Dr. Ekaterina Krantsevich - Riehl, ND
Sina Naturopathic Clinic
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Tel: 604-336-7462 Fax: 604-336-7463

Date_____

Personal Information
Name: _____ Date of First Visit: _____ PHN# _____
Address: _____ City, Province: _____ Postal code: _____
Telephone (home): _____ (work): _____ (Cell): _____
Email address: _____ Birthday: _____ Age: _____
Occupation: _____ Hrs/wk: _____ How long: _____
How did you hear about us ?: _____

Emergency Contact
Name: _____ Relationship: _____ Phone #: _____

List your current health care providers
_____
_____
_____
_____

Please state your health concerns (in order of importance) How Long?

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Immunization history (Check all that apply)
☐ Tetanus ☐ Measles/mumps/rubella Pertussis ☐ Diptheria ☐ Hepatitis A
☐ Hepatitis B Polio ☐ Flu shot Others: _____

List known allergies or sensitivities:
Foods: _____
Medications: _____
Environmental factors: _____
Chemicals: _____

List all current medications with dosages:
Prescription medications: _____
_____
Over the counter medications: _____
_____
Supplements: _____
_____

What accidents/traumas have you had?
_____
_____

What hospitalizations or surgeries have you had?
_____
_____

What medical tests (x-rays, CT scans, MRI, ECG) have you had?

_____
_____

Family Medical History

Mother**:**_____
Grandparents:_____
Father:_____
Grandparents:_____
Sibling(s):_____

Lifestyle

How often do you eat out? _____
How often do you consume:

Coffee _____ Alcohol _____
Pop _____ Recreational drugs _____
Sugar _____ Tobacco _____
Added salt _____ Artificial sweeteners _____

What are your main interests and hobbies? _____
What exercise do you do and how often? _____
What do you enjoy most in your life? _____
How many hours sleep do you get? _____
Do you awake feeling rested? _____
Do you have supportive relationships? _____
Do you have any occupational hazards? _____
Have you ever been treated for an addiction? _____
Smoked previously? How many years? How many packs per day? _____
_____

General Information

Current height : _____ Current weight: _____
What time of day is your energy best? _____ Worst? _____

Review of Systems: *Check all continuing or recurrent problems*

General

- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue
- ☐ Sleep disturbance

Endocrine

- ☐ Thyroid problem
- ☐ Heat or cold intolerance
- ☐ Hypoglycemia
- ☐ Diabetes
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Fatigue
- ☐ Seasonal depression

Mental / Emotional

- ☐ Depression
- ☐ Mood Swings
- ☐ Anxiety or nervousness
- ☐ Considered/Attempted suicide
- ☐ Tension
- ☐ Poor concentration
- ☐ Memory problems

Neurologic

- ☐ Seizures/epilepsy
- ☐ Paralysis
- ☐ Muscle weakness
- ☐ Numbness or tingling
- ☐ Loss of memory
- ☐ Easily stressed
- ☐ Vertigo or dizziness
- ☐ Loss of balance

Skin

- ☐ Rashes
- ☐ Eczema, Hives
- ☐ Acne
- ☐ Boils

- ☐ Itching
- ☐ Color Change
- ☐ Hair Loss
- ☐ Lumps
- ☐ Dry or scaling
- ☐ Night Sweats
- ☐ Excessive or no sweat

Head

- ☐ Headaches
- ☐ Head Injury
- ☐ Migraines
- ☐ Jaw/TMJ problems
- ☐ Fainting

Ears

- ☐ Hearing loss
- ☐ Ringing
- ☐ Earaches
- ☐ Dizziness
- ☐ Sensitivity to noise
- ☐ Discharge from ears

Nose and Sinuses

- ☐ Frequent colds/flus or infections
- ☐ Nose Bleeds
- ☐ Stuffiness
- ☐ Hayfever
- ☐ Sinus problems
- ☐ Loss of smell

Eyes

- ☐ Glasses or contacts
- ☐ Color blind
- ☐ Double Vision
- ☐ Spots in eyes
- ☐ Recent change in vision
- ☐ Blurred vision
- ☐ Eye pain/strain
- ☐ Sensitive to light
- ☐ Eyes water excessively or dryness
- ☐ Bloodshot or puffy eyes

Mouth and Throat

- ☐ Frequent sore throat
- ☐ Copious saliva
- ☐ Teeth grinding
- ☐ Mouth ulcers
- ☐ Sore tongue/lips
- ☐ Gum problems
- ☐ Hoarseness
- ☐ Loss of voice
- ☐ Dental cavities or infections
- ☐ Jaw clicks
- ☐ Cold sores
- ☐ Mercury amalgam fillings
- ☐ Root canals

Neck

- ☐ Lumps
- ☐ Swollen glands
- ☐ Goiter
- ☐ Pain or stiffness

Cardiovascular

- ☐ Heart disease
- ☐ High/Low Blood Pressure
- ☐ Murmurs
- ☐ Blood clots
- ☐ Fainting
- ☐ Phlebitis
- ☐ Palpitations/Fluttering
- ☐ Rheumatic Fever
- ☐ Chest pain
- ☐ Swelling in ankles

Respiratory

- ☐ Cough
- ☐ Sputum (mucus)
- ☐ Spitting up blood
- ☐ Wheezing
- ☐ Painful breathing
- ☐ Emphysema
- ☐ Difficulty breathing
- ☐ Pain on breathing
- ☐ Shortness of breath
- ☐ Shortness of breath lying down

Gastrointestinal

- ☐ Bowel Movements: How often? ____
  _____
- ☐ Is this a change?_____
- ☐ Constipation
- ☐ Diarrhea
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Change in thirst
- ☐ Change in appetite
- ☐ Abdominal pain or cramps
- ☐ Belching or passing gas
- ☐ Nausea/vomiting
- ☐ Hemorrhoids
- ☐ Black stools
- ☐ Blood or mucus stool
- ☐ Undigested food in stool
- ☐ Ulcer
- ☐ Jaundice (yellow skin)

Urinary

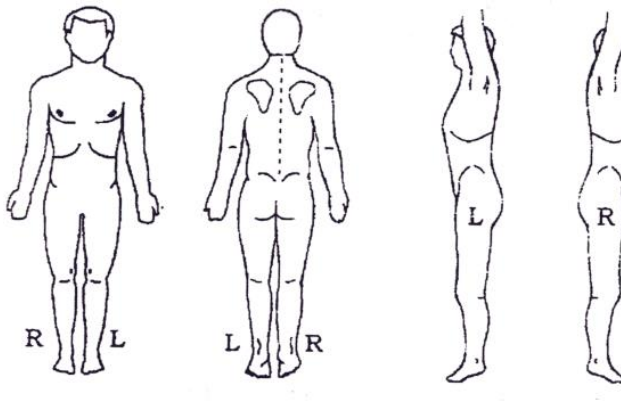
- ☐ Pain on urination
- ☐ Increased frequency

- ☐ Frequency at night
- ☐ Inability to hold urine
- ☐ Blood in urine
- ☐ Difficulty starting to urinate
- ☐ Frequent infections
- ☐ Kidney stones

Musculoskeletal

- ☐ Joint pain or stiffness
- ☐ Broken bones
- ☐ Muscle weakness
- ☐ Muscle spasms or cramps
- ☐ Sciatica
- ☐ Mark areas you currently feel pain:
  use Spacebar & Enter to move X around

X



Blood / Peripheral Vascular

- ☐ Easy bleeding or bruising
- ☐ Anemia
- ☐ Deep leg pain
- ☐ Cold hands/feet
- ☐ Varicose veins
- ☐ Thrombophlebitis
- ☐ Fluid retention

Male Reproduction

- ☐ Hernias
- ☐ Testicular masses
- ☐ Testicular pain
- ☐ Do you do testicular self-exam?
- ☐ Prostate problems
- ☐ Sexually transmitted infection
- ☐ Discharge or sores

- ☐ ☐ Are you sexually active? No Yes
- ☐ Birth control? No Yes, type: _____
- ☐ ☐ Erectile dysfunction
- ☐ Low libido
- ☐ Premature ejaculation
- ☐ Sexually transmitted infection

Female Reproduction / Breasts

- ☐ Do you do breast self-exams?
- ☐ Recent changes in breasts
- ☐ Breast lumps
- ☐ Breast pain/tenderness
- ☐ Nipple discharge
- ☐ Date of last annual exam/PAP _____
  _____
- ☐ Any abnormal PAPs? No ☐ Yes, when ☐
- ☐ Age of first menses? _____
  _____
- ☐ Are you sexually active?
- ☐ Low libido
- ☐ Pain during intercourse
- ☐ Sexually transmitted infection
- ☐ Vaginal dryness
- ☐ Vaginal discharge

<u>if pre-menopausal:</u>

- ☐ Irregular or no cycle:
- ☐ Duration of menses: _____ day
- ☐ Length of cycle: _____ days
- ☐ Bleeding between cycles
- ☐ Abnormal bleeding
- ☐ Painful menses
- ☐ Clotting
- ☐ Heavy or excessive flow
- ☐ Discharge
- ☐ PMS ☐ ☐
- ☐ Birth control? No Yes, type: _____
- ☐ Difficulty conceiving
- ☐ Perimenopausal

<u>if menopausal:</u>

- ☐ Age of last menses
- ☐ Any menopausal symptoms?
- ☐ Vaginal bleeding since menopause

During your initial visit, your Naturopathic Physician will perform a thorough health history, conduct a physical examination (if necessary), and when indicated take blood, saliva, or urine samples. Even the safest therapies may cause complications in certain physiological conditions (ex. pregnancy, breastfeeding, very young children, or those taking multiple medications or those with multiple medical conditions). Some therapies must be used with caution; therefore, it is important that you inform us of any medical conditions or change in medical conditions you have as well as any medications or supplements that you are taking. If you are pregnant or breast-feeding, please advise your Naturopathic Physician immediately.

There may be some health risks associated with naturopathic medicine. These may include but not limited to:

- Aggravation of a pre-existing symptoms
- Allergic reaction to supplements, herbs or prescription medication
- Pain, bruising, or injury from injection, blood draws or acupuncture
- Fainting or puncturing an organ with acupuncture needles

Please initial each statement below

☐ I understand that a record will be kept of the health services provided to me. This health record will be kept confidential and will not be disclosed or released to others without my consent, unless required by law. I understand that I may look at my medical records at any time and can request a copy of them by paying appropriate fees.

☐ I understand that the Naturopathic Physician will answer any questions that I have to the best of his/her abilities. I understand that results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions here).

☐ I understand that charges are to be paid at the times of the visit unless specific arrangements have been made prior to my scheduled appointment. Payment for all dispensary items is due at the time of the visit.

☐ I understand that missed appointments or late cancellations (less than 24-hour notice) will be subject to a $50 fee).

☐ I have read and understood this document and accept the risks involved with receiving naturopathic medicine.

☐ Medical Letters without a Naturopathic Visit will be charged $25.00. These can be claimed on your extended health care plan and may be covered depending on your coverage.

As a patient, you are responsible for the total charges incurred for each visit. If you have extended health coverage for Naturopathic Physicians, you are responsible for billing your own insurance company. Please check with the front desk if the physician has direct billing.

I have read and understood the above stated policies and information. I understand that I am free to withdraw from treatment and to discontinue further participation in these procedures at any time

Patient name (please print)__
Signature of patient/guardian Date:_____

Thank you for taking the time to fill in this information.