Beachstone Wellness ~ Naturopathic Medicine
8523 Rte 19 (lower side entrance), Port Hood NS B0E 2W0
ph. 902.787.3388 fax. 902.787.3383 info@beachstonewellness.ca

Health History Summary

*****Please email, fax, or mail in a copy of your intake form 2 days before your visit.*****

***Please fax any recent bloodwork (within 1 year) to me also or take a copy to your first visit**

Name:	Birth date:	Age:
Address:	City:	Postal Code:
Email:	Tel.(Home)	OK to leave message? Y/N
Occupation:	Employer:	Tel.(Work)
Marital Status: Sgl Mar C/L Sep Div	# of children: Ages:	Tel. (Cell)
Emergency Contact:	Relationship:	Ph.

Have you had an appt with an ND before?	How did you hear of Dr. Glenna?
Name of MD:	Do you have other Health Practitioners?

Please list your health concerns and reason for visit.

1	Since when?
2	Since when?
3	Since when?
4	Since when?
5	Since when?

Please circle the frequency that you use any of the following substances.

Laxatives	Often / Moderately / Rarely / Never	Recreational Drugs	Often / Moderately / Rarely / Never
Pain Relievers	Often /Moderate /Rarely/Never		
Antacids	Often / Moderately / Rarely / Never	Sedatives	Often / Moderately / Rarely / Never

Medical History con't

Date of Late Physical Exam_________________ Height ___________ Weight ___________Bloodtype___
Maximum weight___________ Desired Weight (Explain____________________________
How many times have you been treated with antibiotics? _________________________
Do you have any known allergies? ________ to what?________________________
Which if the following childhood diseases have you had : Measles German Measles Chicken Pox Mumps
Whooping Cough Rheumatic Fever Diptheria Scarlet Fever Polio Other:
Have you had X- rays in the past 3 yrs?____other lab testing/ medical procedures in the last 3 yrs_____

Medications – Prescribed and Over-the-counter.

Med:	Dosage:	Reason:	When did you start?
Med:	Dosage:	Reason:	When did you start?
Med:	Dosage:	Reason:	When did you start?
Med:	Dosage:	Reason:	When did you start?
Med:	Dosage:	Reason:	When did you start?

Supplements/Vitamins/Herbs

Name/brand:	Dosage:	Reason:
Name/brand:	Dosage:	Reason:
Name/brand:	Dosage:	Reason:
Name/brand:	Dosage:	Reason:
Name/brand:	Dosage:	Reason:

Please list and describe any surgeries, hospitalizations and/or, injuries.

Surgery/Hospitalization/Injury	Date:	Comments

Digestion

Do you (burp/have gas/feel uncomfortable) after eating? Y/N How often? Always / Sometimes / Never
How many bowel movements do you have per day? _________
Is there blood/mucus/undigested foods/black stools? ______________________________________
Do you experience constipation or diarrhea? _____ Which? _______________________________
Do you have any rectal itching? Y/N Are your stools (formed or loose)? _____ Is there a strong odour? __

Lifestyle

Do you smoke?____ How many cigarettes per day?_____
Do you exercise? Y/N How many times per week? ________ What forms? _______________
Have you ever been treated for addiction to drugs, alcohol, prescription medications? ________
On a scale of 1-10 how would you rate the quality of your sleep? (10 being great) ____________
How many hours of sleep do you get? ____ How often do you wake during the night? _____
Do you have difficulty falling asleep? ________ Do you wake feeling rested?_______________
On a scale of 1-10 (10 is highest) what is your energy like in the morning?__ afternoon?__ evening?___
Do you nap or rest during the day? Y/N For how long? ___________________________
List the top three sources of stress in your life? 1.___________ 2. ____________ 3. ______________
Do you suffer from depression? ________ Mood swings?__________________
Have you ever had psychiatric/psychological counseling? ___________________________
Have you been a victim of mental, emotional, physical or sexual abuse?__________________________
Do you have unresolved emotional issues or grief? (Explain)____________________________________
____

Do you participate in a Religion/Personal Philosophy? ____
What would you like to change about your life? ____
What do you do in your leisure time? ____
What do you do to relax? ____

Female Reproductive History

Age of first menses?____If periods have stopped, at what age did they stop?_____
Are your cycles regular? Y/N Periods begin every____days and lasts_____days.
Are your periods Heavy Medium Light (Circle one) What color is the blood?______________
Are there any clots? Y/N Any cramps with your period? Y/N
Do you have any spotting, or bleeding between periods? Y/N Do you have premenstrual symptoms? Y/N
Number of pregnancies____ Number of abortions____Number of miscarriages____
Number of live births& Maternal Age________________ Any problems getting pregnant? Y/N
Have you been sexually active? ____ Any painful/difficult intercourse? ________
Do you get regular PAP smears? Y/N Any abnormal PAPs Y/N
Do you do regular breast self exams? Y/N Have you noticed any breast lumps? Y/N
Any abnormal vaginal discharge? Y/N Current Birth Control (if applicable) _______ Past Methods _____
What is your sexual orientation? (circle) Heterosexual Homesexual Bisexual Bisexual Undecided
Have you ever contracted a Sexually Transmitted Disease? Yes/No Which Disease (s)?___________

Family History

Please put a check by the illness that was/is present in your family.

	Mother	Father	Sibling	Grandparents	You
Alcoholism					
Anemia					
Asthma					
Cancer- give type					
Autoimmune disease (lupus, etc)					
Chronic Fatigue/Fibromyalgia					
Eczema/Psoriasis					
Thyroid					
Tuberculosis/Lung Disease					
Heart Disease/Angina					
Arthritis					
Kidney Disease					
Depression/Mood Swings					
Osteoporosis					
Diabetes					
High Blood Pressure					
Schizophrenia/Delusions/Alzheimer's					
Other					

Nutritional Habits

Please describe a typical days' diet
Breakfast____
Lunch ____
Supper ____
Snacks ____
Beverages (total quantity and include alcohol)____
How much water do you drink each day?__________
Do you drink Coffee? ____how many cups /day? ______ Do you drink Black tea? How many____cups/day?
Please list your favorite foods____
Do you have any food cravings? Please list ____________________________
Do you have any allergies, or food sensitivities? ____
Are there any foods that you avoid because they made you feel unwell or sick? ______________
Do you follow any specific type of diet? ie. Vegetarian, grain-free, diabetic?__________________

Is there anything else that you feel I should know about you?

Informed Consent

Dr. Calder utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the bodies own ability to heal and to improve the quality of life and health through natural means. They include Nutritional Supplementation, Botanical medicine, Homeopathy, Acupuncture, Nutritional Counseling and Physical Medicine.
Dr. Calder will conduct a thorough case history. A symptom based physical exam, blood and/or urinary lab reports may be used as part of the treatment.

Statement of Acknowledgment

As a patient of Dr. Calder, I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. I also recognize that even the gentlest therapies potentially have their complications, in certain physiological conditions, or in very young children, or in those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre -existing symptoms, allergic reaction to supplements, or herbs; pain, fainting, bruising or injury from injections, or acupuncture; muscle strains and sprains.

I understand that a fee will be charged for any missed appointments, or cancellations with less than 24 hour notice.

Fees and Cancellation Policy

Initial Naturopathic Visit- 60 minutes- $210.00
Initial Naturopathic Pediatric Visit- 45 minutes- $190.00 (17 years of age and younger)
45 min Naturopathic Visit- 45 minutes- $ 145.00
Follow Up Adult and Pediatric Naturopathic Visit- 30 minutes- $100
Naturopathic Acute 15 minute Visit- $65.00
B-12 Injections- $25

Naturopathic medical services are covered under most extended health care plans. Check your policy for details. We will provide a receipt upon payment that you can submit with your claim.

While we do make every effort to contact patients in the days preceding their appointments, this confirmation should not eliminate the responsibility of the patient to take note of and attend their appointments.
If you need to cancel an appointment, please leave a message on our voice-mail at 902-787-3388 to avoid a charge being applied to be your account.
We appreciate you understanding and cooperation.

I have read and understand the cancellation policy

______________________________ ______________________________ ___________________

Name Signature Date

Welcome to Beachstone Wellness! We Look Forward to Working with you on Your Health!