Absolute Health
INCORPORATED

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email: info_rosschiro@shaw.ca

Please print and complete these forms and bring them with you to your initial visit. Otherwise, please arrive 20 minutes before your visit to complete them in clinic.
Please also bring all relevant medical records (labs and imaging) to your initial visit or have your doctor fax them to 780-414-0061

Personal Information

Name: _____ Date of First Visit:_____

PHN# _____

Birth Sex: ☐M ☐F Gender Identity:_____

Birthdate: _____

Address: _____ City:_____,

Province: _____ Postal code: _____

Primary phone #: _____Secondary phone #: _____

If you are under 18 years of age, please list the name, relationship, and contact information of the person who is legally responsible for you:

Name: _____ *Relation:* _____

Phone#: _____

Emergency Contact

Name: _____ *Relation:* _____

Phone#: _____

Are any other physician(s) or healthcare practitioners treating you? If yes, please list the name(s) and phone number(s):

_____PH:_____

_____PH:_____

Please list your health concerns

_____

_____

_____

Immunizations: Please check any immunizations you have had and note any reactions:

☐ Diphtheria, Pertussis, Tetanus, Polio, Hib
☐ MMR (measles, mumps, rubella)

- ☐ Influenza (flu shot)
- ☐ Hepatitis A and/or B
- ☐ HPV (Gardasil)
- ☐ Other

Please list known allergies or sensitivities:

Foods:_____

_____

Medications:_____

_____

Environmental factors:_____

_____

Chemicals:_____

_____

Please list all current prescription and non prescription (including birth control pills, aspirin etc.) medications with dosages:

_____

_____

_____

_____

Please list all current supplements with dosages if known:

_____

_____

_____

_____

Please list any hospitalizations, serious injuries, and/or surgeries: (date and type):

_____

_____

_____

Lifestyle: Please report your utilization of the following and their frequency.

	Daily	**Weekly**
Tobacco	_____	_____
Alcohol	_____	_____

Recreational Drugs _____ _____
Coffee/caffeine _____ _____
Exercise _____ _____

Family medical history: Please check areas pertaining to blood relatives NOT including yourself, and note whether the condition is from the maternal (M) or paternal (P) side of your family:

M	P		M	P	
☐	☐	Alcoholism	☐	☐	Neurologic disorder
☐	☐	Asthma	☐	☐	Substance abuse
☐	☐	Anxiety	☐	☐	Thyroid problems
☐	☐	Arthritis	☐	☐	Depression
☐	☐	Cancer	☐	☐	Eating disorder
☐	☐	Epilepsy	☐	☐	Diabetes
☐	☐	Hay fever/allergies	☐	☐	Liver disease
☐	☐	Heart disease/stroke	☐	☐	Mental disorders
☐	☐	High blood pressure	☐	☐	Kidney disease

Other: Please list:

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

General
- ☐ Night Sweats
- ☐ Stress
- ☐ Fatigue
- ☐ Sleep disturbance
- ☐ Dizziness
- ☐ Exposure to toxic chemicals

Endocrine
- ☐ Thyroid condition
- ☐ Heat or cold intolerance
- ☐ Blood sugar irregularities
- ☐ Easy weight gain
- ☐ Excessive thirst

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

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

Skin
- ☐ Rashes, Eczema, Hives
- ☐ Infections/fungus/athletes foot
- ☐ Itching
- ☐ Moles/growth
- ☐ Hair/nail changes
- ☐ Dry or scaling
- ☐ Other:_____

Head

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

Ears

- ☐ Hearing loss
- ☐ Ringing
- ☐ Earaches or infection

Nose and Sinuses

- ☐ Frequent colds/flus or infections
- ☐ Nose Bleeds
- ☐ Hay fever/rhinitis/congestions
- ☐ Sinus problems/congestion
- ☐ Loss of smell

Eyes

- ☐ Recent change in vision
- ☐ Blurred vision
- ☐ Eye pain/strain
- ☐ Redness/itching of eyes

Mouth and Throat

- ☐ Frequent sore throat/hoarseness
- ☐ Mouths sores/gum problems
- ☐ Loss of sense of taste
- ☐ Dental cavities or infections
- ☐ Root canals
- ☐ Mercury amalgam fillings
- ☐

Cardiovascular

- ☐ Angina, heart attack
- ☐ High/Low Blood Pressure
- ☐ Murmurs
- ☐ Chest pain
- ☐ Palpitations/Fluttering, irregular beat
- ☐ Poor circulation

Blood/ Peripheral Vascular

- ☐ Easy bleeding or bruising
- ☐ Anemia
- ☐ Clots/ thrombosis/ DVT

Respiratory

- ☐ Cough
- ☐ Difficult of painful breathing
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Positive TB test

Gastrointestinal

- ☐ Constipation
- ☐ Diarrhea/ loose stools
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Change in thirst or appetite
- ☐ Abdominal pain or cramps
- ☐ Belching or gas/bloating
- ☐ Nausea +/- vomiting
- ☐ Hemorrhoids
- ☐ Blood or mucus in stool
- ☐ History of parasites
- ☐ Gall bladder disease
- ☐ Liver disease/ Jaundice (yellow skin)
- ☐ History of eating disorder

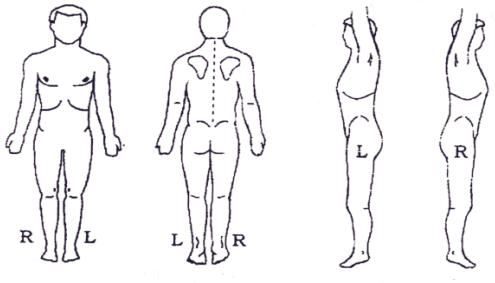
Urinary

- ☐ Pain on urination
- ☐ Excessive urination
- ☐ Frequency at night
- ☐ Inability to hold urine
- ☐ Blood in urine
- ☐ Frequent infections
- ☐ Kidney stones

Musculoskeletal

- ☐ Joint pain or stiffness
- ☐ History of broken bones

- ☐ Muscle weakness, spasms or cramps
- ☐ Mark areas you currently feel pain:



Male

- ☐ Hernias
- ☐ Testicular mass or pain
- ☐ Prostate problems
- ☐ Discharge or sores
- ☐ Difficulty in stopping or starting urination
- ☐ Decreased flow or force of urination
- ☐ Sexual difficulties
- ☐ Sexually transmitted disease

Breast (male and female)

- ☐ Self exam regularly
- ☐ Recent changes in breasts
- ☐ Breast lumps/pain/tenderness
- ☐ Discharge

Female

- ☐ Pregnant? Yes No Maybe
- ☐ Number of pregnancies: _____
- ☐ Number of births: _____
- ☐ Number of miscarriages/abortions: _____
- ☐ Date of last pap: _____
- ☐ History of abnormal pap
- ☐ Age of first menses? _____
- ☐ Sexual difficulties
- ☐ History of sexually transmitted disease
- ☐ Abnormal discharge

if pre-menopausal:

- ☐ Length of cycle: _____ days
- ☐ Days of flow: _____ days
- ☐ Irregular or no cycle
- ☐ Bleeding between cycles
- ☐ Painful menses
- ☐ Heavy or excessive flow
- ☐ PMS
- ☐ Birth control? No Yes, type: _____

if menopausal:

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

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history, perform a physical exam and may employ specific diagnostic testing, if it is deemed necessary, which will be discussed in your visit.

It is very important that you inform your Naturopathic Doctor of any disease process that you are suffering from, and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

There may be slight health risks to treatment by naturopathic medicine. These are rare, but include and are not limited to:

- Possible aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles
- Muscle strains and sprains, disc injures from spinal manipulation

Statement of acknowledgement and consent

As a patient of Absolute Health incorporated, I, _____ _____ have read the information and understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself in writing or unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

The information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs.

I hereby consent to naturopathic treatment from Dr. Cindy Tran, ND and intend this consent to cover the entire course of treatment for my present condition. I understand this consent is voluntary and may be revoked at any time.

Signature:_____Date:_____

Cancellation policy

*I understand that I am required to give a minimum of **24 hours notice** if I am unable to make my appointment. In the event that I miss an appointment without sufficient notice, I may be charged the full cost of the missed appointment.*

Signature:_____Date: _____