Fredericton Naturopathic Clinic

Dr. Kerri Dow, ND
288 Union Street
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P: 506-450-9440  F: 506-455-4417

**Completed forms may be faxed to 455-4417 or brought with you on your first visit.**

Patient Name (full):_____

Sex: M / F  Age:_____  Date of birth: _____

Weight:_____  Height:_____

____

Address:

_____

Emergency contact:_____Phone:_____Relation: _____

Telephone home:_____Work:_____Cell: _____

May we leave messages relating to your visits? Y / N Which Phone Number? _____

Email: _____

Occupation:_____Employer: _____

Marital status: single / married / separated / divorced / widowed / cohabitating / monogamous

Do you have naturopathic coverage? Y / N

Have you seen a naturopathic doctor in the past? Y / N

How did you hear about Dr. Kerri?

- Google
- Referral from a healthcare practitioner
- Referral from a friend or family member
- Facebook

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## MEDICAL CONTACT INFORMATION

**PLEASE obtain your family physician's fax number for us so that records may be requested if needed.**

| Family Physician | Other | Other |
|---|---|---|
| Name: | Name: | Name: |
| Address: | Address: | Address: |
| Phone: | Phone: | Phone: |
| Fax: | | |

## HEALTH PRIORITIES AND CHIEF CONCERNS

Please list your main health concerns or reasons for seeking treatment.

| | |
|---|---|
| 1. | Severity (0-10 scale) |
| 2. | |
| 3. | |
| 4. | |

## HEALTH HISTORY

Please indicate any diagnosed medical condition, hospitalization or surgery.

| 1. | Date | Ongoing Y/N |
|---|---|---|
| 2. | | |
| 3. | | |
| 4. | | |

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If you are female, are you currently pregnant? YES NO

How would you describe your general state of health? Excellent Good Fair Poor

## ALLERGIES AND/OR SENSITIVITIES (FOOD, DRUG, ENVIRONMENTAL)

| Allergy | Details of Reaction |
|---|---|
| 1. | |
| 2. | |
| 3. | |

## MEDICATIONS / SUPPLEMENTS / VITAMINS / HERBS

| Medication / Vitamin | Dose | Date started | Reason |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

Please list any previous medications / vitamins taken for more than 3 months.

| Medication / Vitamin | Dose | Date started | Reason |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

Were you ever on antibiotics for an extended period of time? Please explain when and for how long.

Do you get regular screening tests done by another doctor? (PAP, blood test, etc.) YES NO

Date of last physical exam:

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## FAMILY MEDICAL HISTORY

Please indicate if a close relative has had any of the following:

| Illness | Relative | | Relative |
|---|---|---|---|
| Alcoholism | | Liver or Kidney disease | |
| Alzheimer's | | High Blood Pressure | |
| Cancer | | Stroke | |
| Depression | | Heart Disease | |
| Diabetes | | Other significant illness | |

## HABITS AND LIFESTYLE

Do you exercise regularly? Y / N Type: Frequency: x / per week

Do you use any of the following? Please circle.

Aspirin / Laxatives / Antacids / Diet pills / Birth control: pills / implants / injections

Alcohol – form and how much per day or week: _____

Tobacco – form and amount per day:_____Number of years: _____

Caffeine – form and amount per day: _____

Recreational drugs – form and how often: _____

Do you have any dietary restrictions (religious, vegetarian, vegan, paleo, etc.)? _____

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Please outline a typical day's diet:

| Breakfast | Lunch | Dinner | Snacks |
|---|---|---|---|
| | | | |

Please indicate if you consume any of the following:

- Fresh vegetables Frequency:_____
- Fresh fruit Frequency:_____
- Cold water fish Frequency:_____
- Canned tuna Frequency:_____
- Other canned goods Frequency:_____
- Microwave dinners Frequency:_____
- Deli meats Frequency:_____
- Processed foods Frequency:_____
- 'Diet' or 'Lite' foods / Splenda /Aspartame Frequency:_____
- Red meat Frequency:_____
- Dairy products Frequency:_____
- Fast food Frequency:_____

How many cups of the following do you drink on an average day?

Water:_____Coffee:_____Tea:_____ Milk:_____ Fruit / Veg juice:_____ Soft drinks: _____

Cravings: sugar / chocolate / dairy / salty foods / other: _____

Rate your stress level (circle): Low / Average / High / Unbearable

Which factors most contribute to your stress? Health / Career / Family / Financial / Other: _____

How many hours sleep do you get per night, on average?_____Do wake up feeling well-rested? _____

Are you exposed to significant tobacco smoke? Y / N

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How would you describe the emotional climate of your home? _____

What expectations do you have from this visit to the clinic? Circle the statement that best applies. Be as honest as possible.

1) Seeking information/treatment as a one-time visit only.
2) Hoping to begin the process of resolving my health concerns.
3) Hoping to begin the process of achieving an optimal state of health.
4) No expectations; just curious about naturopathic medicine.

What long-terms expectations or goals do you have from working with a naturopathic doctor?

_____

_____

Name any frequent habits that you believe may be obstacles to cure / detrimental to your health.

_____

What is your level of commitment to addressing any lifestyle factors that may be contributing to your symptoms and having a negative impact on your health? (10 equals 100% committed)

1 2 3 4 5 6 7 8 9 10

Is there anything you feel is important that has not been covered?

_____

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# REVIEW OF SYSTEMS

**Circle "Y" for current issues or "P" for a previous concern.**

### Skin & Nails

Y / P Acne
Y / P Psoriasis
Y / P Hives
Y / P Eczema
Y / P Changes in moles
Y / P Nail changes

### Head / EENT

Y / P Headache / migraine
Y / P Dizziness
Y / P Double vision
Y / P Glaucoma
Y / P Cataracts
Y / P Seeing spots
Y / P Impaired hearing
Y / P Ear infection
Y / P Ringing in ear
Y / P Frequent nosebleeds
Y / P Hayfever
Y / P Sinus problems
Y / P Hoarseness of voice
Y / P Mouth/lip/tongue sores
Y / P Mercury fillings
Y / P Goiter

### Respiratory

Y / P Chronic cough
Y / P Excess phleghm/mucus
Y / P Frequent colds
Y / P Asthma/wheezing
Y / P Chest pain
Y / P COPD/bronchitis
Y / P Pneumonia
Y / P Tuberculosis
Y / P Emphysema
Y / P Last chest x-ray: _____

### Vascular

Y / P Heart disease
Y / P High blood pressure
Y / P Stroke
Y / P Arrhythmia
Y / P Chest pain / angina
Y / P Rheumatic fever
Y / P Palpitations
Y / P Easy bruising/bleeding
Past ECG date:_____
Y / P Cold hands/feet
Y / P Deep leg pain
Y / P Extremity numbness
Y / P Swelling ankles
Y / P Extremity ulcers
Y / P Phlebitis

### Urinary

Y / P Pain on urination
Y / P Urgency
Y / P Hesitancy
Y / P Increased frequency
Y / P Frequent infections
Y / P Blood in urine
Y / P Kidney stones

### Gastrointestinal

Y / P Frequent nausea
Y / P Frequent vomiting
Y / P Hernia
Y / P Ulcers
Y / P Hepatitis
Y / P Food allergy/sensitivity
Y / P Indigestion/bloating
Y / P Excess burping/gas
Y / P Change in appetite/thirst
Y / P Gallbladder issues
Y / P Hemorrhoids
Y / P Blood in stool
Y / P Mucus in stool
Y / P Frequent diarrhea
Y / P Constipation
# of bowel movements per day ____

### Endocrine

Y / P Excess thirst
Y / P Excess hunger
Y / P Excess sweating
Y / P Thyroid issues
Y / P Diabetes
Y / P Hypoglycemia
Y / P Excess fatigue
Y / P Poor concentration
Y / P Hair loss
Y / P Brittle nails
Y / P Sensitive to heat / cold

### Neurological

Y / P Fainting
Y / P Numbness/tingling
Y / P Seizures
Y / P Paralysis
Y / P Muscle weakness
Y / P Loss of balance
Y / P Loss of memory
Y / P Speech problems
Y / P Head injury

### Musculoskeletal

Y / P Joint pain/stiffness
Y / P Arthritis
Y / P Joint swelling
Y / P Muscle weakness
Y / P Muscle spasms/cramps
Y / P Sciatica

### Sexual Health

Y / P Change in sex drive
Y / P Infection/STI
Y / P HIV/AIDS
Y / P Pain with intercourse

### Male

Y / P Hernias
Y / P Testicular masses
Y / P Prostate issues
Y / P Erectile dysfunction
Y / P Testicular pain

### Female

Y / P Breast lumps
Y / P Fibrous breasts
Date of last breast exam: _____
Y / P Irregular cycles
Y / P Spotting
Y / P Clots
Y / P Excessive flow
Y / P Excessive discharge
Y / P Yeast infection
Duration of cycle _____
Duration of flow _____
# pregnancies _____
# live births _____
# miscarriages _____
# abortions _____
Date of last PAP test: _____
Type of birth control: _____
Y / P Endometriosis
Y / P Ovarian cysts
Y / P Fibroids
Y / P Cervical dysplasia
Y / P Abnormal PAP
Y / P Difficulty conceiving

### Mental-Emotional

Y / P Depression
Y / P Anxiety
Y / P Insomnia
Y / P Drug abuse
Y / P Alcohol abuse
Y / P Suicidal
Y / P Bipolar disorder
Y / P Schizophrenia
Y / P Seasonal depression

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PLEASE ALLOW AT LEAST 24 HOURS NOTICE FOR CANCELLATIONS

We have reserved a special timeslot for Dr. Kerri to meet you. If you cannot make your scheduled appointment, please call us as soon as possible to reschedule your time. When adequate notice is not provided, the time that was set aside for your appointment goes unfilled. This policy is set to ensure that patients on the wait list can be seen in a timely fashion. We really appreciate your co-operation.

Thank you!