INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3
TEL: 416 760 9424
FAX: 416 760 0029
INNATEWELLNESS.CA

# Personal Information

| Today's Date | Name | | Sex<br>M F |
|---|---|---|---|
| Date of Birth (DD/MM/YYYY) | Age | Weight | Height |
| Address<br><br><br>Email | Contact Information<br>[h]<br><br>[w]<br><br>[c] | | In case of emergency notify<br><br><br>Contact number |
| Innate Wellness will email you confirmation of your upcoming appointments. If you wish to be contacted by phone, please list the best number to contact you. | | | |
| Occupation | Employer | | |
| How did you learn about Innate Wellness? | | | |

INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3
TEL: 416 760 9424
FAX: 416 760 0029
INNATEWELLNESS.CA

# General Health Questionnaire

**Please take the time to fill out this questionnaire carefully to help us provide you with a complete evaluation. If you have further questions, concerns, or comments, please bring them to our attention.**

Please list your additional Health Care Providers (i.e. Medical Doctor, Chiropractor, Medical Specialist, etc.)

| | | |
|---|---|---|
| Name<br>Occupation<br>Phone | Name<br>Occupation<br>Phone | Name<br>Occupation<br>Phone |

Major Concerns (in order of importance): Since

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

To what extent do your concerns affect your daily activities (i.e. work, sleep, eating, etc)?

_____
_____

Have you consulted a physician in regards to your condition(s)? What, if any, diagnosis have you received?

_____
_____

What, if any, treatments have you received? Are you still receiving those treatments?

_____
_____

Is there anything that makes it better? Is there anything that makes it worse?

_____
_____

INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3
TEL: 416 760 9424
FAX: 416 760 0029
INNATEWELLNESS.CA

## Medical History

Please list **all** prescribed and over-the-counter medications, vitamins, minerals, herbs, and homeopathic remedies, which you are **presently** using.

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you get regular screening tests by another doctor? Y / N Which tests?_____

_____

If you are female, are you currently pregnant? Yes No

Please check any conditions or symptoms that apply to you:

| | | |
|---|---|---|
| ❒ Accidents / significant trauma | ❒ Addiction(s) | ❒ Aids/HIV + |
| ❒ Anaemia | ❒ Arthritis-Rheumatoid/Osteo | ❒ Asthma/Bronchitis/Pneumonia |
| ❒ Cancer | ❒ Candida | ❒ Colitis |
| ❒ Cholesterol Issues | ❒ Chronic Fatigue | ❒ Chronic Pain |
| ❒ Common Allergies | ❒ Crohn's Disease | ❒ Diabetes I or II |
| ❒ Diverticulitis | ❒ Gastritis/Pancreatitis | ❒ Headaches |
| ❒ Heart Disease | ❒ Hepatitis | ❒ High / Low Blood Pressure |
| ❒ Hives | ❒ Hypo / Hyperglycaemia | ❒ IBS |
| ❒ Infertility | ❒ Insomnia | ❒ Impotence |
| ❒ Kidney Issues | ❒ Liver / Gall Bladder Disease | ❒ Migraines |
| ❒ Osteoporosis | ❒ Prostrate | ❒ Seizures / Epilepsy |
| ❒ Skin Disorders | ❒ Stroke | ❒ Surgeries |
| ❒ TB | ❒ Thyroid Imbalances | ❒ Other |

Please list any other relevant medical history:

_____
_____
_____

INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3
TEL: 416 760 9424
FAX: 416 760 0029
INNATEWELLNESS.CA

## Lifestyle

Do you participate in regular physical activities? What do you do and how often?

_____

Do you follow a particular diet or avoid any specific foods? Any food intolerances?

_____

Please indicate usage per day/week/month:

| | | | |
|---|---|---|---|
| Cigarettes | _____ per day/wk/mth | Alcohol | _____ per day/wk/mth |
| Recreational Drugs | _____ per day/wk/mth | Chewing tobacco | _____ per day/wk/mth |

## General Traditional Chinese Medicine Health History

**During the Day, Do You Feel:**

- ❒ chills
- ❒ fever
- ❒ both
- ❒ perspiration when not active
- ❒ frequently tired
- ❒ normal energy levels
- ❒ better than normal energy

**At Night I…**

- ❒ have difficulty falling asleep
- ❒ have dreams that wake me up
- ❒ have difficulty staying asleep
  - what time(s) are you waking up? _____
- ❒ wake up feeling hot/sweaty
- ❒ feel anxious*
- ❒ have heart palpitations*

**Please indicate if during the day also*

**Hair, Teeth, Eyes, and Skin:**

- ❒ have experienced hair loss
- ❒ premature greying
- ❒ clench or grind your teeth
- ❒ have experienced tooth loss
- ❒ eyes get dry, blurry, strained when tired
- ❒ see 'floaters'
- ❒ rashes
- ❒ eczema
- ❒ hives/uticaria
- ❒ pimples/acne
- ❒ ulcerations

**Neuropsychological:**

- ❒ anxiety
- ❒ panic attacks
- ❒ irritability/anger
- ❒ seizures
- ❒ fearfulness
- ❒ poor memory
- ❒ racing thoughts/worry
- ❒ dizziness
- ❒ difficulty concentrating
- ❒ depression
- ❒ loss of balance
- ❒ treated for emotional problems?

**Respiratory:**

- ❒ breathing difficulties
- ❒ sinus problems
- ❒ nose bleeds
- ❒ cough
- ❒ excessive phlegm

**Urinary:**

- ❒ wake during the night to urinate
- ❒ urinate first thing when I wake
- ❒ have frequent urination
- ❒ incontinence
- ❒ unusual colour
- ❒ unusual odour
- ❒ urgency to urinate
- ❒ mucus in your urine
- ❒ burning sensation

INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3
TEL: 416 760 9424
FAX: 416 760 0029
INNATEWELLNESS.CA

**Bowel Movements:**

❒ constipation ❒ frequency ❒ dry
❒ diarrhea ❒ mucus ❒ urgency to go first thing in AM
❒ rectal pain ❒ runny

**Appetite/Digestion:**

How much water do you drink in a day? _____

Do you prefer:
❒ warm/hot fluids ❒ cold fluids

Are you frequently thirsty?
❒ yes ❒ no ❒ sometimes

How Is Your Appetite?
❒ good ❒ normal ❒ poor

After eating do you experience?
❒ "gnawing hunger"
❒ bloating
❒ gas
❒ fatigue/sleepiness
❒ acid regurgitation
❒ nausea/vomiting
❒ cravings for sweet/salty

**Gynaecological/Reproductive:**

Age of first menses? _____

Age of menopause? _____

Number of days in cycle? _____

Flow of Bleeding?
❒ light ❒ normal ❒ heavy

Is there clotting? ❒ yes ❒ no

If yes, are they: ❒ big ❒ small

Are you Pregnant? ❒ yes ❒ no

Birth Control: ❒ yes ❒ no

How Long: _____

Regular Cycles? ❒ yes ❒ no Painful? ❒ yes ❒ no

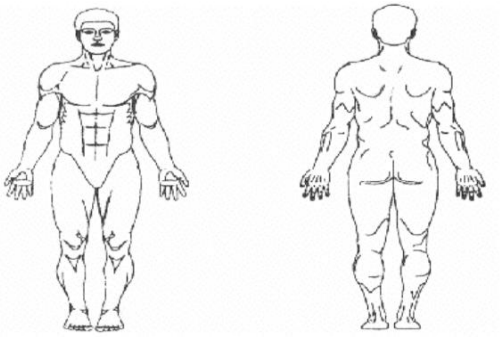
What colour is the blood?
❒ light red ❒ red ❒ dark red ❒ purple ❒ brown ❒ black

Do you have any of the following:
❒ vaginal discharge ❒ PMS ❒ endometriosis
❒ breast pain/lumps ❒ cervical dysplasia ❒ cysts/fibroids

No. of Pregnancies? No. of Miscarriages?

**Indicate Type Of Pain and Where:**

❒ Sharp ❒ Cold
❒ Dull ❒ Pulsing
❒ Achy ❒ Pulling
❒ Hot ❒ Throbbing
❒ Shooting ❒ Tingling
❒ Moving ❒ Tension
❒ Weakness ❒ Numbness



**What Makes The Pain/Discomfort Better or Worse?**

| | | | | | |
|---|---|---|---|---|---|
| application of cold | ❒ better | ❒ worse | when active | ❒ better | ❒ worse |
| application of pressure | ❒ better | ❒ worse | when resting | ❒ better | ❒ worse |
| application of heat | ❒ better | ❒ worse | in the evening/night | ❒ better | ❒ worse |
| when under stress | ❒ better | ❒ worse | upon waking | ❒ better | ❒ worse |
| when tired | ❒ better | ❒ worse | | | |

INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3
TEL: 416 760 9424
FAX: 416 760 0029
INNATEWELLNESS.CA

# Informed Consent

We would like you to understand the services we provide, the costs involved, and what we do with the personal information we obtain about you. If you have any questions about this, please ask. This informed consent begins today and is between the Registered Acupuncturist (R.Ac) and the person named at the end of this document.

Even the gentlest therapies may cause complications in certain physiological conditions. It is very important, therefore, that you inform your R.Ac immediately of any conditions that are contra-indicated for acupuncture (such as pacemakers, blood clotting issues, etc.), as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant or trying to become pregnant, please advise your R.Ac immediately.

Health risks associated with Acupuncture include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process;
- Slight bleeding, bruising, dizziness/light-headedness or tenderness from acupuncture;
- Fainting or puncturing of an organ with acupuncture needles

---

**Please check the box ( ☑) to indicate you have read and understand the following:**

**Disclaimer of Health Care Related Services**

☐ I understand that the R.Ac will answer any questions that I have to the best of his ability. I understand that the results are not guaranteed. I do not expect the R.Ac to be able to anticipate and explain all risks and complications. I will rely on him to exercise judgment during the course of the procedure which he feels at the time is in my best interests, based upon the facts then known.

☐ I understand that the diagnosis and treatment plan is based on Traditional Chinese Medicine and does not constitute a Western medical diagnosis. I understand that any treatment or advice provided to me by my R.Ac is not mutually exclusive of any treatment or advice that I may be receiving now or in the future from a physician, surgeon, or any other licensed health care provider.

☐ I understand that I am at liberty to seek or may continue to seek treatment or advice from a physician, surgeon or any other licensed health care provider and it has not been suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider. It is my responsibility to advise my other health care provider(s) of these therapies and/or herbal supplements I am currently taking.

INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3
TEL: 416 760 9424
FAX: 416 760 0029
INNATEWELLNESS.CA

**Confidentiality**

☐ I intend this consent form to cover 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 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 without my consent, unless required by law.

**Payments & Appointment Etiquette**

☐ I understand the fee schedule as stated below and I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period preceding my appointment time. I understand Innate Wellness' lateness policy that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive and I am ready for my appointment.

☐ I understand that I may purchase any recommended medicines or supplements from the dispensary at Innate Wellness or a pharmacy or retail store of my choice.

Patient Name _____ Signature _____ Date _____
(please print)

# Fee Schedule

## New Patient Initial Assessment

| | |
|---|---|
| First Assessment + Treatment (90min.) | 130.00 |

## Treatment Plan & Follow-up Appointments

| | |
|---|---|
| Follow Up Treatment (45min.) | 90.00 |
| Acute Treatment (~30min.) | 55.00 |
| Package of 3 Treatments | 255.00 |

## Supplements and Remedies

Supplements and remedies are available from the office dispensary or from a naturopathic pharmacy of your choice.

**Missed Appointment Fee** (less than 24 hours business days' notice) **Full price of the appointment**

Prices are subject to change. We accept Cash, Visa, MasterCard, and Interac Debit.