

## M & Y Chiropractic Health and Wellness Centre

### Confidential Health History Report

**PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Abuse            | <input type="checkbox"/> Diphtheria                | <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Pneumonia          |
| <input type="checkbox"/> AIDS/HIV         | <input type="checkbox"/> Diverticulitis            | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Polio              |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Eating disorder           | <input type="checkbox"/> Herpes/shingles          | <input type="checkbox"/> Rheumatic fever    |
| <input type="checkbox"/> Aneurism         | <input type="checkbox"/> Eczema                    | <input type="checkbox"/> Influenza                | <input type="checkbox"/> Rubella            |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Scarlet fever      |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Endometriosis             | <input type="checkbox"/> Lupus                    | <input type="checkbox"/> Scoliosis          |
| Type: _____                               | <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Malaria                  | <input type="checkbox"/> Sjogren's          |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Fever blisters            | <input type="checkbox"/> Measles                  | <input type="checkbox"/> Spinal cord injury |
| Type: _____                               | <input type="checkbox"/> Fibromyalgia              | <input type="checkbox"/> Miscarriage              | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Multiple sclerosis       | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Celiac disease   | <input type="checkbox"/> Goiter                    | <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Typhoid fever      |
| <input type="checkbox"/> Chorea           | <input type="checkbox"/> Gout                      | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Venereal disease   |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Hardening of the arteries | <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Vertigo            |
| <input type="checkbox"/> Crohn's disease  | <input type="checkbox"/> Hearing impaired          | <input type="checkbox"/> Pleurisy                 | <input type="checkbox"/> Whooping cough     |
| <input type="checkbox"/> Diabetes         |  |   |   |

Are there any of these from which you feel you have been never well since? \_\_\_\_\_

<b>DATE OF LAST:</b>	6 mths	6-18	18+	Never	<b>HABITS:</b>	Heavy	Moderate	Light	None
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laxatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Hormones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Personal Habits**

What do you enjoy most in your life? \_\_\_\_\_

What are your main interests or hobbies? \_\_\_\_\_

What do you worry about most in your life? \_\_\_\_\_

What nurtures you? \_\_\_\_\_

Do you exercise? **Yes / No** *If yes, what do you do and how often?* \_\_\_\_\_

Do you have a religious or spiritual practice? **Yes / No**

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) \_\_\_\_\_

Do you have a problem falling asleep? \_\_\_\_ Staying asleep? \_\_\_\_ How much do you sleep? \_\_\_\_ hours

How many hours do you think you need? \_\_\_\_ Do you wake refreshed? \_\_\_\_\_

Do you nap or rest horizontally throughout the day? **Yes / No** For how long? \_\_\_\_\_

How is your body temperature, compared to others? Warmer Cooler Average

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Do you enjoy your work? **Yes/No**    Do you take vacations? **Yes/No**

How often do you get colds, flus, sore throats in a year? \_\_\_\_\_

**Family History**

	Mother	Father	Sibling	Grandparent		Mother	Father	Sibling	Grandparent
Cancer					Kidney Disease				
Tuberculosis					Diabetes				
Heart Disease					Asthma				
Stroke					Depression				
High Blood Pressure					Other: _____				

**Occupational/Household**

Is your home damp or moldy at all? **Yes/No**                      Do you have a specialized air filtration at home? **Yes/No**

Do you work in an office building? **Yes/No**                      Do the windows open? **Yes/No**

Do you work in the presence of toxic fumes or chemicals? **Yes / No**

Do any of your hobbies involve toxic materials? **Yes / No**

Are you currently exposed to second hand smoke? **Yes / No**

What do you use for drinking water? *(Circle)* **Tap Water    Bottled Water    Filtered Water    Rev. Osmosis**

Is there anything else you feel I should know about you? \_\_\_\_\_

\_\_\_\_\_

Please list any additional comments regarding your health and well being: \_\_\_\_\_

\_\_\_\_\_

***In order to help us to better understand your health care needs and requirements please answer the following:***

Committing to changes in my health is \_\_\_\_\_

\_\_\_\_\_

What happens when you are not being accountable? \_\_\_\_\_

\_\_\_\_\_

How do you want to be supported in your health care needs? \_\_\_\_\_

\_\_\_\_\_

Thank you for taking the time to fill in this lengthy questionnaire.

It is a valuable resource in understanding your health.

**16775 Yonge St. Ste 214 Newmarket, ON L3Y 8J4 (905) 898-6644**

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**CONSENT TO TREATMENT**

Naturopathic medicine is a unique approach to improving health and treating illness. Focusing on prevention, and using natural substances and treatments, Naturopathic Doctors support and stimulate the body's ability to heal itself. The methods used in this clinic for assessment include case history taking, physical examination and laboratory testing. Therapeutics include nutrition, homeopathy, botanical (herbal) medicine, physical medicine, hydrotherapy, detoxification techniques, acupuncture, hypnosis and lifestyle counseling.

Each person must sign this document before any treatment will be rendered.

My signature acknowledges that I have been informed and understand that:

(1) I am encouraged to create a comprehensive health care team working towards my best interests and continue to seek medical care from other health care practitioners qualified to practice in Ontario such as a physician, surgeon, dentist, chiropractor, etc., as required.

(2) I understand that Naturopathic Doctors are required by their licensing boards to perform a screening physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is accepted by the attending practitioner.

(3) I have received a full and complete explanation of the treatments or services that I may receive at this office and hereby authorize and consent to treatment.

(4) I understand that working with a Naturopathic Doctor involves a team-like approach and while I expect my Naturopathic Doctor to provide me with appropriate individualized advice as to how to attain my wellness goals, I also commit to being responsible for my own health. If I am having difficulty following a treatment plan that I have agreed to, I will contact my Naturopathic Doctor so that we can make whatever modifications are necessary for my lifestyle to ensure that I continue to work towards my goal of wellness at whatever pace we decide on together.

(5) I agree to pay my full account at the time of each visit or treatment, including fees for services and costs of supplements, reference materials and laboratory tests. I am aware that these fees are not covered by OHIP. In the event that an invoice is not paid in a timely manner, I understand that 2% per month interest will be added to any outstanding balances.

(6) I am aware that I can purchase the products recommended by my Naturopathic Doctor at the location of my choice. I am under no obligation to purchase products at M&Y Chiropractic Health & Wellness Centre.

(7) I understand that to provide me with Naturopathic goods and services, M&Y Chiropractic Health & Wellness Centre must collect and use some personal information about me as required by law and governing bodies. Any other use of any personal information will require my express written consent.

(8) I understand that payment is due at the requested appointment time. I understand that M&Y Chiropractic Health & Wellness Centre requires a minimum of 24 HOURS NOTICE of any appointment change or cancellation. If I do not give 24 hour notice or fail to appear for my requested appointment time, I agree to pay the full fee for my appointment. I understand that this time is reserved for me.      Initials\_\_\_\_\_

I, \_\_\_\_\_, have read, understood and acknowledge the above statements.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Primary ND: \_\_\_\_\_ Date: \_\_\_\_\_

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