p>May we leave voicemails at the above phone numbers? If so, please select which ones. No confidential information is left on voicemails. <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work</p>		
Email Address: _____		
<p>Would you like to receive our newsletter for news, events, and special offers? (sent once a month or less)</p> <input type="checkbox"/> Yes <input type="checkbox"/> No		<p>Preferred method of contact:</p> <input type="checkbox"/> Phone <input type="checkbox"/> Email
Emergency Contact Information		
Primary Contact: _____		Relationship: _____
Phone number(s) for emergency contact: _____		

Other Healthcare Providers

Name of Doctor:	Telephone #:
Are you currently under their care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last visit: Date of last physical:
Name of Doctor:	Telephone #:
Are you currently under their care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last visit: Date of last physical:
May we contact these practitioners to share your treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Health Concerns

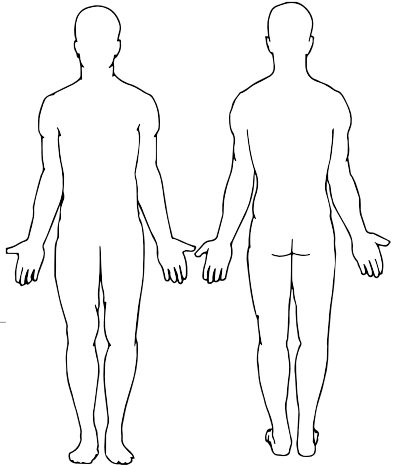
What are your most important health concerns? Please list as many as you have, in order of importance:

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):

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?

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?

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

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

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, sidedness, approximate year(s)):

Concussions (# and approximate year(s)):

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

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__

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: _____

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: _____

Visit Billing Procedures Are As Follows

Naturopathic Services

Initial Visit - 75 minutes	\$180
Follow up - 60 min	\$125
Follow up - 45 min	\$90
Follow up - 30 min	\$75
Follow up - 15 min	\$45

Phone consult \$30 flat rate and \$3 for each additional minute over 15.

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.