Rise up for health

Tara Annesley B.Sc., N.D., C.Ht.

Patient Information Form

Today's Date: _____
day/month/year

Name: _____
(first) *(middle)* *(last)*

Address: _____

City: _____ Postal Code: _____

Telephone *Home*: _____ *Work*: _____ *Cell:* _____

Date of birth: _____ Age: _____ Gender: ☐ Male ☐ Female
day/month/year

Occupation: _____ Employer: _____

email address: _____ May we add you to our email list? Yes ☐ No ☐

Emergency contact: _____ Telephone: _____

Referred by:

Name: _____

☐ Yellow pages ☐ Ad ☐ Website ☐ Other

Have you had previous naturopathic care? Yes ☐ No ☐ If yes, when? _____

Family Physician: _____ Telephone: _____

Chiropractor: _____ Telephone: _____

Other Heath Care Providers: Telephone: _____

Do you have any major health complaints? Please list them in order of importance.

Are you under medical / therapeutic care? ☐ Yes ☐ No

If yes, for what condition? _____

What treatments are you receiving? _____

: 905-836-2723
: www.riseupforhealth.com

52 Burgess Crescent
Newmarket, Ontario L3X 2T7

What medications do you take? _____

_____

What supplements or remedies do you take daily? _____

_____

_____

General History

Height: _____ Weight: _____ Ideal Weight: _____

When was your last physical examination? _____
How often do you have a bowel movement ☐ 1/day ☐ 2/day ☐ More than 2/day ☐ 1/week ☐ Other:
Do you have any specific dietary restrictions? _____
Do you have any know food sensitivities? _____

_____

How many glasses of water do you drink a day? ___ How many prescriptions of antibiotics have you taken in the past 2 years? ___
Do you have any environmental allergies? Please list _____

_____

What surgery or major injuries have you had? _____

_____

Please check off any of the following that apply to you:

☐ Use Tobacco
☐ Use Alcohol
☐ Use recreational drugs
☐ Diet often
☐ Sleep well
☐ In contact with tobacco smoke
☐ Use caffeinated beverages
☐ Eat three meals a day
☐ Wake rested
☐ Take vacations
☐ Enjoy your work
☐ Exposure to chemicals
☐ Average 6-8 hours sleep
☐ Watch television

Do you exercise regularly? Yes ☐ No ☐ How often? ___ x weekly ___ x monthly

What is your current stress level (0 - no stress - 10 - nervous breakdown) 0 1 2 3 4 5 6 7 8 9 10

Where would you put your current energy level (0 - none - 10 - fantastic) 0 1 2 3 4 5 6 7 8 9 10

Patient Past History

Which (if any) of the following conditions do you currently have or have had in the past?

- ☐ Artificial heart valve
- ☐ Cancer
- ☐ Influenza
- ☐ Kidney disease
- ☐ Leukemia
- ☐ Malaria
- ☐ Measles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Migraine
- ☐ Hepatitis C
- ☐ HIV
- ☐ Pelvic Inflammatory Disease
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Rubella
- ☐ Scarlet fever
- ☐ Osteoporosis
- ☐ Ovarian Cysts
- ☐ Organ transplant
- ☐ Chemotherapy
- ☐ Chickenpox
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Fibroid tumors
- ☐ Gallstones
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Stroke
- ☐ Heart attack
- ☐ Whooping cough
- ☐ Stroke
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Rheumatoid arthritis
- ☐ Parkinson's disease
- ☐ Fibromyalgia
- ☐ Epilepsy
- ☐ Warts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Eczema
- ☐ Psoriasis
- ☐ Anemia
- ☐ Pneumonia
- ☐ Diverticulitis
- ☐ Asthma
- ☐ Heart Murmur
- ☐ Artificial joints (hip. knee)
- ☐ Irritable Bowel Syndrome
- ☐ Eating disorder
- ☐ Herpes / shingles
- ☐ Sexually Transmitted Disease

Any other medical conditions?_____

Have any of the above conditions afflicted or led to the death of any of your family members? If so, please indicate their relation to you (e.g. mother, father, brother, grandparent etc.) and their age at the time of their illness of death: _____

_____

_____

Symptom Record

Please check the appropriate box for any of the following symptoms which you now have or have had previously. Do not check a box if the symptom does not relate to your specific history.

O - Occasional F - Frequent C - Constant

O	F	C	*Circulatory & Respiratory*
☐	☐	☐	Dizziness
☐	☐	☐	Shortness of breath
☐	☐	☐	Fainting
☐	☐	☐	Bronchitis
☐	☐	☐	Allergies
☐	☐	☐	Sinus problems
☐	☐	☐	Frequent colds
☐	☐	☐	Cold feet or hands
☐	☐	☐	Night sweats
☐	☐	☐	Cold sweats
☐	☐	☐	Swollen ankles
☐	☐	☐	Varicose veins
☐	☐	☐	Angina
☐	☐	☐	Heart palpitations

O	F	C	
☐	☐	☐	Hay fever
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Leg cramps
☐	☐	☐	Wheezing
			Skin
☐	☐	☐	Eczema
☐	☐	☐	Hives
☐	☐	☐	Acne
☐	☐	☐	Change in mole
☐	☐	☐	Nail changes
☐	☐	☐	Bruise easily
☐	☐	☐	Itching

O	F	C	Rash
☐	☐	☐	*Muscle & Joint*
☐	☐	☐	Headaches
☐	☐	☐	Joint stiffness
☐	☐	☐	Joint swelling
☐	☐	☐	Muscle spasms/cramps
☐	☐	☐	Broken bones
☐	☐	☐	Strains/sprains
☐	☐	☐	Back pain
☐	☐	☐	Neck pain
☐	☐	☐	Weakness
☐	☐	☐	Leg/foot pain
☐	☐	☐	Arm/hand pain
☐	☐	☐	Jaw pain / TMJ

Please check the appropriate box for any of the following symptoms which you now have or have had previously. Do not check a box if the symptom does not relate to your specific history.

O - Occasional F - Frequent C - Constant

O	F	C	*Eyes*
☐	☐	☐	Eye pain
☐	☐	☐	Impaired vision
☐	☐	☐	Wear glasses/contacts
☐	☐	☐	Double vision
☐	☐	☐	Blurring
☐	☐	☐	Itching
☐	☐	☐	Redness
☐	☐	☐	Tearing / dry eyes
			Ears / Nose
☐	☐	☐	Hearing impaired
☐	☐	☐	Ear infections
☐	☐	☐	Tubes in ears
☐	☐	☐	Hay fever
☐	☐	☐	Loss of smell
☐	☐	☐	Nasal obstruction
☐	☐	☐	Nosebleeds
			Mouth & throat
☐	☐	☐	Dental cavities
☐	☐	☐	Loss of taste
☐	☐	☐	Gum problems
☐	☐	☐	Loss of taste
☐	☐	☐	Sore throat

O	F	C	*Digestive*
☐	☐	☐	Indigestion
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Hemorrhoids
☐	☐	☐	Heartburn
☐	☐	☐	Hernias
☐	☐	☐	Ulcer
☐	☐	☐	Loss of appetite
☐	☐	☐	Excessive hunger
☐	☐	☐	Excessive thirst
☐	☐	☐	Bloating
☐	☐	☐	Intestinal gas / burping
☐	☐	☐	Nausea
☐	☐	☐	Hypoglycemia
☐	☐	☐	Abdominal pain
			Neurological
☐	☐	☐	Numbness / tingling
☐	☐	☐	Twitching of face
☐	☐	☐	Fatigue
☐	☐	☐	Chronic pain
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of memory
☐	☐	☐	Loss of balance
☐	☐	☐	Paralysis
☐	☐	☐	Nervousness

O	F	C	
☐	☐	☐	Ringing in ears
☐	☐	☐	Anxiety
☐	☐	☐	Depression
☐	☐	☐	Phobias
			Genito-Urinary
☐	☐	☐	Bed wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Bladder infection
☐	☐	☐	Frequent urination
☐	☐	☐	Kidney stones
☐	☐	☐	Burning on urination
			Male Reproductive
☐	☐	☐	Hernia
☐	☐	☐	Discharge or sores
☐	☐	☐	Prostate problems
☐	☐	☐	Testicular masses
			Female Reproductive
☐	☐	☐	PMS
☐	☐	☐	Painful menses
☐	☐	☐	Heavy flow
☐	☐	☐	Spotting midcycle
☐	☐	☐	Vaginal discharge
☐	☐	☐	Vaginal itching

Please list any additional comments regarding your health and well-being. _____

_____

_____

_____

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Consent to Treatment

1. This is to acknowledge that I have been informed and I understand that:
    1. Any treatment or advice provided to me as a patient of Tara Annesley N.D. is not mutually exclusive from any treatment or advice that I may now be receiving or may in future receive from another health care provider
    2. I am at liberty to seek or continue medical care from a physician, surgeon or other health care provider qualified to practice in Ontario
    3. No employee, agent or anyone else under the direction of Tara Annesley N.D. is suggesting or recommending me to refrain from seeking or following the advice of another health care practitioner
    4. The treatment are therapies recommended or rendered by Tara Annesley N.D. may be different than those usually offered by a medical doctor or other health care practitioner
2. I agree to pay my full account at the time of each visit or treatment, including fees for services, costs of supplements, costs of laboratory tests and other fees.
3. I have read and understood the privacy statement for Tara Annesley N.D.
4. I declare I have received a full and complete explanation of the treatment or services I may receive from Tara Annesley N.D. and hereby do authorize and consent to treatment.

Client name: _____ Client Signature: _____

Date: _____

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Naturopathic Care Fee Schedule

Fees are based on $130.00 per hour. Additional charges may apply if time is exceeded.

Please allow 24 hours if needed to reschedule or cancel your appointment. Missed appointments without sufficient cancellation time will incur the FULL FEE of the appointment.

	Adults	Children
Initial consultation (60 - 90 minutes)	$ 180.00	$ 130.00
Subsequent consultations (30 minutes)	$ 65.00	$ 50.00
Consultation (60 minutes)	$ 130.00	$ 100.00
Initial acupuncture	$ 130.00	
Acupuncture (30 minutes)	$ 65.00	
Telephone consultations (per each 30 minutes)	$ 65.00	
Email consultations (per 15 minutes to research/reply)	$ 35.00	

- Children are those individuals less than 16 years of age
- Fees are payable by Visa, Mastercard, Interac, cheque or cash at the end of each visit
- Fees do NOT include the GST / HST
- Any prescribed supplements are not included in the above fees
- Any additional lab work / testing is not included in the above fees
- Please note that these fees are not covered by OHIP. However they may be covered by your extended health care plan. Please check your individual plan for details

I have read, fully understand and agree to honour the fee schedule listed above:

Date: _____ Client's signature: _____

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