INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3

TEL: 416 760 9424
FAX: 416 760 0029

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Personal Information

Today's Date	Name			Sex M F
Date of Birth (DD/MM/YYYY)	Age	Weight		Height
Address Email	Contact Information [h] [w] [c]		In case of emergency notify 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?				

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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 check the Practitioners you are currently seeing – check all the apply

☐ Medical Doctor ☐ Naturopath ☐ Chiropractor ☐ Herbalist

☐ Dentist ☐ Acupuncturist ☐ Massage Therapist ☐ Homeopathic Doctor

☐ Psychiatrist ☐ Osteopath ☐ Other ___________________________________

☐ Chinese Medicine Practitioner

Medications – please list all your current medications

Medication Name	Duration	Condition/Reason

Natural Health Products – please list all your current supplements (vitamins, minerals, herbs, etc.)

Product Name	Dose	Duration	Condition/Reason

Wellness – please list your main health concerns (e.g. digestion, migraines, weight loss/gain, etc.)

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Health History

Diagnoses - please list any diagnoses received here, including health concerns recently or in the past, as far back as childhood

Family Health History – please list all health issues (e.g. diabetes, cancer, high blood pressure, etc) for both parents and siblings

Please check the symptoms you are currently experiencing – check all that apply

☐ Headaches	☐ Itchy Eyes	☐ Skin Rash	☐ Itchy Skin
☐ White Spots on Nails	☐ Ridges on Nails	☐ Brittle nails	☐ Oily Skin
☐ Coated Tongue	☐ Dry Scalp	☐ Other ______________________	
☐ Red Bumps on back of arms			

Hours of Sleep per Night	☐ 3-5	☐ 6-7	☐ 8-10+
Do you wake feeling rested?	☐ Yes	☐ No	☐ Sometimes
Do you exercise?	☐ Yes	☐ No	☐ Sometimes
If yes, please indicate what you do and how often.			

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Indicate your energy level from day to day (1 being low, 10 being high)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1-Low 5 High-10

Does your energy change throughout the day – write low, normal, high in the corresponding time slots

___________	___________	___________	___________	___________	___________
6am-9am	9am-Noon	Noon-3pm	3pm-6pm	6pm-9pm	9pm-Sleep

Do you have any known allergies or suspected food intolerances – please list all

Please check any digestive concerns you've experienced – check all that apply

☐ Bloating	☐ Heartburn	☐ Gas	☐ Cramping
☐ Indigestion	☐ Constipation	☐ Loose Stools	☐ Diarrhea

How many bowel movements do you have a day? ☐ 0 ☐ 1 ☐ 2+

How many glasses of water do you drink per day?

What is the source of your water? ☐ Filtered ☐ Tap ☐ Reverse Osmosis ☐ Bottled

Do you drink caffeinated beverages? ☐ Yes ☐ No
If so, how many times per day/week? ___________ per day ___________ per week

Do you drink carbonated beverages? ☐ Yes ☐ No
If so, how many times per day/week? ___________ per day ___________ per week

Do you drink diet drinks? ☐ Yes ☐ No

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Do you consume alcohol? ☐ Yes ☐ No	If so, how many times per day/week? __________ per day __________ per week
Do you smoke? ☐ Yes ☐ No	If so, how many times per day/week? __________ per day __________ per week
How many fruits do you eat per day? ____________________	How many vegetables do you eat per day? ____________________
Are the fruits & vegetables you eat organic?	☐ Yes ☐ No ☐ Sometimes

Do you have any food cravings – please list all

Please list the top 5 foods you eat most often

Do you have any dietary restrictions – e.g. no red meat, vegan, no milk/dairy, etc.

Are there foods you're not willing to give up?

Is there any particular food you feel addicted to?

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Your Sexual Health

Do you have a healthy sex drive? ☐ Yes ☐ No	If not, when was the last time you remember having one?
At what age did you reach puberty?	
Do you have any hormonal issues that you are aware of? ☐ Yes ☐ No	If so, please explain

Your Emotional Health

Has there been any significant emotional trauma in your life? Divorce, separation, family problems, death of someone close, abuse, etc.	If so, please describe
Do you eat more or less when stressed? ☐ More ☐ Less	Do you ever eat for emotional reasons? ☐ Yes ☐ No
Indicate your stress level (1 being low, 10 being high on an average day) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 1-Low 5 High-10	
List the source of your stress. Be specific	
What is your method of coping with stress?	
Are all your relationships healthy and fulfilling? ☐ Yes ☐ No	If no, please explain
Do you have or have you ever had an eating disorder? Either under-eating or over-eating?	If so, please explain

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Women Only – Reproductive Health

Please indicate any symptom of PMS you experience – check all that apply

☐ Bloating	☐ Cramping	☐ Headaches
☐ Change in Mood	☐ Irritability	☐ Breast Tenderness
☐ Cravings	☐ Other	

Please indicate any symptom of menopause you experience – check all that apply

☐ Hot Flashes	☐ Cravings	☐ Headaches
☐ Change in Mood	☐ Irritability	☐ Weight Gain
☐ Body Aches	☐ Other	

Do you experience emotional upset at the same each month? ☐ Yes ☐ No	If so, be specific, depression, anxiety, nervousness, excitability, extreme emotions, etc.
How often do you have a menstrual cycle?	How long is your menstrual cycle?
Are you on birth control? ☐ Yes ☐ No	If so, how many months/years? __________ months __________ years
Are you on any form of hormone replacement? ☐ Yes ☐ No	If so, how many months/years? __________ months __________ years

Have you given birth? ☐ Yes ☐ No If so, how many times?	Have you had an abortion? ☐ Yes ☐ No If so, how many times?	Have you had a miscarriage? ☐ Yes ☐ No If so, how many times?
Have you had fertility treatments? ☐ Yes ☐ No	If yes, please describe	

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Your Nutritional Expectations

What are you expecting from your nutrition program?

How do you think your nutrition program will affect your daily life?

Have you tried any nutrition programs or diets in the past to reach your goals? Were you successful?

How would you rate your nutrition within these areas (poor, needs improvement, good, or excellent)

Scheduling/Planning	
Balancing Carbs, Fast, Protein Rations	
Level of Commitment to a Program	

Please include anything else you want to cover in your nutrition session.

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Your Wellness Journal

Please write down absolutely everything you eat & drink in a seven day period. Exact measurements are not necessary. Do not change anything from your current diet to get the most out of the feedback you receive. It's important we can evaluate your typical habits. Please list all liquids you consume (not water) with your daily meals (e.g. tea, coffee, pop, etc.). Make a note of any foods that cause a reaction (bloated, tired, headache, constipation, etc.) in the 'comments' section.

Day 1

Breakfast	Lunch	Snack	Dinner	Dessert	Comments

Time: ________ Time: ________ Time: ________ Time: ________ Time: ________ Time: ________

Day 2

Breakfast	Lunch	Snack	Dinner	Dessert	Comments

Time: ________ Time: ________ Time: ________ Time: ________ Time: ________ Time: ________

Day 3

Breakfast	Lunch	Snack	Dinner	Dessert	Comments

Time: ________ Time: ________ Time: ________ Time: ________ Time: ________ Time: ________

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Day 4

Breakfast	Lunch	Snack	Dinner	Dessert	Comments

Time: ________ Time: ________ Time: ________ Time: ________ Time: ________ Time: ________

Day 5

Breakfast	Lunch	Snack	Dinner	Dessert	Comments

Time: ________ Time: ________ Time: ________ Time: ________ Time: ________ Time: ________

Day 6

Breakfast	Lunch	Snack	Dinner	Dessert	Comments

Time: ________ Time: ________ Time: ________ Time: ________ Time: ________ Time: ________

Day 7

Breakfast	Lunch	Snack	Dinner	Dessert	Comments

Time: ________ Time: ________ Time: ________ Time: ________ Time: ________ Time: ________

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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 Holistic Nutritionist (HN) and the person named at the end of this document.

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

<u>Disclaimer of Health Care Related Services</u>

☐ I take full responsibility for my health, healing and progress on my nutrition plan. I acknowledge change can take time and I am ready for a plan that is not about fad diets or quick fixes, but about smaller changes over time leading to sustainable change.

☐ I understand that any treatment or advice provided to me by my HN 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.

<u>Confidentiality</u>

☐ 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 and this record will be kept confidential. Information may be shared at my request with a Medical doctor, Naturopathic doctor or other healthcare practitioner I deem appropriate.

<u>Payments & Appointment Etiquette</u>

☐ 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)

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Fee Schedule

New Patient Initial Assessment

First Assessment (60min)	100.00

Your HN may suggest further testing as part of the initial assessment

Treatment Plans & Follow-up Appointments

45-50 minutes (“long”)	100.00
20-30 minutes (“short)	60.00
Customized Packages	10% discount off total cost

Treatment Packages

Grocery Store Tour	175.00
Kitchen Pantry Raid	150.00
Cleanse/Detox Programs	TBD

Supplements and Remedies

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

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

Additional HST where applicable. Prices are subject to change.

We accept Cash, Visa, MasterCard, and Interac Debit.