PARALLEL CHIROPRACTIC & WELLNESS CENTRE

Naturopathic Patient Entrance Form

Patient Name: ____ **Date:** ________________________

Home Address: ____ **Postal Code:** _________________

Phone #: __________________**Work #:** __________________ **Cell #:** ____________________________

Date of Birth: (Month)____(Day)____(Year)_______ Female___Male___

Were you recommended to our clinic? If yes, by whom? ______________________________________

Marital Status: S__M__W__D__C/L__ Name of spouse:_________________ Ph#________________

Occupation:_______________________

Email:____ As per CASL I consent to receive emails from you____(Initial)

Medical Doctor: ____ **Phone:** ____________________

Reasons for consulting this clinic: ____

Health History – ***Please check symptoms you have or have had in the past year:***

General	***Cardiovascular***	***Genito-Urinary***	***Men Only***
☐ Chills ☐ Depression ☐ Dizziness/Faint ☐ Headaches ☐ Fever ☐ Forgetfulness ☐ Nervousness ☐ Numbness ☐ Sweats ☐ Sleep Deprivation ☐ Weight Loss ☐ Arthritis ☐ Allergies ***Muscle/Joint/Bone*** Having pain, weakness, or numbness in: ☐ Neck ☐ Shoulders ☐ Upper Back ☐ Middle Back ☐ Lower Back ☐ Hips ☐ Legs ☐ Knees/Ankles ☐ Feet/Toes ☐ Arms/Wrists ☐ Hands/Fingers ☐ Jaw	☐ Diabetes ☐ Heart Disease ☐ Stroke (TIA) ☐ Chest Pain ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Irregular Heart Beat ☐ Rapid/Slow Heart Rate ☐ Poor Circulation ☐ Do you smoke? ☐ Varicose Veins ☐ Shortness of Breath ☐ Difficulty Inhaling Completely ***Gastrointestinal*** ☐ Poor Appetite ☐ Bloating ☐ Bowel Changes ☐ Constipation ☐ Diarrhea ☐ Excessive Hunger ☐ Excessive Thirst ☐ Gas ☐ Indigestion ☐ Nausea/Vomiting ☐ Stomach Pain Other__________________ ________________________	☐ Frequent Urination ☐ Lack of Bladder Control ☐ Painful Urination ***Eye, Ear, Nose, Throat*** ☐ Blurred vision ☐ Crossed eyes ☐ Double vision ☐ Sinus Problems ☐ Asthma ☐ Hay Fever ☐ Hoarseness ☐ Persistent Cough ☐ Difficulty Swallowing ☐ Earaches ☐ Ear discharge ☐ Hearing Loss ☐ Ringing in Ears ☐ Nosebleeds ☐ Vision – Flashes/Halo ☐ Contact Lenses ☐ Headaches ☐ Tension ☐ Migraines Other__________________ ________________________	☐ Erectile Difficulties ☐ Other ***Women Only*** ☐ Breast lump ☐ Menstrual Problems ☐ Hot Flashes ☐ Other Date of mammogram: ________________________ Are you pregnant? ________________________ Number of children_______ ***Skin*** ☐ Bruise Easily ☐ Hives ☐ Itching ☐ Change in moles ☐ Rash ☐ Eczema ☐ Psoriasis ***General*** Date of last Physical: ________________________ Other___________________

Please list any medications you are taking____
____
Please list any illnesses or surgeries and their dates____
____
Please list any accidents and their dates____
____

Naturopathic Medicine - Professional Fee Schedule

Adult Initial Visit: - Case history, recommended treatment (90 minutes) $155.00
Follow Up Visits: 15 minutes - $45.00
30 minutes - $70.00
45 minutes - $95.00
60 minutes - $125.00
90 minutes - $155.00

Seniors & Children Initial Visit: Case history, recommended treatment (60 minutes) $110.00

Constitutional Homeopathy: 90 minutes - $155.00
Telephone consultations - $45/15minutes, $70/30 minutes & up
E-mail consultations - $30.00 & up

Naturopathic Medicine Consent Form

I understand that Naturopathic Medicine does not diagnose illness or disease. Naturopathic Medicine is not a substitute for medical examination or a medical diagnosis and it is recommended that I also have a medical doctor while undergoing naturopathic treatment. I have stated all my known medical conditions and take it upon myself to notify my naturopathic physician of any changes in my health. This consent form shall cover the entire course of my treatment.

Please be advised there is a 24-hour cancellation policy in effect; ANY appointment not cancelled within 24 hours will be billed the FULL appointment price.

I have read, understood and consent to the above mentioned fee schedule, and I declare that the above information is correct and that I have not withheld any medical information.

Signature____________________________ Date___________________________