

*Please read carefully and fill out as completely as possible. The information provided by this questionnaire will become part of your records at our clinic and is treated as confidential.*

**Name:**

**DOB** *(DD/MM/YY)***:**

**Phone:**

**Email:**

**Family Physician:**

**PHN:**

**Address:**

**Check (X) if you want to opt out of our newsletter:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Strength/Dosage |  | Vitamins / Supplements | Quantity |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **Known Allergies:** |
| **Surgery/Medical History:** |
|  |
|  |
| **Family History:** |
|  |
|  |
|  |
|  |
| **Emergency Contact: Phone Number:** |
| **Relationship to you:** |

**What are your biggest health issues and or goals with regards to your health? Please list as many as you can in order of importance:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Adrenal/ Stress Evaluation**

When is your best time of day (X): Morning Afternoon Evening

What time do you generally go to bed?

What time do you generally wake up?

Are you hungry first thing in the morning?

**Part A:**

Please check all that apply:

|  |  |
| --- | --- |
| Feeling that you are constantly racing from one task to the next |  |
| Feeling wired but tired |  |
| Struggle to calm down before bedtime, or a second wind that keeps you up late at night |  |
| Feeling of anxiety or nervousness- can’t stop worrying about beyond your control |  |
| Quickness to feel anger or rage |  |
| Memory lapses or feeling distracted, especially when under stress |  |
| Sugar cravings |  |
| Weight gain, particularly around the abdomen |  |
|  Skin conditions like eczema or thin skin |  |
|  Bone loss, such as osteoporosis or osteopenia |  |
|  High blood pressure or rapid heartbeat |  |
|  High blood sugar (pre-diabetes) or shakiness between meals |  |
|  Indigestion, ulcers or reflux disease |  |
|  More difficulty recovering from physical injury than in the past |  |
|  Unexplained pink/purple stretch marks on belly or back |  |
| Total: |  |

**Part B:**

Please check all that apply:

|  |  |
| --- | --- |
| Fatigue or burnout- use caffeine to stay awake or fall asleep at a movie |  |
| Loss of stamina (especially 2-5 PM) |  |
| Pessimistic point of view |  |
| Crying episodes for no reason |  |
| Decreased problem solving ability |  |
| Feeling stressed most of the time |  |
| Insomnia or difficulty staying asleep, especially between 1 and 4 AM |  |
| Low blood pressure |  |
| Postural hypotension (stand up from lying down and feel dizzy) |  |
| Low or unstable blood sugar |  |
| Salt cravings |  |
| Excess sweating |  |
| Nausea, vomiting or diarrhea |  |
| Loose stool alternating with constipation |  |
| Muscle weakness, especially around the knee. Possibly with muscle and joint pain |  |
| Hemorrhoids or varicose veins |  |
| Blood pools easily or show bruises easily |  |
| Total: |  |

**Male Hormone Evaluation**

Please check all that apply:

|  |  |
| --- | --- |
| Lack of energy |  |
| Decrease in strength and/or endurance |  |
| Loss of height |  |
| Decreased enjoyment of life  |  |
| Feel sad and/or grumpy |  |
| Decreased libido (sex drive)  |  |
| Lack of Desire to be intimate |  |
| Are your erections less strong |  |
| During sexual intercourse, has it been more difficult to maintain your erection to completion of intercourse  |  |
| Are you falling asleep after dinner |  |
| Loss of Motivation |  |
| Flat Mood |  |
| Diminished sense of well being |  |
| Has there been a recent deterioration in your work performance |  |

**Digestion Evaluation**

Bowel Movements: How often?

Is this a change for you?

Do you experience Constipation regularly?

Do you experience diarrhea regularly?

**Diet: Please list approximately how many times per week each is consumed**

|  |
| --- |
| Red Meat |
| Dairy  |
| Wheat |
| Eggs |
| Shellfish |
| Soy |
| Sugar (refined or otherwise eg. breakfast cereals)  |
| Coffee |
| Alcohol |
| Smoking |
| Recreational Drugs |



**Informed Consent to Treatment**

1. I understand that the practitioners at this health centre are Naturopathic Physicians, and will use only natural, non-invasive methods of assessment and treatment.
2. I understand that any advice given to me as a patient at Divine Elements Health Centre is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.
3. I understand that I am at liberty to seek, or to continue medical care from another health care provider qualified to practice in B.C.
4. I understand that the Naturopathic Physician reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.
5. I understand that I am accepting or rejecting this care by my own free will.
6. I understand that no employee or physician at Divine Elements Health Centre is suggesting to me to refrain from seeking advice from another health care provider.
7. I understand that the services here are not covered by MSP, and that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests.
8. **I understand that 48-hours notice is required for any appointment cancellation or a no show; otherwise I will be responsible for a cancellation fee of $100.**
9. **I understand that all therapies and supplements are non-refundable.**
10. **I understand that prices may change without notice.**
11. I understand that any therapies recommended will be explained to me in full by my physician, and I will give consent to treatment based on informed consent.

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

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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