

Naturopathic and Allergy Clinic -2022

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

E-transfer and 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 Dr. Fateh Srajeldin BSc., ND**, (for patients from infancy to age 16 years). It is to help our medical team evaluate your child's 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 child's health. We will only accept your child's case if we believe that you are intending to apply our ① instructions, ② remedies, ③ therapies and ④ diet as given to treat your child. Rest assured that all information will remain completely confidential. **Please make sure to answer all questions that have the mark (*), Thank you.**

Child's information

*Last name: _____ *First name: _____ Middle name: _____
*Date of birth: MM. DD. YY. Sex: Male, Female, Height: _____ Weight: _____ Last physical date: _____
*Child has been unwell for: _____ Yrs., Physician's name who treated my child as: _____
My child was treated by a Medical Dr., Chiropractor, Naturopath Dr., Psychiatrist, Hospital, Homeopath, Herbs.
Was treatment terminated?: Yes, No, Did treatment achieve its goal % (explain): _____
* My child was treated
for: _____
* My child is currently is suffering from and needs treatment
for: _____
Family members who have similar conditions: Mother, Father, Brother(s), Sister(s), Daughter(s), Son(s), Adopted.
Number of older brothers: _____ Number of older sisters: _____ Child's rank in the family is: _____
Number of younger brothers: _____ Number of younger sisters: _____ Child's favorite sport is: _____
*Child's home address: _____ Suite: _____ City: _____ Province: _____ PC code: _____
Child lives: With Both Parents, With Father, With Mother, Alternates Between Parents, With Relatives, Foster Home.

Father's Information

Last name: _____ First name: _____ Father's occupation: _____ Age: _____
Home address: * Same as above _____ Suite: _____ City: _____ Province: _____ PC code: _____
Home telephone (): _____ Office telephone (): _____ Ext. _____
Cellular number (): _____ email: _____ @ _____

Mother's Information

Last name: _____ First name: _____ Mother'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 one or both parents 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, Currently a patient, Word of mouth, Surfing the Net, Office Pamphlet, TV Interview

Dear Parents / Guardians:

The following several pages contain ① declaration form, ② physical examination consent form (no internals), 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 child's 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 and your child will spend approximately thirty minutes with your physician to setup your child's general diet thereafter. Your child is expected to apply the diet as given no ifs and buts. 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 messages, then please give us written instructions here: _____

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

IN GENERAL. NA <input type="checkbox"/>			
Value	P	F	C
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever or Chills.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhaustion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats (cold or warm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Central obesity...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden weight loss...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot lose weight...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any contact with animals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

* RESPIRATORY Sx. NA <input type="checkbox"/>			
Value	P	F	C
COVID-19 Exposure..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Croup.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pleurisy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whooping Cough....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult to breath...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting blood / phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthmatic symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Common Cold.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis, Chronic/Acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sarcoidosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking Now / Past..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana Now / Past..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* SKIN Sx. NA <input type="checkbox"/>			
Value	P	F	C
Acne.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boils.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warts.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blisters.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rosacea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitiligo.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impetigo.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melasma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Athletes foot.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Tags.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brittle Nails.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin, dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin, ring worms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin, itch or burn.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats profusely.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives Large or Small....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corns on Feet / Toes....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Treatments, Circle if:

Proactive acne therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hydra Facial	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Laser hair removal ...	Yes <input type="checkbox"/>	No <input type="checkbox"/>

BONES, JOINTS, MUSCLES Sx NA <input type="checkbox"/>			
Value	P	F	C
TMJ.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herniated Disc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uric Acid Sx.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck stiffness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful tail bone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Growing pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle twitches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain between ribs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sternum joints pain...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baker's Cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps at night...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Arch of feet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tennis elbow.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pain (P) or numbness (N) in:

*Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Between shoulders...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Elbows.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Fingers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*knuckles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Feet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Heels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitation....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CARDIO-VASCULAR NA <input type="checkbox"/>			
Value	P	F	C
Aneurysm (Vent Aorta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow heart beat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Septal defect.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina / Chest pain...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnea on exertion..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ablation procedure...	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> NA

* GASTRO-INTESTINAL Sx. NA <input type="checkbox"/>			
Value	P	F	C
Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fissures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Belching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart burn.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acid reflexes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal worms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive hunger.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A / B / C....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal distension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloated after meals...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lactose intolerant ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyps.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleepy after meals....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful to swallow....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food particles in stool.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pyloric Stenosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recent Colonoscopy....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCALP & HAIR NA <input type="checkbox"/>			
Value	P	F	C
Dandruff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair lice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair splits.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp itchy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alopecia Areata	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alopecia Universalis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp painful.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair implant.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair is (Dry or Oily)....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baldness patches....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* SLEEP Sx. NA <input type="checkbox"/>			
Value	P	F	C
Time child sleeps.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minutes to fall asleep.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your wake up time.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is sleep interrupte ___X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snoring.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you day-nap?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Sleepy all day.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Sleeping Meds.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Using CPAP.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

MOUTH Sx.		NA <input type="checkbox"/>		
	Value	P	F	C
Mercury filling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thrush on tongue.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mumps.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snore.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gums bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive teeth to cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive teeth to hot..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taste changed lately..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drop during sleep ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged tonsils.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral herpes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canker sores.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOSE Sx.		NA <input type="checkbox"/>		
	Value	P	F	C
Nose tip itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleed (epistaxis)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing spells Am, Pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wears (Perfume, Cologne)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EARS Sx.		NA <input type="checkbox"/>		
	Value	P	F	C
Vertigo.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear noise.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear aches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear redness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear canal itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear discharge.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perforated eardrum...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive ear wax...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EYES Sx.		NA <input type="checkbox"/>		
	Value	P	F	C
Eyes itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties on eye lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failing vision.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sight (Near or Far) .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bags under eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark circle under eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THROAT Sx.		NA <input type="checkbox"/>		
	Value	P	F	C
Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged tonsils.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat irritation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voice changed lately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEAD Sx..		NA <input type="checkbox"/>		
	Value	P	F	C
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light headed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cluster Headache....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache after MVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache on waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache if hungry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache Meds	_____			
Headache per Week	_____			
Migraine Meds	_____			
Migraine per Week	_____			

* VACCINATIONS,		NA <input type="checkbox"/>	
	Yes	No	
Vaccination (Infancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaccination (Childhood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaccination (Teenage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaccination (Adulthood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COVID-19 Vaccination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy shots Now / Past.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flu shots: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* ALLERGIES Sx.		NA <input type="checkbox"/>		
	Value	P	F	C
Seasonal allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fall.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Winter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spring.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- house dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- dust mites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- dairy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- Sulfur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- weeds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- food additives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- trees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- grains.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- vegetables..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- food.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- grasses.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- animals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- chemicals ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- insects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- Perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- cosmetics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perfumes: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cologne: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE Sx,		NA <input type="checkbox"/>		
	Value	P	F	C
Goiter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Juvenile.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Puffy face.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protruded eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerant to heat/cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addison's disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GENITAL/URINARY Sx.		NA <input type="checkbox"/>		
	Value	P	F	C
UTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pubic itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys stones.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination (Night)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination (Day).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot hold urine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine incontinence.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult starting urine.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* NERVOUS Sx.		NA <input type="checkbox"/>		
	Value	P	F	C
OCD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD Symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD Symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety due to abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Traumatic Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobic Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to worry...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loses temper often...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to cry.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low self esteem.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopeless outlook.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to be shy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dislike criticism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frightening dreams...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frightening thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard to concentrate...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts of suicide...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Grand Mal / Petit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wets pants constantly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grinds teeth during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bell's Palsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MALIGNANCIES Sx.		NA <input type="checkbox"/>		
	Value	P	F	C
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of Cancer	_____			
Malignancy Stage	_____			
Metastasized Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Receiving Chemo	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Receiving Radiation	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

*** List of Used Medication** NA

Medications	Past	Taking	Allergic
Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warfarin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis Oil.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mistletoe Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ventolin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symbicort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Janumet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metformin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitagliptin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Zolofit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin meds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metformin meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tylenol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gravol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antacids.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety meds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping pills.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormones.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chelation Therapy....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myer's cocktail IV.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mega Vit C IV.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B12 Injections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* For Matured Males		NA <input type="checkbox"/>		
	Value	P	F	C
Testicular hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in testicles....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed wetting issues....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

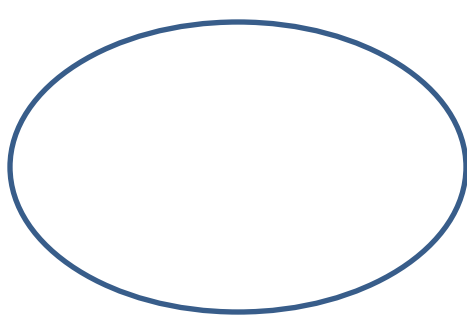
*** For Mature Females** NA

	Value	P	F	C
Constant PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congested breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy menstrual flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular cycle.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in breast.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal bleeding....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleed between cycles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pads	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tampons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral contraceptive...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last cycle	_____			

HABITS

If street drugs usage	Current	Past
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

FINE MOTORS TEST
 (Without your assistance)
 Have your child draw or write any
 thing in this space below



Personal Notes

- No parental history, child was adopted
- Did not have a healthy childhood

*** HABITS and frequencies**

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

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...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescribed drugs				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Street drugs/narcotics				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicable diseases				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Personal Notes

- No parental history, I was adopted
- Did not have a healthy childhood

My Child's Current Diet (Please Complete)

The next table revolves around your child's dietary habits. The intention is to unfold food that contain Aluminium and MSG or whether your child's food stimulates or contains histamine. This may be very beneficial in understanding the real causes behind your child's conditions. Please answer the following questions to the best of your abilities.

My child eats the following during breakfast?

- 1-
- 2-
- 3-
- 4-
- 5-

My child eats the following during lunch?

- 1-
- 2-
- 3-
- 4-
- 5-

My child eats the following during dinner?

- 1-
- 2-
- 3-
- 4-
- 5-

My child eats the following during snacks?

Mid-Day:

Afternoon:

Before bed time:

Foods that your child craves?

My child craves the following:

- 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

My child craves following types of food

- My child follows a strict dietary plan
- Most of my child's meals are whole home cooked
- My child eats out lesser today than 5 years ago
- My child avoids refined grains, breads & pastas
- My child avoids deep fried foods
- My child eats sugary foods & dessert 3 times/wk.
- My child avoids diet foods
- My child avoids Colas, Pops, Sodas
- My child eats gluten free food
- My child avoids potential Allergic foods .
- My child eats frozen or canned foods

My child consumes fruits and vegetables as follows

My child consumes:

- 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
- My child makes eats fruits &/or vegetables daily
- My child eats **canned** or **frozen** fruits & veggie
- My child eats 1, 2, 3 salads a day / a week

My child eats the following

My child consumes:

- 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
- My child adds Lemon / Lime juice to the salad

My child digestion is best describes as follows

- My child is often bloated
- My child has low energy after eating
- My child is often constipated
- My child's brain is foggy after eating
- My child has a general digestive upset after eating
- My child has excess mucus after eating
- My child has gas or flatulence
- My child has acid reflux &/or heartburn
- Having a bowel movement is often difficult
- My child runs to the bathroom after food
- My child's stool varies in size & consistency

My child consumes the followings

My child must add the following to food

- Vinegar
- Balsamic Vinegar
- Apple Cider
- Cheese
- Butter
- Mayonnaise
- White sugar
- Salt
- MSG

I do not understand why my child has the following symptoms

My child always feel like

- Eating often eat when I feel guilt or depressed
- Eating & not knowing why
- Eat to reward myself
- My child eats when low of energy
- My child is hungry & often don't know why?

The following section is required to list your child's medical history, sicknesses, rough times and hospitalizations, I am interested in every medication given to your child especially antibiotics, cortisone and oral contraceptive pill. You should list the starting year of diseases and the year of their cure such as tonsillitis, ears, lungs, throat, skin smoking, street drugs etc. Also list the year of admission to hospital for whatever reason.

INSTRUCTIONS AS IT IS VERY IMPORTANT

Information should be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. Some important notes to consider are : **1- How many months were you breast fed for after birth, 2- When did you start your period, 3- time of solids introduction during infancy, 4- Time of starting smoking and drugs if any 5- List all your diseases and corresponding Pharmaceutical drugs of any kind, (age at first cycle).**

* Duration	Year	Age	<input type="checkbox"/> I was not breast fed Or <input type="checkbox"/> I was breast fed for _ _ months & started solid food at _ _ months.		
		Yr. of Birth			
		3 Months			
		6 Months			
		9 Months			
		1 Yr.			
		3 Months			
		6 Months			
		9 Months			
		2 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		3 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		4 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		5 Yrs.			
		6 Yrs.			
		7 Yrs.			
		8 Yrs.			
		9 Yrs.			
		10 Yrs.			
		11 Yrs.			
		12 Yrs.			
		13 Yrs.			
		14 Yrs.			
		15 Yrs.			
		16 Yrs.			

Please add another sheet if needed

Fees of Examinations and services

Fees for first examination are pre-paid at time of booking the appointment by cash, Visa, Master Card, American Express and Interac. **We do not bill insurance companies.**

City	Choice ✓	Code	Explanations (Listed time of visits and therapies are approximate)	Our fee schedule	Exclusion
Toronto Clinic		Adult examination fee	First Examination for those who are under 16 years old is up to 1.5 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 blood work are NOT included.	\$189.00 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 \$198 deposit to secure the appointment.	\$189.00 None Taxable	
		Requisition Ex2	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 \$198.00. 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.	\$189.00 None Taxable	
		EX5	Subsequent follow-up examination is up to 30 Mins. To review major symptoms changes. Prescribed remedies are NOT included.	\$90.00 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.

For example:

GASTRO-INTESTINAL

Value	P	F	C	
③	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Gas
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Jaundice
②	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
⑦	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart burn
③	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Indigestion
③	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Constipation
③	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Poor appetite
②	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
③	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Liver trouble
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Colon trouble
②	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pain over stomach
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	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.

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

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	Age	Description of incidents
	(2006)	Birth Day	<input type="checkbox"/> I was not breast fed Or <input type="checkbox"/> I was breast fed for _ ? months & started solid food at _ ? months.
	2007	1	Was not breast fed, used formula
		2	
		3	1 st set of tubes in the ears
		4	
		5	
		6	2 nd set of tubes in ears plus antibiotics
	2013	7	
		8	Asthmatic symptoms, inhalers were prescribed and used daily
	2015	9	
		10	
		11	3 rd set of tubes in the ears
	2018	12	

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.

- | | |
|---|--|
| <ul style="list-style-type: none"> • Do you have now or recently developed any of the following symptoms? • Fever or Chills <input type="checkbox"/> Yes <input type="checkbox"/> No • New onset of cough <input type="checkbox"/> Yes <input type="checkbox"/> No • Worsening chronic cough <input type="checkbox"/> Yes <input type="checkbox"/> No • Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No • Difficulty breathing <input type="checkbox"/> Yes <input type="checkbox"/> No • Sore throat <input type="checkbox"/> Yes <input type="checkbox"/> No • Difficulty swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No • Decrease or loss of sense of taste or smell <input type="checkbox"/> Yes <input type="checkbox"/> No • Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No • Unexplained fatigue/muscle aches <input type="checkbox"/> Yes <input type="checkbox"/> No • Nausea/vomiting diarrhea, abdominal pain <input type="checkbox"/> Yes <input type="checkbox"/> No • Pink eye (conjunctivitis) <input type="checkbox"/> Yes <input type="checkbox"/> No | <ul style="list-style-type: none"> • Runny nose or nasal congestion <input type="checkbox"/> Yes <input type="checkbox"/> No • Have you travelled outside Canada in the last 14 days? <input type="checkbox"/> Yes <input type="checkbox"/> No • Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

Parents' or Guardians' Declaration & Consent to Child Examination and Treatment

Child's Name (please print) _____ **Date:** _____

Consent to Assessment and Treatment

I understand that the clinics Naturopath, Dr. Fateh Srajeldin, B.Sc., ND, practices with an eclectic approach to health care. Initial patients' visit to see the naturopath will include discussing your child's medical history from birth to present date, standard physical examination, evaluation of your child's diet and prescribing remedies based on your child's ❶ medical history, ❷ physical examination, ❸ current symptoms and ❹ the results of your child's blood works (if available). Further, I understand that testing with traditional blood work and functional testing may be requested. I understand that the treatments can include Clinical Nutrition, Vitamins, Minerals, Enzymes, Co-Enzymes, Anti-Oxidants, Botanical medicine and Homeopathic medicine, Orthomolecular Supplementation, Acupuncture and Intravenous Therapy.

I understand that the clinic's mission statement is *"a Naturopathic Doctor is to provide safe and effective treatments to restore health permanently in the quickest, gentlest, least harmful way."*

I understand that Dr. Fateh Srajeldin, B.Sc., ND is a licensed Naturopathic Doctor (ND) not a Medical Doctor and his examinations and treatments and laboratory blood requisitions are not covered by OHIP. I also understand that Naturopathic examination, treatments, therapies and remedies are not covered by the Ontario Health Insurance Plan (OHIP). I understand that my child's Naturopathic examinations, treatments and therapies could be covered by my extended health insurance plan at my place of employment (if available). I understand that 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.

I understand that any treatment provided to my child as a patient of Dr. Fateh Srajeldin B.Sc., ND is not mutually exclusive from any treatment or any advice that I may be receiving or may in the future be receiving from another licensed health care provider. I understand that 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 medical therapy and naturopathic/drugless therapy, including homeopathy, are different kinds of therapies. Dr. Fateh Srajeldin, B.Sc., ND strives to provide the best possible diagnosis and course of treatment. However, 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 examination may last approximately ninety minutes more or less. Further, I understand that the naturopath may spend approximately sixty minutes with me to setup my child's diet thereafter. I will apply the diet as given. Along with the diet, my child's daily remedies, frequency and therapies will be set too.

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 Naturopathic Doctor.

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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 of my child as been described above and as the examining naturopath sees necessary to help my child overcome his/her symptoms.

I will provide a copy of my child's most recent blood work done in the past six months. Alternatively, I will arrange, bring, mail or fax all my child's medical tests, (blood, urine, x-ray, ultrasound, MRI, and surgery results), pertaining to his/her health from his/her physician's office or the hospital if he/she was treated at a hospital.

I will answer the questionnaire concerning my child's health to the best of my ability and knowledge. I will pay for all my child's 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 any 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 without a notice.

Parent's / Gradian's Signature: _____ Date: _____

Office Witness _____ Date: _____

Note

Before the date of your appointment, if possible, please arrange, bring, mail or fax all your medical tests, (blood, urine, x-ray, ultrasound, MRI, and surgery results), pertaining to your child's health from your child's physician's office or the hospital if your child was treated at a hospital.