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 visitThere is a bluebin outside our clinic door we use for patient's supplement pick ups you can drop the intake form off in if you wish.

Name:	Birth date:	Age:
Address:	City:	Postal Code:
Email:	Ph.(Home)	OK to leave message? Y/N
Occupation:	Employer:	Ph.(Work)
Marital Status: Sgl Mar C/L Sep Div	Number of children:	
Emergency Contact:	Relationship:	Ph.
Name of MD:	Date of last physical Exam:	

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.

Alcohol	Often / Moderately / Rarely / Never	Tobacco	Often / Moderately / Rarely / Never
Hormones	Often / Moderately / Rarely / Never	Coffee/Tea	Often / Moderately / Rarely / Never
Cortisones	Often / Moderately / Rarely / Never	Laxatives	Often / Moderately / Rarely / Never
Sedatives	Often / Moderately / Rarely / Never	Antacids	Often / Moderately / Rarely / Never
Recreational drugs	Often / Moderately / Rarely / Never		

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:

Check box for **N(now), P(past).**

N □ P □ Allergies	N □ P □ Weight Problems	N □ P □ Cancer	N □ P □ Headaches
N □ P □ Asthma	N □ P □ Gallstones	N □ P □ Epilepsy	N □ P □ Alopecia
N □ P □ Eczema	N □ P □ Gout	N □ P □ Migraine	N □ P □ Varicose Veins
N □ P □ Psoriasis	N □ P □ Arthritis	N □ P □ Pneumonia	N □ P □ Broken Bones
N □ P □ Ear Infection	N □ P □ Thyroid Problems	N □ P □ Diabetes	N □ P □ Numbness
N □ P □ Strep Throat	N □ P □ Anemia	N □ P □ Malaria	N □ P □ Tingling
N □ P □ Hay fever	N □ P □ High Blood Pressure	N □ P □ Tuberculosis	N □ P □ Cold Hands
N □ P □ Measles	N □ P □ Rheumatic Fever	N □ P □ Small Pox	N □ P □ Cold feet
N □ P □ Mumps	N □ P □ Fainting	N □ P □ Polio	N □ P □ Visual Problems
N □ P □ Chicken Pox	N □ P □ Poor Memory	N □ P □ Parasites	N □ P □ Warts
N □ P □ Whooping cough	N □ P □ Balance Problems	N □ P □ Gas/bloating	N □ P □ Mono
N □ P □ Diphtheria	N □ P □ Speech Problems	N □ P □ Hemorrhoids	N □ P □ Depression
N □ P □ Scarlet Fever	N □ P □ Ringing in Ears	N □ P □ Herpes	N □ P □ Anxiety
N □ P □ Sinusitis	N □ P □ Jaundice	N □ P □ Venereal Disease	N □ P □ Sexual Abuse
N □ P □ Canker	N □ P □ Hepatitis	N □ P □ Syphilis	N □ P □ Rape
N □ P □ Acne	N □ P □ Alcoholism	N □ P □ Gonorrhea	N □ P □ Emotional Abuse
N □ P □ Tonsillitis	N □ P □ Stroke	N □ P □ Miscarriage	N □ P □ Child Abuse

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 do you experience this problem? Always / Sometimes / Never
How often do you have bowel movements? ____
Is there blood/mucus/undigested foods/black stools? _____________________________________
Do you ever have alternating constipation and diarrhea? Y/N How often? __________________
Do you have any rectal itching? Y/ Are your stools (formed or loose)? Any diarrhea? _______
Does your gas have a strong odor? Y/N Do you have flatulence (gas) frequently? Y/N

More Health History
Do you exercise? Y/N If yes, how often? (Circle one) Often Moderately Sedentary
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? ____
Do you nap or rest during the day? Y/N For how long? ______________________
How many times per year do you get a cold, or flu? ______________________________________
When was the last time you were on an antibiotic? ________ What was it for?
____

Reproductive Health
Please let me know if there is anything you would like to discuss about your reproductive health.
____

Male
How often do you get up in the night to urinate? ______Has this increased recently? Y/N
Any problems with impotency? (Getting, or maintaining erection) Y/N
Do you have abnormal discharges from your penis? Y/N _______________________________
Any prostate problems? Y/N Have you had your prostate examined? Y/N When? _________

Kidney & Bladder
Have you ever had a bladder infection? Y/N How many? ______
How was it treated? ____
Do you have difficulty stopping, or starting urination? Y/N

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

	Mother	Father	Sibling	Grandparents	Other relative
Cancer					
T.B.					
Heart Disease					
Arthritis					
Kidney Disease					
Depression					
Anemia					
Asthma					
Diabetes					
High Blood Pressure					
Other					

Diet Diary

Please record all foods eaten over a two- day period. Include 1 weekend day and please note if any symptoms appear after a meal.

	Breakfast	Snack	Lunch	Snack	Supper	Snack
Day 1						
Day 2						

NOTES:

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 you would like me to know about your health?

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 Nutrition(individual diets and supplementation), Botanical medicine, Homeopathy, Acupuncture, Hydrotherapy, Counseling, Physical Medicine and Neurotherapy. Dr. Calder will conduct a thorough case history. A physical exam, blood and/or urinary lab report may be used as part of the treatment work up.

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 venipuncture, injections, or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.

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

Fees and Cancellation Policy

Initial Naturopathic Visit- 60 minutes- $210
45 min Naturopathic Visit- 45 minutes- $145.00
Initial Naturopathic Pediatric Visit- 45 minutes- $190.00 (17 years of age and younger)
Follow Up Adult and Pediatric Naturopathic Visit- 30 minutes- $100
B-12 Injections- $25.00

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
We appreciate you understanding and cooperation.
I have read and understand the cancellation policy

____________________________ ____________________________ __________________
Name Signature Date

Welcome to Beachstone Wellness!