BELMONT Naturopathic Chiropractic Massage Therapy
NATURAL HEALTH CENTRE

201-690 BELMONT AVENUE WEST
KITCHENER ON N2H 1M6
(P)519-578-7489 (F)519-578-9747
WWW.BELMONTNATURALHEALTH.COM

Tom Daly, BSc. ND
Arla Kasaj, HBSc. ND

Hello and thank you for making a commitment to your health through naturopathic medicine. Enclosed you will find an intake form, consent form, and review of systems form to be filled out before your first visit. Here are answers to some frequently asked questions:

- *Why so many forms to fill out?* An important principle of naturopathic medicine is to treat the underlying causes of a health concern. This process is comparable to the detective work in a mystery novel; it takes some time to gather all of the clues and often there are details that seem insignificant to the reader but play an important role in finally solving the mystery. This is why we ask for your patience in exploring some of the details regarding your health, and some extra diligence on your part in paying attention to the details of your symptoms and overall well-being.
- *What about supplements?* Nutritional and herbal supplements are often required for successful treatment. In designing individualized treatment plans we always try to minimize the number of items required while still gaining a therapeutic benefit for the patient. We will recommend items that we have found to be of high quality and effectiveness. Some of these are only available through health care professionals such as naturopathic doctors, and others are available at better health food stores. You are under no obligation to purchase items directly from this clinic.
- As this clinic has clients with various environmental sensitivities, we kindly ask that you refrain from wearing clothes that smell like smoke, paint or other strong odours as this can cause irritation and reactions in other allergic patients.
- *How long before I see results?* This depends on a number of factors, including the nature of the condition treated, patient compliance and the forms of treatment agreed upon. Many acute conditions such as coughs, colds and infections can be resolved very quickly. Chronic concerns such as arthritis, allergies and digestive problems usually take a number of months of commitment to treatment.
- *Are telephone consultations available?* Yes, ongoing communication is an important part of successful treatment and is therefore encouraged. Telephone inquiries are provided free of charge up to five minutes. Consultations requiring more time and discussion are billed at the regular hourly rate after five minutes. Where applicable long distance costs will also be charged.
- *Missed appointments?* Without 24 hours notice, will be billed at the hourly rate.
- *Please include a recent photograph of yourself/patient with your Intake form.*
- *In the interests of cleanliness,* please feel free to bring a quiet amusement/toy for your child during his/her appointment.

Naturopathic medicine is most effective when you are an active participant in your health care. Therefore we will do my best to explain the reasoning behind various treatment options and to answer any questions you may have regarding your care.

Thank you for taking the time to go through these materials. We look forward to meeting with you soon.

Sincerely,

Tom Daly, B.Sc., N.D. and Arla Kasaj, HBSc., N.D.

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Declaration and Consent to Treatment

Patient Name: _____ Date: _____
please print

Assessment and Treatment

Tom Daly and Arla Kasaj practice naturopathic medicine using a combination of the following forms of treatment: standard medical techniques (i.e. physical examination and lab work), nutrition, traditional Oriental medicine, homeopathic medicine, botanical medicine (i.e. herbs), physical treatments and lifestyle counselling.

After taking a thorough case history, you will receive information about your diagnosis and/or treatment, alternative courses of action, costs, expected benefits, risks, side effects, and in each case the consequences of not having the diagnosis and /or treatment acted upon. As with any form of medical intervention there can be health risks associated with treatments by naturopathic medicine. Some possible side effects could be aggravation of pre-existing symptoms, an allergic reaction to supplements or herbs, and/or pain, bruising, or fainting from acupuncture.

I understand that Tom Daly and Arla Kasaj are licensed Naturopathic Doctors (N.D.). Any treatment or advice provided to me as a patient of Tom Daly or Arla Kasaj is not exclusive from any treatment or advice that I may receive in the future from another licensed health care provider. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.

I understand that in the event of a medical emergency, I am advised to seek conventional medical care at a hospital or clinic if I am unable to reach my Naturopathic Doctor.

I understand that the products available through the clinic dispensary may be available through retailers of natural health products in the community.

I understand that I have the right to ask any questions regarding the nature of my treatment, including foreseen risks and benefits. I understand that, as in any medical treatment, results are not guaranteed. With this knowledge, I voluntarily consent to Naturopathic care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

I welcome professional dialogue regarding my case between members of my care team at Belmont Natural Health Centre. Yes / No

Patient Fees

Adult	$144 per hour
Senior (65+) or Student/Child (17 and under)	$120 per hour
Initial 75 minute Adult Consult	$180
Non-patient BIA	$30.00 + tax.

Missed appointments without 24 hours cancellation notice will be billed at hourly rate

I have read all of the above and accept that these are the terms and conditions while under the Naturopathic care of Tom Daly, B.Sc. N.D. or Arla Kasaj, HBSc. N.D.

Signature: _____ Date: _____
Patient or Parent/Guardia

Client Health History

General Information

Name_____Birthdate_____Age_____Sex M☐ F☐

Address_____Postal Code_____

Telephone: Home_____Work_____May leave message? Y☐ N☐

Occupation_____Employer_____

Practitioner name and phone_____ Last physical exam_____

Laboratory tests performed?_____ Your blood type_____

How did you hear about our clinic? _____

Email Address: _____ Would you like to receive our newsletter? Y☐ N☐

NOTE: This questionnaire is intended to provide a well-rounded perspective of your current health and well being. There will be opportunity to elaborate on any questions. All information is kept confidential.

Major Health Concerns

What is your main reason for coming in today?_____

Please list other health concerns in order of importance to you:

Concern	Since	Details

Current treatments, including any medications taken (prescription or over-the-counter):

Treatment	Since	Provider

Your Health History

Please list any surgeries, injuries, hospitalizations or diagnostic procedures you have had:

Occurrence	Since	Details/Complications

Please list the most significant stressful events in your life. Are any of these events continuing to impact you?

Are you currently, or have you in the past, worked with a counselor, psychologist, social worker, pastor or other therapist? Y N When?_____

Do you use any of the following? If so, how often?

Antacids: _____ Laxatives: _____ Drugs: _____ Over the Counter Meds: _____

Tobacco: _____ Alcohol: _____ Caffeine: _____ Hormones: _____

Which of the following conditions have you had? Please indicate "now (n) or past (p)":

Abscesses		Diabetes		HIV		Peritonitis		Stroke	
Abortion		Emphysema		Influenza		Pleurisy		Syphilis	
Alcoholism		Epilepsy		Kidney Disease		Pneumonia		Tonsillitis	
Allergies		Gall Stones		Leukemia		Rheumatic Fever		Thyroid problem	
Amnesia		Goiter		Malaria		Rubella		Tuberculosis	
Arthritis		Gonorrhea		Measles		Scarlet Fever		Typhoid Fever	
Asthma		Gout		Miscarriage		Sexual Abuse		Venereal Warts	
Bronchitis		Hay Fever		Mononucleosis		Skin Disease		Warts	
Cancer		Heart Disease		Mumps		Strep Throat		Whoop. Cough	
Chicken Pox		Hepatitis		Parasites		Sinusitis		Worms	
Cold Sores		Herpes Genitalia		Pelvic Inflam Dz.		Sunstroke		Yellow Fever	
Depression									

List any other major conditions you've had:_____

From all of the above are there any conditions or life events after which you have never felt totally well again, or which have been more severe than usual? Please describe:_____

_____

Have you ever had a reaction to a vaccination?_____

Are you aware of any contact with environmental hazards (e.g. chemicals, pollutants, etc.) at the workplace, home, or during leisure activities?
If so please describe._____

What is your main drinking water source? City (tap), Spring, Reverse Osmosis.

Family Health History

In the following table, please indicate which of the following ailments, have affected your relatives. Please specify any other major ailments not listed here.

Alcoholism ☐ Allergies ☐ Arthritis ☐	Asthma ☐ Cancer ☐ Depression ☐	Diabetes ☐ Epilepsy ☐ Gout ☐	High Blood Pressure ☐ Heart Disease ☐ Hypoglycemia ☐	Mental Illness ☐ STD ☐ Stroke ☐	Thyroid Dz ☐ Tuberculosis ☐ Ulcer ☐

Relative	Age (If living)	Age at death	Ailments and Cause of Death
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles			
Paternal Grandmother:			
Paternal Grandfather:			
Paternal Aunts/Uncles			

General Health

Please answer the following questions, or circle the option which best applies to you.

You currently live with? SPOUSE, PARTNER, PARENTS, FRIEND, CHILDREN, ALONE

Ages of children_____

Present weight?____One year ago?_____Current energy level (1=poor, 10=excellent)? _____

When in the day is your energy the best?_____Worst?_____

Have you ever experienced persistent fatigue or weakness?_____

What is your level of work satisfaction (1=very unsatisfied, 10=extremely satisfied)?_____

Do you exercise?Y☐N☐ How much and how often? _____

Do you take vacations?Y☐N☐ When and how long was your last vacation? _____

Do you have a religious or spiritual practice? Y ☐ N ☐

Do you have problems falling or staying asleep? Y ☐N☐

What is the quality of your sleep? _____Do you ever sweat while sleeping? Y ☐ N☐

Do you wake feeling refreshed?☐Y N☐ Do you ever nap during the day? Y☐ N☐

Compared to those around you do you generally feel warmer, cooler, or average? _____

How often do you get colds, influenza, sore throat during the year? _____

Do you experience symptoms (e.g. agitation, fatigue sweating, others) if you skip a meal?☐Y N☐

Do you get lightheaded if you rise quickly from a sitting or lying position? ☐Y N☐

Any known or suspected allergies?_____

What do you feel is your weakest organ system and why?_____

Emotionally, do you have a tendency toward: ANXIETY, DEPRESSION, MOOD SWINGS, ANGER, FEARS

Digestion

Which of the following do you experience? Please indicate "now (n) or past (p)":

Gas	☐	Bloating	☐	Abdominal pain/discomfort	☐	Fullness	☐	Heartburn	☐
Diarrhea	☐	Small and hard stools	☐	Yellow or light coloured stools	☐	Rectal bleeding	☐	Constipation	☐
Hemorrhoids	☐	Loose stools	☐	Strong smelling stools	☐	Nausea	☐		

How often do you have a bowel movement? _____ Has this changed in recent years?Y☐N☐

Do you ever have any of the following in your stool? BLOOD, MUCUS, UNDIGESTED FOOD

Kidneys and Bladder

How many bladder infections have you had in the last 3 years? _____

How were they treated? _____

Your usual urine colour is? DARK YELLOW, BRIGHT YELLOW, PALE, CLEAR, CLOUDY

Does your urine have a strong odor? Y N

Which of the following do you experience? Please indicate "now (n) or past (p)":

difficulty holding urine		difficulty passing urine		pain with urination		burning with urination		blood in urine		kidney stones	

Other Symptoms

Which of the following do you experience? Please indicate "now (n) or past (p)":

Rashes	☐	Dry Skin	☐	Headaches	☐	Swollen Glands	☐	Heart Flutters	☐
Acne	☐	Chest Pain	☐	Sinus Problems	☐	Wheezing	☐	Ankle Swelling	☐
Easy Bruising or Bleeding	☐	Persistent Itching	☐	Muscle Cramps	☐	Joint Pain	☐	Numbness Or Tingling	☐
Excess Thirst Or Hunger			☐	Difficulty Breathing			☐	Canker Sores	☐

Female Reproduction

Age at first menses? _____ Are your cycles regular? Y N

Average number of days? _____ Is your period? HEAVY, MEDIUM, LIGHT

Is blood? LIGHT RED, DARK RED, MEDIUM, CLOTTED Is there spotting between periods? Y☐ N☐

Do you experience any of the following related to your cycle?

water retention	☐	headaches	☐	depression	☐	mood swings	☐
breast tenderness	☐	irritability	☐	cravings	☐	other	☐

Do you get vaginal itching? Y☐ N☐

Do you get vaginal discharge? Y☐ N☐

Do you get breast lumps? Y☐ N☐

Number of pregnancies _____ abortions _____ miscarriages? _____

Have you had difficulty becoming pregnant? Y☐ N☐ Do you use birth control? Y☐ N☐

If so, what type do you currently use? _____

Have you used birth control in the past? Y☐ N☐ What type? _____

Do you have any sexual difficulties? Y☐ N☐

Have you ever been physically or sexually abused? Y☐ N☐

Have you experienced menopausal symptoms? Y☐ N☐

Do you get regular Pap smears? Y N Have any been abnormal? Y☐ N☐

Male Reproduction

Do you ever experience? TESTICULAR PAIN, TESTICULAR MASSES/LUMPS

Do you have any abnormal discharge from penis? Y☐ N☐ Sores on penis? Y☐ N☐

Any history of sexually transmitted disease? Y☐ N☐

Do you wake at night to urinate? Y☐ N☐ Has this changed in recent years? Y☐ N☐

Are you aware of any prostate problems? Y☐ N☐ When was your last prostate exam? _____

Do you have difficulty getting or maintaining an erection? Y☐ N☐

Do you have any sexual difficulties? Y☐ N☐

Have you ever been physically or sexually abused? Y☐ N☐

Do you use birth control? Y☐ N☐

If so, what type do you currently use? _____

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