Naturopathic and Allergy Clinic - 2023

Telephone (416) 207-0207, fax (416) 207-0272

E-Transfer or Email: clinic@live.com

Confidential Adult Patient's Case History (to be completed before your visit in INK only please)

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Dear Patient: This form was specifically designed by our **Naturopathic Doctor, the clinic director Fateh Srajeldin ND,** to help our medical team evaluate your current health condition. Please complete this health questionnaire to the best of your knowledge. Your answers will help us determine in what ways we can help restore your health. We will only accept to treat your health concerns if we believe that you are intending to apply our ① instructions, ② remedies, ③ therapies and ④diet as given to treat your condition. Rest assured that all information will remain completely confidential. **Please make sure to answer all questions that have the mark (✳) Thank you.**

Personal information

✳Last name: _____ ✳First name: _____ Middle name: _____

✳Date of birth: ___MM. DD. YY.___ Sex: ❑ Male, ❑ Female, Height: _____ Weight: _____ Last physical date: _____

✳My Occupation is: _____ My employer is: _____

✳I have been unwell for: _____ Yrs., Physician's name who treated me was: _____

I was treated by a ❑ Medical Dr., ❑ Chiropractor, ❑ Naturopath Dr., ❑ Psychiatrist, ❑ Hospital, ❑ Homeopath, ❑ Herbs.

Was treatment terminated? : ❑ Yes, ❑ No, Did treatment achieve its goal % (explain): _____

✳I was treated for: _____

_____

✳I am currently suffering from the following and need treatment for (**Must list your current symptoms here Please**): _____

_____

_____

Family members who have similar conditions: ❑ Mother, ❑ Father, ❑ Brother(s), ❑ Sister(s), ❑ Daughter(s), ❑ Son(s), ❑ Adopted.

I am: ❑ Single, ❑ Married, ❑ Divorced, ❑ Separated, ❑ Common Law, ❑ Widow. Number of children: __ (Males __ , Females __)

Number of older brothers: _____ Number of older sisters: _____ My rank in the family is: _____

Number of younger brothers: _____ Number of younger sisters: _____ My favorite sport is: _____

✳My home address: _____ Suite: _____ City: _____ Province: _____ PC code: _____

✳My home telephone ( ): _____ ✳My office telephone ( ): _____ Ext. _____

✳My Cellular number ( ): _____ ✳My email: _____ @ _____

My Fax number ( ): _____ .

My Spouse's / Partners Information

Last name: _____ First name: _____ My spouse's occupation: _____ Age: _____

Home address: ♀ Same as above _____ Suite: _____ City: _____ Province: _____ PC code: _____

Home telephone ( ): _____ Office telephone ( ): _____ Ext. _____

Cellular number ( ): _____ email: _____ @ _____

In case of an emergency who may we contact

✳First name: _____ ✳Last name: _____ ✳Relationship: _____

Telephone (H): ( ) _____ (W): ( ) _____ Ext. _____ Fax: ( ) _____

Do you or your spouse have an extended health insurance at work ❑ Yes, ❑ No.? Name of Insurance company: _____

Do we have your permission to email you information and updates concerning your health plus seasonal promotions Yes ❑, No ❑

✳Who referred you to this Clinic : _____

❑ Office sign, ❑ Our Website, ❑ Surfing the Net, ❑ Office Pamphlet, ❑ Word of mouth.

Do you consent to the presence of a student from the Canadian College of Naturopathy to observe during your visit : Yes ❑, No ❑

Dear Patient:

The following several pages contain ① declaration form, ② physical examination consent form , ③ medical health questionnaire, ④ medical history form and ⑤ dietary questionnaire. There is a section that contains some crucial questions concerning both parents which pertain to your total health as well. Please take some time to answer all of the following questions as accurately as possible. The total interview and the actual examination may last approximately ninety minutes more or less. Further, you will spend approximately thirty minutes with your physician to setup your diet thereafter. You are expected to apply the diet as given. Along with the diet, your daily remedies, frequency and therapies will be set too.

I consent to request a written permission from the Naturopath should I wish to record, video tape or photograph the session or any part at the clinic whether the video tape or photograph includes the naturopath or not.

Please note that naturopathic services are not covered by the Ontario Health Insurance Plan (OHIP). Naturopathic examinations, treatments and therapies could be covered by an extended health insurance plan at your place of Employment. You may consult with your insurance company directly about their coverage. We, at the clinic, do not deal directly with insurance companies and we have no Information about your coverage.

Privacy: All your files and information are extremely confidential, however if you have any extra information concerning more steps of privacy concerning mail, email, phone calls or leaving phone massages, then please give us written instructions here: _____

_____

Read through the following list of symptoms that apply to you now or in the past. Please ignore symptoms that are not related to your condition. Please check mark ☑ the boxes under the appropriate columns if a symptom is **(P)** = **Past**, **(F)** = **F**requent and **(C)** = **C**onstant then place a numerical value under **Value, ie (1 = very low and 10 = very high). Thank you.**

IN GENERAL.

NA ❑

	Value	P	F	C
Anemia ……..	❑	❑	❑	❑
Fever or Chills……	❑	❑	❑	❑
Exhaustion……..	❑	❑	❑	❑
Chronic Fatigue…….	❑	❑	❑	❑
Mononucleosis……	❑	❑	❑	❑
Sweats (cold or warm)	❑	❑	❑	❑
Central obesity…	❑	❑	❑	❑
Sudden weight loss…	❑	❑	❑	❑
Cannot lose weight…	❑	❑	❑	❑

Any contact with animals ❑ **Yes** ❑ **NO**

✱ RESPIRATORY Sx. .

NA ❑

	Value	P	F	C
COVID-19 Sx……..	❑	❑	❑	❑
Croup……..	❑	❑	❑	❑
Pleurisy……..	❑	❑	❑	❑
Phlegm (Yellow, clear, white)…	❑	❑	❑	❑
Wheezing……..	❑	❑	❑	❑
Chest pain……..	❑	❑	❑	❑
Chronic cough……..	❑	❑	❑	❑
Thymus tatus……	❑	❑	❑	❑
Whooping Cough…..	❑	❑	❑	❑
Difficult to breath…	❑	❑	❑	❑
Spitting (Blood / Phlegm)	❑	❑	❑	❑
Asthmatic symptoms	❑	❑	❑	❑
Common Cold……	❑	❑	❑	❑
Bronchitis, (Chronic/Acute)	❑	❑	❑	❑
Sarcoidosis……	❑	❑	❑	❑
Tuberculosis……..	❑	❑	❑	❑
Emphysema……..	❑	❑	❑	❑
Pneumonia……..	❑	❑	❑	❑
Diphtheria……	❑	❑	❑	❑
Influenza……	❑	❑	❑	❑
Smoking (Now / Past)..	❑	❑	❑	❑
Marijuana (Now / Past)..	❑	❑	❑	❑

SKIN Sx. .

NA ❑

	Value	P	F	C
Acne……	❑	❑	❑	❑
Boils……	❑	❑	❑	❑
Warts……..	❑	❑	❑	❑
Lupus……..	❑	❑	❑	❑
Blisters……..	❑	❑	❑	❑
Rosacea……..	❑	❑	❑	❑
Shingles……..	❑	❑	❑	❑
Vitiligo……..	❑	❑	❑	❑
Impetigo……..	❑	❑	❑	❑
Melasma……..	❑	❑	❑	❑
Eczema……..	❑	❑	❑	❑
Psoriasis.. ……..	❑	❑	❑	❑
Athletes foot……..	❑	❑	❑	❑
Dry skin……..	❑	❑	❑	❑
Varicose veins……..	❑	❑	❑	❑
Brittle Nails……..	❑	❑	❑	❑
Hyperpigmentation ……	❑	❑	❑	❑
Skin, ring worms…..	❑	❑	❑	❑
Skin, itch or burn……	❑	❑	❑	❑
Sweats profusely…..	❑	❑	❑	❑
Hives Large or Small…..	❑	❑	❑	❑
Corns on Feet / Toes…..	❑	❑	❑	❑

Current Treatments. Circle if :

Proactive acne therapy	Yes ❑	**No** ❑
Chemical peels ……	Yes ❑	**No** ❑
Microdermabrasion	Yes ❑	**No** ❑
Hydra Facial ……	Yes ❑	**No** ❑
Laser hair removal …	Yes ❑	**No** ❑

✱ BONES, JOINTS, MUSCLES Sx

NA ❑

	Value	P	F	C
TMJ……	❑	❑	❑	❑
Gout ……..……..	❑	❑	❑	❑
Scoliosis ……..	❑	❑	❑	❑
Arthritis ……	❑	❑	❑	❑
Bursitis ……..	❑	❑	❑	❑
Tremor ……..	❑	❑	❑	❑
Neuralgia ……	❑	❑	❑	❑
Baker's Cyst	❑	❑	❑	❑
Herniated Disc ……	❑	❑	❑	❑
Uric Acid Sx……	❑	❑	❑	❑
Neck stiffness……..	❑	❑	❑	❑
Fibromyalgia……..	❑	❑	❑	❑
Tennis elbow……	❑	❑	❑	❑
Painful tail bone……..	❑	❑	❑	❑
Growing pain……..	❑	❑	❑	❑
Sciatica pain……..	❑	❑	❑	❑
Swollen Joints……..	❑	❑	❑	❑
Osteosclerosis……..	❑	❑	❑	❑
Osteoporosis……..	❑	❑	❑	❑
Muscle twitches……..	❑	❑	❑	❑
Upper back pain……..	❑	❑	❑	❑
Middle back pain……	❑	❑	❑	❑
Lower back pain…….	❑	❑	❑	❑
Pain between ribs……	❑	❑	❑	❑
Sternum joints pain…	❑	❑	❑	❑
Rheumatoid arthritis..	❑	❑	❑	❑
Leg cramps at night	❑	❑	❑	❑
Carpal Tunnel Syndrome	❑	❑	❑	❑

Pain (P) or numbness (N) in:

*R/L Shoulders …….	❑	❑	❑	❑
*Between shoulders…	❑	❑	❑	❑
*R/L Upper Arms …….	❑	❑	❑	❑
*R/L Forearms …..…	❑	❑	❑	❑
*R/L Elbows……	❑	❑	❑	❑
*R/L Hand ……	❑	❑	❑	❑
*R/L Fingers……	❑	❑	❑	❑
*R/L knuckles……	❑	❑	❑	❑
*R/L Hips ……	❑	❑	❑	❑
*R/L Legs……	❑	❑	❑	❑
*R/L Thighs …….	❑	❑	❑	❑
*R/L Knees ……	❑	❑	❑	❑
*R/L Legs …….	❑	❑	❑	❑
*R/L Ankles ……	❑	❑	❑	❑
*R/L Feet……..	❑	❑	❑	❑
*R/L Heels ……	❑	❑	❑	❑
*R/L Toes……	❑	❑	❑	❑
*Arch of feet…….	❑	❑	❑	❑
Aneurysm (Vent Aorta)	❑	❑	❑	❑

CARDIO-VASCULAR

NA ❑

	Value	P	F	C
Heart palpitation…..	❑	❑	❑	❑
Arrhythmia……..	❑	❑	❑	❑
Slow heart beat……..	❑	❑	❑	❑
Septal defect……..	❑	❑	❑	❑
Heart Murmur……..	❑	❑	❑	❑
Angina / Chest pain…	❑	❑	❑	❑
Poor circulation……..	❑	❑	❑	❑
High blood pressure...	❑	❑	❑	❑
Low blood pressure…	❑	❑	❑	❑
Dyspnea on exertion..	❑	❑	❑	❑
Shortness of breath….	❑	❑	❑	❑
High cholesterol……..	❑	❑	❑	❑
Ablation procedure…	❑ **Yes**			❑ **NA**

✱ GASTRO-INTESTINAL Sx.

NA ❑

	Value	P	F	C
Gas ……	❑	❑	❑	❑
Fissures ……..	❑	❑	❑	❑
Diarrhea…….	❑	❑	❑	❑
Constipation…….	❑	❑	❑	❑
Colitis…….	❑	❑	❑	❑
Bulimia……..	❑	❑	❑	❑
Burping …….	❑	❑	❑	❑
Belching…….	❑	❑	❑	❑
Painful to swallow…..	❑	❑	❑	❑
Stomach ulcers……..	❑	❑	❑	❑
Acid refluxes……..	❑	❑	❑	❑
Heart burn…….	❑	❑	❑	❑
Indigestion…….	❑	❑	❑	❑
Poor appetite…….	❑	❑	❑	❑
Hemorrhoids…….	❑	❑	❑	❑
Liver trouble…….	❑	❑	❑	❑
Colon trouble…….	❑	❑	❑	❑
Intestinal worms…….	❑	❑	❑	❑
Excessive hunger……	❑	❑	❑	❑
Stomach pain…….	❑	❑	❑	❑
Gall bladder pain…….	❑	❑	❑	❑
Hepatitis A / B / C....	❑	❑	❑	❑
Abdominal distension	❑	❑	❑	❑
Bloated after meals....	❑	❑	❑	❑
Lactose intolerant …	❑	❑	❑	❑
Ulcerative colitis…….	❑	❑	❑	❑
Rectal bleeding …….	❑	❑	❑	❑
Rectal itch……..	❑	❑	❑	❑
Crohn's disease……..	❑	❑	❑	❑
Diverticulitis……...	❑	❑	❑	❑
Colon polyps…….	❑	❑	❑	❑
Sleepy after meals…..	❑	❑	❑	❑
Food particles in stool.	❑	❑	❑	❑
Pyloric Stenosis……..	❑	❑	❑	❑
Recent Colonoscopy…..	❑	❑	❑	❑

SCALP & HAIR

NA ❑

	Value	P	F	C
Dandruff ……	❑	❑	❑	❑
Psoriasis……	❑	❑	❑	❑
Hair loss……	❑	❑	❑	❑
Hair lice……..	❑	❑	❑	❑
Hair splits……...	❑	❑	❑	❑
Scalp itchy……..	❑	❑	❑	❑
Alopecia Areata …….	❑	❑	❑	❑
Alopecia Universalis	❑	❑	❑	❑
Scalp painful……...	❑	❑	❑	❑
Hair implant……..	❑	❑	❑	❑
Hair is (Dry or Oily)…..	❑	❑	❑	❑
Baldness patches…..	❑	❑	❑	❑

✱ SLEEP Sx.

NA ❑

	Value	P	F	C
Time you go to bed_____.	❑	❑	❑	❑
Minutes to fall asleep ____	❑	❑	❑	❑
Your wake up time ____.	❑	❑	❑	❑
Is sleep interrupte ___X	❑	❑	❑	❑
Snoring……..	❑	❑	❑	❑

Do you day-nap?	Yes ❑	**No** ❑
Sleepy all day _____	Yes ❑	**No** ❑
Sleeping Meds_____	Yes ❑	**No** ❑
Using CPAP_____	Yes ❑	**No** ❑
I do shift work_____	Yes ❑	**No** ❑

MOUTH Sx . NA ❑

	Value	P	F	C
Mercury filling……..	❑	❑	❑	❑
Bad breath often …..	❑	❑	❑	❑
Thrush on tongue…..	❑	❑	❑	❑
Mumps……..	❑	❑	❑	❑
Dry mouth Day / Night ..	❑	❑	❑	❑
Gums bleeding……..	❑	❑	❑	❑
Sensitive teeth to cold	❑	❑	❑	❑
Sensitive teeth to hot..	❑	❑	❑	❑
Taste changed lately..	❑	❑	❑	❑
Drool during sleep ..	❑	❑	❑	❑
Enlarged tonsils…….	❑	❑	❑	❑
Angular Cheilitis……	❑	❑	❑	❑
Cold sores…….	❑	❑	❑	❑
Oral herpes…….	❑	❑	❑	❑
Canker sores……..	❑	❑	❑	❑

NOSE Sx. NA ❑

	Value	P	F	C
Nose tip itch …….	❑	❑	❑	❑
Nose bleed (epistaxis)…	❑	❑	❑	❑
Nasal obstruction ….	❑	❑	❑	❑
Nasal congestion ….	❑	❑	❑	❑
Sneezing spells Am, Pm	❑	❑	❑	❑
Sinus infection…….	❑	❑	❑	❑
Post nasal drip…….	❑	❑	❑	❑
Wears (Perfume, Cologne)	❑	❑	❑	❑

EARS Sx. NA ❑

	Value	P	F	C
Vertigo……..	❑	❑	❑	❑
Tinnitus …….	❑	❑	❑	❑
Ear noise……	❑	❑	❑	❑
Ear aches……	❑	❑	❑	❑
Ear redness……	❑	❑	❑	❑
Ear canal itch……	❑	❑	❑	❑
Ear discharge……	❑	❑	❑	❑
Perforated eardrum…	❑	❑	❑	❑
Excessive ear wax…	❑	❑	❑	❑
Ear deafness …	❑	❑	❑	❑

EYES Sx. NA ❑

	Value	P	F	C
Eyes itch…….	❑	❑	❑	❑
Chalazion …….	❑	❑	❑	❑
Eyes redness …….	❑	❑	❑	❑
Eyes discharge …….	❑	❑	❑	❑
Sties on eye lid R / L….	❑	❑	❑	❑
Failing vision…….	❑	❑	❑	❑
Blepharitis R or L	❑	❑	❑	❑
Xanthelasma ……	❑	❑	❑	❑
Glaucoma…….	❑	❑	❑	❑
Cataract…….	❑	❑	❑	❑
Conjunctivitis …….	❑	❑	❑	❑
Inflamed eye lids (upper / lower).	❑	❑	❑	❑
Blurry eyes R or L…….	❑	❑	❑	❑
Dark circle under eyes	❑	❑	❑	❑

THROAT Sx. NA ❑

	Value	P	F	C
Colds …….	❑	❑	❑	❑
Tonsillitis…….	❑	❑	❑	❑
Cold sores…….	❑	❑	❑	❑
Sore throat…….	❑	❑	❑	❑
Throat itch…….	❑	❑	❑	❑
Enlarged tonsils…….	❑	❑	❑	❑
Throat irritation…….	❑	❑	❑	❑
Voice changed lately	❑	❑	❑	❑
Frequent choking on water	❑	❑	❑	❑

HEAD Sx.. NA ❑

	Value	P	F	C
Upper sinuses congestion	❑	❑	❑	❑
Lower sinuses congestion	❑	❑	❑	❑
Fainting ……..	❑	❑	❑	❑
Dizziness…….	❑	❑	❑	❑
Migraine …….	❑	❑	❑	❑
Headache…….	❑	❑	❑	❑
Light headed……..	❑	❑	❑	❑
Tension Headache ….	❑	❑	❑	❑
Cluster Headache….	❑	❑	❑	❑
Headache after MVA	❑	❑	❑	❑
Headache on waking	❑	❑	❑	❑
Headache if hungry	❑	❑	❑	❑

Headache Meds _____

Headache per Week _____

Migraine Meds _____

Migraine per Week _____

✱ VACCINATIONS, NA ❑

	Yes	No
Vaccination (Infancy)	❑	❑
Vaccination (Childhood)	❑	❑
Vaccination (Teenage)	❑	❑
Vaccination (Adulthood)	❑	❑
COVID-19 Vaccination	❑	❑
Allergy shots Now / Past.	❑	❑
Flu shots: _____	❑	❑
Others: _____	❑	❑

✱ ALLERGIES Sx. NA ❑

	Value	P	F	C
Seasonal allergies…..	❑	❑	❑	❑
Summer ……..	❑	❑	❑	❑
Fall……	❑	❑	❑	❑
Winter……	❑	❑	❑	❑
Spring……	❑	❑	❑	❑
Have allergies to dogs …	❑	❑	❑	❑
Have allergies to cats ….	❑	❑	❑	❑
Allergy- house dust	❑	❑	❑	❑
Allergy- dust mites	❑	❑	❑	❑
Allergy- dairy…….	❑	❑	❑	❑
Allergy- Sulfur……	❑	❑	❑	❑
Allergy- medication	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- weeds……	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- food additives	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- trees……..	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- grains…….	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- vegetables..	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- food……..	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- grasses…..	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- animals…..	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- chemicals ..	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- insects…..	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- Perfumes	❑	❑	❑	❑
Name: _____	❑	❑	❑	❑
Allergy- cosmetics…..	❑	❑	❑	❑
Perfumes: _____	❑	❑	❑	❑
Cologne: _____	❑	❑	❑	❑

ENDOCRINE Sx, NA ❑

	Value	P	F	C
Goiter…….....	❑	❑	❑	❑
Diabetes Mellitus…..	❑	❑	❑	❑
Diabetes Juvenile…..	❑	❑	❑	❑
Puffy face….....	❑	❑	❑	❑
Protruded eyes….....	❑	❑	❑	❑
Hypoglycemia….....	❑	❑	❑	❑
Hyperthyroidism…..	❑	❑	❑	❑
Hypothyroidism…..	❑	❑	❑	❑
Intolerant to heat/cold	❑	❑	❑	❑
Addison's disease…..	❑	❑	❑	❑

GENITAL / URINARY Sx . NA ❑

	Value	P	F	C
UTI …….....	❑	❑	❑	❑
Pubic itch…….....	❑	❑	❑	❑
Bed wetting…….....	❑	❑	❑	❑
Blood in urine….....	❑	❑	❑	❑
Kidneys stones….....	❑	❑	❑	❑
Frequent urination (Night)	❑	❑	❑	❑
Frequent urination (Day).	❑	❑	❑	❑
Cannot hold urine…..	❑	❑	❑	❑
Kidney's infections…..	❑	❑	❑	❑
Burning urination…...	❑	❑	❑	❑
Genital Herpes….....	❑	❑	❑	❑
Urine incontinence…..	❑	❑	❑	❑
Slow urination….....	❑	❑	❑	❑
Swollen ankles….....	❑	❑	❑	❑
Difficult starting urine.	❑	❑	❑	❑

✱ NERVOUS Sx. NA ❑

	Value	P	F	C
Tics……	❑	❑	❑	❑
OCD……	❑	❑	❑	❑
Unhappy ……	❑	❑	❑	❑
Depressed……	❑	❑	❑	❑
Anxious……	❑	❑	❑	❑
Epilepsy……	❑	❑	❑	❑
Anxiety due to abuse	❑	❑	❑	❑
Panic Disorder……	❑	❑	❑	❑
ADD Symptoms…….	❑	❑	❑	❑
ADHD Symptoms…..	❑	❑	❑	❑
Post Traumatic Stress	❑	❑	❑	❑
Phobic Disorder……	❑	❑	❑	❑
Hyper-activity…….	❑	❑	❑	❑
Schizophrenia…….	❑	❑	❑	❑
Alzheimer …….	❑	❑	❑	❑
Tendency to worry…	❑	❑	❑	❑
Loses temper often….	❑	❑	❑	❑
Tendency to cry…….	❑	❑	❑	❑
Low self esteem…….	❑	❑	❑	❑
Hopeless outlook……	❑	❑	❑	❑
Wets pants constantly	❑	❑	❑	❑
Tendency to be shy….	❑	❑	❑	❑
Dislike criticism…….	❑	❑	❑	❑
Frightening dreams….	❑	❑	❑	❑
Frightening thoughts	❑	❑	❑	❑
Convulsions…	❑	❑	❑	❑
Parkinson's Disease.	❑	❑	❑	❑
Hard to concentrate….	❑	❑	❑	❑
Thoughts of suicide…	❑	❑	❑	❑
Multiple sclerosis……	❑	❑	❑	❑
Seizure Grand Mal / Petit	❑	❑	❑	❑
Grinds teeth during sleep	❑	❑	❑	❑
Bell's Palsy……	❑	❑	❑	❑
Facial nerve Palsy……	❑	❑	❑	❑
Cerebral Palsy……	❑	❑	❑	❑

Please note: complete this page before the appointment to avoid form filling charges.

MALIGNANCIES Sx. NA ❑

	Value	P	F	C
Leukemia ……	❑	❑	❑	❑
Lymphoma ……	❑	❑	❑	❑

Type of Cancer _____

Malignancy Stage _____

Metastasized Cancer	Yes ❑	No ❑
Receiving Chemo	Yes ❑	No ❑
Receiving Radiation	Yes ❑	No ❑
Mistletoe treatments	Yes ❑	No ❑

LIST OF YOUR DRUGS NA ❑

Medications	Past	Taking	Allergic
Antibiotics……	❑	❑	❑
Warfarin ……	❑	❑	❑
Cortisone……	❑	❑	❑
Cannabis Oil……	❑	❑	❑
Mistletoe Therapy……	❑	❑	❑
Ventolin ……	❑	❑	❑
Symbicort ……	❑	❑	❑
Janumet ……	❑	❑	❑
Metformin ……	❑	❑	❑
Sitagliptin ……	❑	❑	❑
Zoloft ……	❑	❑	❑
Insulin meds. ……	❑	❑	❑
Metformin meds.....	❑	❑	❑
Aspirin ……	❑	❑	❑
Tylenol ……	❑	❑	❑
Advil ……	❑	❑	❑
Gravol ……	❑	❑	❑
Antacids……	❑	❑	❑
Anxiety meds. …...	❑	❑	❑
Depression meds.....	❑	❑	❑
Sleeping pills……	❑	❑	❑
Hormones……	❑	❑	❑
Thyroid meds……	❑	❑	❑
Hypertension……..	❑	❑	❑
Intravenous Therapy	❑	❑	❑
Chelation Therapy….	❑	❑	❑
Myer's cocktail IV…..	❑	❑	❑
Mega Vit C IV……	❑	❑	❑
B_{12} Injections……..	❑	❑	❑
Acupuncture Therapy	❑	❑	❑
Massage Therapy ……	❑	❑	❑
Colon Therapy …….	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑

✱ Dates of past Surgeries NA ❑

Hernia operation _____

Gallbladder removed _____

Tonsillectomy _____

Tubes in ears _____

Appendectomy _____

Nasal adenoids _____

Cancer surgery _____

Knee operation _____

Hysterectomy _____

Tubal ligation _____

C Section _____

Skin Piercing _____

How many tattoos _____

Prosthesis (Implants) _____

✱ SEXUALITY

	No	Yes
Abstainer ……	❑	❑
Sexually active ……	❑	❑
Heterosexual ……	❑	❑
Homosexual ……	❑	❑
Bisexual ……	❑	❑

✱ FOR FEMALES

	Value	P	F	C
My **maiden name** is _____				
White Vaginal discharge	❑	❑	❑	❑
Vaginitis	❑	❑	❑	❑
Vaginal warts	❑	❑	❑	❑
Trichomoniasis	❑	❑	❑	❑
Gonorrhea	❑	❑	❑	❑
Genital herpes Yrs.__	❑	❑	❑	❑
Cervical HPV	❑	❑	❑	❑
Endometriosis	❑	❑	❑	❑
Vulvodynia	❑	❑	❑	❑
Breasts dimpling	❑	❑	❑	❑
Breast Lumps	❑	❑	❑	❑
Infertility Yrs. __	❑	❑	❑	❑
Uterine fibroids	❑	❑	❑	❑
Constant PMS	❑	❑	❑	❑
Hot flashes	❑	❑	❑	❑
Irregular cycle	❑	❑	❑	❑
Menopausal symptom	❑	❑	❑	❑
Birth control				
*Oral contraceptive	❑	❑	❑	❑
Plan B ……	❑	❑	❑	❑
Spermicidal cream	❑	❑	❑	❑
Intrauterine device	❑	❑	❑	❑
Withdrawal… ……	❑	❑	❑	❑
Rhythm……	❑	❑	❑	❑
Tubal ligation……	❑	❑	❑	❑
Diaphragm ……	❑	❑	❑	❑
NuvaRing ……	❑	❑	❑	❑
Diva Cup ……	❑	❑	❑	❑
Pads……	❑	❑	❑	❑
Tampons……	❑	❑	❑	❑
Condom (Lubricated)	❑	❑	❑	❑
Condom (Dry)	❑	❑	❑	❑

Date of last cycle _____.

*Pap smear date _____.

Total of pregnancies _____.

Total of Miscarriages _____.

Total of abortions _____.

Total of stillbirths _____.

Date last breast exam _____.

If need breasts exam **Yes** ❑ **No** ❑

Your initials please: (must) _____.

✱ FOR MEN

	Value	P	F	C
*Enlarged prostate…	❑	❑	❑	❑
*Penile discharge……	❑	❑	❑	❑
Painful testicles ……	❑	❑	❑	❑
Lumps in testicles……	❑	❑	❑	❑
Testicular varicocele	❑	❑	❑	❑
Testicular large & small	❑	❑	❑	❑
Testicular Pain R / L	❑	❑	❑	❑
Testicular lumps ……	❑	❑	❑	❑
Impotence ……	❑	❑	❑	❑
Vasectomy……	❑	❑	❑	❑
Erectile Dysfunction	❑	❑	❑	❑
Condom Uses (OCC, All Times)	❑	❑	❑	❑

Date of prostate exam _____

If need prostate exam **Yes** ❑ **No** ❑

Your initials please: (must) _____

✱ HABITS and their frequencies

	Value	P	F	C
Water, cups per day: ……	❑	❑	❑	❑
Coffee Per day / Wk ……	❑	❑	❑	❑
Whey Protein Per day / Wk ……	❑	❑	❑	❑
Milk Servings Per day / Wk ……	❑	❑	❑	❑
Cheese Servings Per day / Wk…	❑	❑	❑	❑
Yogurt Servings Per day / Wk	❑	❑	❑	❑
Ice Cream Serv. Per day / Wk	❑	❑	❑	❑
Eggs # -------- Per day / Wk …	❑	❑	❑	❑
Alcohol Per day / Wk ……	❑	❑	❑	❑
Beer Per day / Wk ……	❑	❑	❑	❑
Wine R / W Per day / Wk ……	❑	❑	❑	❑
Smoothies, Shakes Per day / Wk	❑	❑	❑	❑
Butter / Margarine Per day / Wk	❑	❑	❑	❑
Nutella Per day / Wk ……	❑	❑	❑	❑
Peanut Butter Per day / Wk ……	❑	❑	❑	❑
Chocolate Milk Per day / Wk	❑	❑	❑	❑
Sugar White / Brown Per day / Wk	❑	❑	❑	❑
Sugar Products Per day / Wk	❑	❑	❑	❑
Cakes Per day / Wk ……	❑	❑	❑	❑
Candies Per day / Wk ……	❑	❑	❑	❑
Donuts, Muffins Per day / Wk	❑	❑	❑	❑
Eat three meals a day……..	❑	❑	❑	❑
Eat two meals a day……	❑	❑	❑	❑
Eat one meal a day……..	❑	❑	❑	❑
Cigarettes per day_____	❑	❑	❑	❑
Marijuana Per day / Wk……	❑	❑	❑	❑
Street drugs now / past…….	❑	❑	❑	❑
Hard drugs now / past……..	❑	❑	❑	❑

YOUR PARENTS

The following questions pertain to your parents health before and while your mother was pregnant with you. The answer to the following would help determine the strength of your inner constitution.

	Value	Mom	None	Dad
Allergies				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Alcoholism				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Smoking				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Epilepsy				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Asthma				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Prescribed drugs				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Street drugs/narcotics				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑
Communicable diseases				
before pregnancy…	❑	❑	❑	❑
during pregnancy…	❑	❑	❑	❑
during breast feeding	❑	❑	❑	❑

Personal Notes

No parental history, I was adopted ❑

Did not have a healthy childhood ❑

Please complete this page before the appointment to avoid form filling charges.

DIET (must be completed accurately)

The next table revolves around your dietary habits. This may be very beneficial in understanding the real causes behind your conditions. Please answer the following questions to the best of your abilities.

What do you eat during breakfast?

1-
2-
3-
4-
5-

What do you eat during lunch?

1-
2-
3-
4-
5-

What do you eat during dinner?

1-
2-
3-
4-
5-

What do you eat or during snacks?

Mid-Day:

Afternoon:

Before bed time:

FOODS THAT YOU CRAVE?

I crave:

- ❑ Chocolate
- ❑ Crunchy foods such as chips & crackers
- ❑ Caffeine such as coffee, tea, & energy drinks
- ❑ Cola, Pop, Soda
- ❑ Sugary foods and Desserts
- ❑ Hard Candy or Gum
- ❑ Protein
- ❑ Dairy
- ❑ Salty foods
- ❑ Fast foods
- ❑ Wine with meals
- ❑ Beer with meals

TYPE OF FOOD THAT YOU CONSUME?

- ❑ I have a strict dietary plan that I follow
- ❑ Most of my meals are home cooked whole foods
- ❑ I eat out less often today than I did 5 years ago
- ❑ I avoid refined grains, breads & pastas
- ❑ I avoid deep fried foods
- ❑ I eat sugary foods & dessert less than 3 times wk.
- ❑ I avoid diet foods
- ❑ I avoid Colas, Pops, Sodas
- ❑ I eat gluten free food
- ❑ I avoid foods that I have allergies to _____.
- ❑ I buy frozen or canned fruits and vegetables

When do you consume fruits / vegetables?

I consume:

- ❑ **NO** servings of fruit and vegetables at all
- ❑ Fruits &/or vegetables during breakfast
- ❑ Fruits &/or vegetables during lunch
- ❑ Fruits &/or vegetables during dinner
- ❑ Fruits &/or vegetables for snacks
- ❑ I make time to eat fruits &/or vegetables daily
- ❑ I prepare **fresh** fruits & vegetables
- ❑ I prepare **canned** or **frozen** fruits & vegetables
- ❑ I eat salad 1, 2, 3 a day / a week or **Never**

WHAT FRUITS & VEGETABLES DO YOU CONSUME?

I consume:

- ❑ A wide variety of **organic** fruits
- ❑ A wide variety of **regular** fruits
- ❑ A wide variety of **organic** vegetables
- ❑ A wide variety of **regular** vegetables
- ❑ A wide variety of vegetables
- ❑ A wide range of green leafy vegetables
- ❑ A wide color range of fruits & vegetables
- ❑ Broccoli, cauliflower, kale & Brussels sprouts
- ❑ I add Lemon / Lime juice to my salad

THE FOLLOWING BEST DESCRIBE YOUR DIGESTION?

- ❑ I am often bloated
- ❑ I have low energy after eating
- ❑ I am often constipated
- ❑ I have general digestive upset after eating
- ❑ I have excess mucus after eating
- ❑ I often have gas or flatulence
- ❑ I often have acid reflux &/or heartburn
- ❑ Going to the bathroom is often difficult
- ❑ I run to the bathroom immediately after food
- ❑ My stool varies in size & consistency

DO YOU CONSUME THE FOLLOWING IN MY FOOD ?

I must add the following to my food

- ❑ Vinegar
- ❑ Balsamic Vinegar
- ❑ Apple Cider
- ❑ Cheese
- ❑ Butter
- ❑ Mayonnaise
- ❑ I am hungry & often don't know why
- ❑ White sugar
- ❑ Salt
- ❑ MSG

THE FOLLOWING YOU DO NOT UNDERSTAND WHY ?

I always feel like

- ❑ Eating often eat when I feel guilt or depressed
- ❑ Eating & not knowing why
- ❑ Eat to reward myself
- ❑ I often eat when I am low energy especially in the
- ❑ I am hungry & often don't know why

Please be as specific as possible since the medical history may hold the key to your complete recovery.

*******************PLEASE COMPLETE BEFORE YOUR VISIT***********

The following section is required to list your medical history, sicknesses, rough times and hospitalizations, I am interested in every medication taken in your life especially antibiotics, cortisone and oral contraceptive pills. You should list the starting year of diseases and the year of their cure such as tonsillitis, problems with your ears, lungs, throat, skin etc. Also list the year of admission to the hospital for whatever reason. ***SEE AN EXAMPLE ON PAGE 9.*** **(PLEASE READ THE INSTRUCTIONS IT IS VERY IMPORTANT)**

Information should be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. ***You may choose to fill this sheet with your doctor before your examination.***

Some important notes to consider are

1- breast feeding at birth, 2- Start of cycle, 3- time of Solids introduction during infancy, 4- smoking and 5- drugs of any kind, (age at first cycle).

Duration	Year	Age	Description of incidents
✱	( )	Birth Day	❑ I was not breast fed **Or** ❑ I was breast fed for __ months & started solid food at __ months.
		1 Yr.	
		2 Yrs.	
		3 Yrs.	
		4 Yrs.	
		5 Yrs.	
		6 Yrs.	
		7 Yrs.	
		8 Yrs.	
		9 Yrs.	
		10 Yrs.	
		11	
		12	
		13	
		14	
		15	
		16	
		17	
		18	
		19	
		20 Yrs.	
		21	
		22	
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		30 Yrs.	
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		50 Yrs.	
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		53	
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		56	
		57	
		58	
		59	
		60 Yrs.	
		61	
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		71	
		72	

Please add another sheet or proceed to next page for Covid-19 questionnaire

Mandatory by law that COVID questionnaire for everyone and every visit

Naturopathic Doctors and all other regulated health practitioners are required by the Ontario Ministry of Health & Long-Term Care to screen every patient attending an in-person appointment. If you answer "yes" to any of the following questions, we cannot see you for an in-person appointment and you must get tested for COVID-19.

- **Do you have now or recently developed any of the following symptoms?**
  - Fever ❒ Yes ❒ No
  - New onset of cough ❒ Yes ❒ No
  - Worsening chronic cough ❒ Yes ❒ No
  - Shortness of breath ❒ Yes ❒ No
  - Difficulty breathing ❒ Yes ❒ No
  - Sore throat ❒ Yes ❒ No
  - Difficulty swallowing ❒ Yes ❒ No
  - Decrease or loss of sense of taste or smell ❒ Yes ❒ No
  - Chills ❒ Yes ❒ No
  - Headaches ❒ Yes ❒ No
  - Unexplained fatigue/muscle aches ❒ Yes ❒ No
  - Nausea/vomiting diarrhea, abdominal pain ❒ Yes ❒ No
  - Pink eye (conjunctivitis) ❒ Yes ❒ No
  - Runny nose or nasal congestion ❒ Yes ❒ No
  - Have you travelled outside Canada in the last 14 days? ❒ Yes ❒ No
  - Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? ❒ Yes ❒ No
  - It must be clear and understood that the Naturopathic doctors don't write any types of covid exemption...? ❒ Yes ❒ No
  - Did you take Covid vaccinations Once / Twice.? ❒ Yes ❒ No

Signature Date

Date & signature of the patient + Accompanied persons or the guardian (MUST) . Please list the names of people accompany the patient who live at your same residence. Those who don't live with you must fill a new COVID-19 FORM.

City	Choice ✔	Code	Explanations (Listed time of visits and therapies are approximate)	Our fee schedule	Exclusion
Toronto Clinic		Adult examination fee	First Examination is up to 2 Hrs. that includes evaluations of your symptoms listed in the application form, physical examination (no internals), discussion of the examination findings, adjust your diet according to findings and prescribe remedies. Prescribed remedies and any blood work aare **NOT** included.	**$229.00** None Taxable	**Remedies and blood work are NOT included in the first examination or any subsequent examination fee.**
		Deposits before examinations	All New patients' appointments require $225 deposit to secure the appointment.	**$229.00** None Taxable	
			All New appointments scheduled **out-side our regular hours** ie before our opening hours, closing hours, Sundays and other holidays require a full payment of first visit $225.00. A receipt can be emailed to you upon receiving the fee or an invoice will handed to you on your appointment day. . Prescribed remedies or lab tests are NOT included.	**$229.00** None Taxable	
		Requisition Ex2	First visit for food sensitivity blood test is up to 30 Min., to obtain an allergy testing **requisition**. The visit includes a discussion about your allergies, causes , symptoms and provide a requisition for **Food Sensitivity** IgG Test. The Cost of the 222 food allergens testing is $420 @ Life Labs, or @ DynaCare. No physical examination, remedies or other blood tests are included.	**$135.00** None Taxable	
		EX5	Subsequent follow-up examination is up to 30 **Mins**. To review major symptoms changes. Prescribed remedies are **NOT** included.	**$99.00** None Taxable	
		Report Reading	30 minutes of reading, evaluating and reporting any of reading and evaluating blood work or lab results.	**$50.00** None Taxable	
		No Show	We ask for your courtesy to give us **heads up of 48 hours cancellation** call so that a lengthy chunk of the day (2 hours) in our busy day won't be wasted idling while someone else may, desperately, need the same slot. Unfortunately, a cancellation fee will apply to those who do not respect our time.	**$50.00 non-taxable**	

Hints to help you fill in this medical history application:

The following are some hints on how to fill the application form as accurate as possible. Every question has two forms of answers. The first group of answers are placed under **Value** which explains the intensity of the symptom when it come using numbers from (1 to 10). Intensity of a symptom has nothing to do with the frequency of the symptom whether daily or once a week or one a month. Number (1 to 3) indicates the symptom's intensity is very small when it comes. On the other hand, a number (4 or 7) indicates that the symptom's intensity is disturbing and bothersome when it comes. The number (8 to 10) symptom's intensity is very painful whether the symptom appears every day or once a month. You should assign or estimate number to every question as you see it. This is not a right or wrong questions.

The second group of answers determines whether a symptom should be marked as **one** of the following answers

C… ☑ symptoms are present daily or
F… ☑ symptoms come and go frequently every few days, every week or every month or
P…☑ symptoms appear every several months or every season.

GASTRO-INTESTINAL

Value	P	F	C	
③	❑	❑	☑	Gas
	❑	☑	❑	Jaundice
②	☑	❑	❑	Diarrhea
⑦	❑	❑	☑	Heart burn
③	❑	❑	☑	Indigestion
③	❑	❑	☑	Constipation
③	❑	☑	❑	Poor appetite
②	☑	❑	❑	Hemorrhoids
③	❑	☑	❑	Liver trouble
	❑	☑	❑	Colon trouble
②	❑	❑	☑	Pain over stomach
	❑	☑	❑	Gall bladder trouble

Gas here is a constant symptom that appears daily and little bothersome given number 3.

Heart burn here is a constant daily symptom that appears which is very disturbing given the number 7.

Poor appetite here is a moderate symptom that appears frequently and bothersome, given the number 3

Pain over stomach here is a daily symptom, with a little discomfort, given the number 2.

1- breast feeding at birth, 2- time of food introduction during infancy, 3- smoking and 4- drugs of any kind.

The following section is required to list your medical history, sicknesses, rough times and hospitalizations, I am interested in every medication taken in your life especially antibiotics, cortisone and oral contraceptive pills. You should list the starting year of diseases and the year of their cure such as tonsillitis, problems with your ears, lungs, throat, skin etc. Information should be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. ***You may choose to fill this sheet with your doctor before your examination.***
Some important notes to consider are:

Duration	Year (1950)	Age	Description of incidents
		Birth Day	❑ I was not breast fed **Or** ❑ I was breast fed for ___ months & started solid food at ___ months.
	1951	1	**Was not breast fed, used formula**
		2	
		3	**1st set of tubes in the ears**
		4	
		5	
		6	**2nd set of tubes in ears plus antibiotics**
	1957	7	
		8	**Asthmatic symptoms, inhalers were prescribed and used daily**
	1959	9	
		10	
		11	**3rd set of tubes in the ears**
	1962	12	

Adult Declaration & Consent to Examination and Treatment

Name (please print) _____ **Date:** _____

I understand that the clinic's Naturopath, Dr. Fateh Srajeldin, B.Sc., ND, practices with an eclectic approach to health care. The initial patients' visit to see the naturopath at this clinic will include ① **discussing my medical history from birth to date,** ② **standard external physical examination,** ③ **evaluation of my diet and** ④ **prescribing remedies** based on the outcome of my total visit plus my current symptoms and my current laboratory blood work (if available). I understand that blood testing is not included in today's examination fee. I understand that the treatments may include Clinical Nutrition, Vitamins, Minerals, Enzymes, Co-Enzymes, Anti-Oxidants, Botanical remedies, Homeopathic remedies, Orthomolecular Supplementation, Acupuncture and Intravenous Therapy.
I understand that the Dr. Srajeldin's mission statement is to "provide safe and effective treatments to restore health as permanently as possible in the quickest, gentlest, least harmful way." I understand that the success of the treatment hinges on my compliance and application of the treatments.

I understand that Dr. Fateh Srajeldin, B.Sc., ND is a licensed Naturopathic Doctor (ND) not a Medical Doctor and his examinations and treatments are **not covered by OHIP**. I understand that Naturopathic examinations, treatments and therapies could be covered by my extended health insurance plan at my place of employment (if available). It is my responsibility to consult with my insurance company directly. I understand that The Naturopathic and Allergy Clinic does not deal directly with insurance companies and have no information about my coverage.
Any treatment provided to me as a patient of Dr. Fateh Srajeldin B.Sc., ND is not mutually exclusive from any treatment or advice that I may be receiving or may in the future be receiving 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 or elsewhere. I understand that medical therapy and naturopathic/drugless therapy, including homeopathy, are different kinds of therapies.
I understand that Dr. Fateh Srajeldin, B.Sc., ND strives to provide the best possible diagnosis and course of treatment. However, I understand that many factors will be important in determining actual results. Therefore, no representation or warranty is made with respect to any treatment, action or application of medical advice or information given.
I understand that the total interview and the actual physical examination (without an internal) may last approximately ninety minutes more or less. Further, I understand that the naturopath may spend approximately sixty minutes with me to setup my diet thereafter if I choose to have my diet restructured. I will apply the diet as given. Along with the diet, my daily remedies, frequency and therapies will be set too.

I consent to non-commercial , pictures or videos, be taken of my condition e.g., Acne, Eczema, psoriasis, Rosacea, etc., as Dr. Srajeldin advises. These videos or pictures are confidential and never to be used for commercial advertisement. They are intended for the patient's future comparisons of the degree of improvements during the process of the treatment.

For female patients, (NO routine Breast or internal examination).
I understand that while the option of breast examination on page (6) is recommended during first visit for all females over the age of 40 years or starting at age 30 years for those who use or have used alcohol, use or have used oral contraception and / or smoke or have smoked, the examination will only be performed if my health condition warrants an examination in the presence of a female (staff or relative) and I consent and initial "**Breast examination**" in the female section on page (6).

For male patients (NO routine Prostate examination).
I understand that the option for prostate examination on page (6) is recommended during first visit for males over the age of 40 years or starting at age 35 years for those men who use or have used steroids for body building, those men who drink or have drank alcohol and those who smoke or have smoked, the examination will be performed if my health condition warrants an examination and I consent and initial "**Prostate examination**" in the male section on page (6).
I understand that, in the event of a medical emergency, I am advised to seek conventional medical care at a hospital if I am unable to Reach my Naturopathic Doctor.
This is to acknowledge that I have read the above information and understand that these are the terms and conditions at the Naturopathic and Allergy Clinic. I also consent to the examination as been described above and as the examining naturopath sees necessary to help me overcome my symptoms.
I will provide a copy of my most recent blood work done in the past six months. Alternatively, I will arrange, bring, mail or fax all medical tests, (blood, urine, x- ray, ultrasound, MRI, and surgery results), pertaining to my health from my physician's office or the hospital if I was treated at a hospital. I will answer the questionnaire concerning my health to the best of my ability and knowledge. I will pay for all examinations, treatments, therapies and intravenous therapy immediately when rendered.
I understand that remedies and laboratory blood works are not included in the examination fee. I understand that appointment(s) cancellation requires **48** hours advanced notice for full refund otherwise there will be a $50 surcharge applied on each and every examination or therapy missed or cancelled less than or without 48 hour notice.

✱ **Signature:** _____ ✱ **Date:** _____

Witness: _____ **Date:** _____