



**the Natural Family Health Clinic Ltd  
& Chelation Centre**

*Preventing illness-optimizing health, naturally*

Dr. Tamara Browne, Naturopathic Physician  
Unit 8B-5350, Hwy 97, Okanagan Falls, BC, VoH 1R0

PH: 250-497-6681

[www.drtaamarabrowne.ca](http://www.drtaamarabrowne.ca)

email: [drbrownend@outlook.com](mailto:drbrownend@outlook.com)

**By completely filling out this form you will help us help you. All answers will be *completely confidential*. If you have any questions please ask. Thank you.**

Name \_\_\_\_\_ Age \_\_\_\_\_ M \_\_\_ F \_\_\_ Other \_\_\_ Today's Date \_\_\_\_\_

Your care card number \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Address (mailing) \_\_\_\_\_

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E-mail address \_\_\_\_\_

Occupation \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Spouse's name \_\_\_\_\_

If patient is a child: Father's name \_\_\_\_\_ Mother's name \_\_\_\_\_

**Names of other Healthcare providers:**

Medical Doctor \_\_\_\_\_ Naturopathic Physician \_\_\_\_\_

Chiropractor \_\_\_\_\_ Others \_\_\_\_\_

How did you find the clinic? \_\_\_\_\_

Have you had Chelation or Naturopathic IV Therapy in the past? \_\_\_\_\_

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**Your main Health Concern**

Why are you coming to the clinic today?

When did your problem(s) begin?

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**Your Past Medical History: Please check if you have experienced any of these**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Significant trauma  | <input type="checkbox"/> Hepatitis       |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> Allergies. To what? | <input type="checkbox"/> Asthma          |
| <input type="checkbox"/> Autoimmune Disease  | _____  | <input type="checkbox"/> COPD            |
| <input type="checkbox"/> Liver disease       | _____  | _____                                    |
| <input type="checkbox"/> Surgeries           | _____  | <input type="checkbox"/> Other _____     |

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**Family Medical History: please indicate which family member has/had the following**  
**M=mother, F=father, B=brother, S=sister, C=child, GM=Grandmother, GF=Grandfather**

- |                                   |  |  |
|-----------------------------------|--|--|
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma or lung disease  |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Allergies               |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Kidney or liver disease |

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**Occupational Stress** (List known Chemical, physical, or psychological stressors from work or home)

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**Describe your weekly exercise** (Type of exercise, duration, and frequency)

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**Current Medicines:** Include prescriptions, over-the-counter drugs, vitamins, herbs, and any non-medical drugs.

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**Diet**

Are you or have you ever been on a restricted diet? If so, what kind?

**Please describe your average daily diet:**

Morning

Afternoon

Evening

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How many cigarettes do you smoke a day? \_\_\_\_\_

How much coffee, tea, cola, or alcohol do you drink per day? \_\_\_\_\_

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**Please check if the following symptoms are a current or recurring problem****General**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Night sweats       | <input type="checkbox"/> Weight gain                |
| <input type="checkbox"/> Poor sleep    | <input type="checkbox"/> Sweat easily       | <input type="checkbox"/> Weight loss                |
| <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Sudden energy drop (time?) |
| <input type="checkbox"/> Chills        | <input type="checkbox"/> Cravings           | <input type="checkbox"/> Bleed or bruise easily     |
| <input type="checkbox"/> Fevers        | <input type="checkbox"/> Strong thirst      | <input type="checkbox"/> Peculiar tastes or smells  |
- 

**Skin and hair**

- |                                  |   |   |
|----------------------------------|---|---|
| <input type="checkbox"/> Rashes  | <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Recent moles                 |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Loss of hair                   | <input type="checkbox"/> Ulcerations                  |
| <input type="checkbox"/> Eczema  | <input type="checkbox"/> Dandruff                       | <input type="checkbox"/> Other hair or skin problems? |
| <input type="checkbox"/> Pimples |   |   |
- 

**Head, Eyes, Ears, Nose, and Throat**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Color blindness         | <input type="checkbox"/> Sinus problems         |
| <input type="checkbox"/> Head and neck problems | <input type="checkbox"/> Blurry vision           | <input type="checkbox"/> Nose bleeds            |
| <input type="checkbox"/> Concussions            | <input type="checkbox"/> Cataracts               | <input type="checkbox"/> Teeth problems         |
| <input type="checkbox"/> Eye strain             | <input type="checkbox"/> Earaches                | <input type="checkbox"/> Jaw clicks             |
| <input type="checkbox"/> Glasses                | <input type="checkbox"/> Poor hearing            | <input type="checkbox"/> Facial pain            |
| <input type="checkbox"/> Night blindness        | <input type="checkbox"/> Ringing in the ears     | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Eye pain               | <input type="checkbox"/> Sores on lips or tongue |   |
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**Cardiovascular**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Fainting       | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Low blood pressure   | <input type="checkbox"/> Chest pain     | <input type="checkbox"/> Swelling of hands  |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Swelling of feet   |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Blood clots    |   |
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**Respiratory**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Pain with a deep breath | <input type="checkbox"/> Pneumonia      |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Production of phlegm    | <input type="checkbox"/> Other problems |
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**Gastrointestinal**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Indigestion  | <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Rectal pain    |
| <input type="checkbox"/> Gas          | <input type="checkbox"/> Nausea                   | <input type="checkbox"/> Hemorrhoids    |
| <input type="checkbox"/> Bad breath   | <input type="checkbox"/> Vomiting                 | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic laxative use     | <input type="checkbox"/> Diarrhea       |
- 

**Genitourinary**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Frequent urination      | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones     |
| <input type="checkbox"/> Urgency to urinate      | <input type="checkbox"/> Decrease in flow     | <input type="checkbox"/> Impotency         |
| <input type="checkbox"/> Pain on urination       | <input type="checkbox"/> Any particular color | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Do you wake to urinate? | <input type="checkbox"/> Blood in urine       | <input type="checkbox"/> Other problems    |
- 

**Women only: Gynecology and Pregnancy**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Age of first menses                               | <input type="checkbox"/> Unusual menses                    | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Duration of menses                                | <input type="checkbox"/> Heavy                             | <input type="checkbox"/> Painful periods   |
| <input type="checkbox"/> Days between menses                               | <input type="checkbox"/> Light                             | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Date of start of last menses                      | <input type="checkbox"/> Clots                             | <input type="checkbox"/> Vaginal sores     |
| <input type="checkbox"/> Hysterectomy                                      |  | <input type="checkbox"/> Breast lumps      |
| <input type="checkbox"/> Change in body or emotions prior to menstruation? |  |  |
| <input type="checkbox"/> Do you practice birth control? _____              | <input type="checkbox"/> What type and for how long? _____ |  |
- 

**Musculoskeletal**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Neck pain       | <input type="checkbox"/> Knee pain                           | <input type="checkbox"/> Muscle pain     |
| <input type="checkbox"/> Back pain       | <input type="checkbox"/> Foot/Ankle pain                     | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Hand/Wrist pain | <input type="checkbox"/> Hip pain                            |  |
| <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Other joint or bone problems? _____ |  |
- 

**Neuropsychological**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Loss of balance        | <input type="checkbox"/> Depression            | <input type="checkbox"/> Concussion        |
| <input type="checkbox"/> Quick temper/Irritable | <input type="checkbox"/> Susceptible to stress | <input type="checkbox"/> Seizure           |
| <input type="checkbox"/> Poor memory            | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Lack of coordination  |  |

- Have you ever been treated for emotional problems?  
 Have you ever considered or attempted suicide?  
 Any other neurological or psychological problems?
- 

**Comments**

Please describe any other problems you would like to discuss.



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**Informed Consent for Treatment**

- 1) I understand that Dr. Tamara Browne, ND is a Naturopathic Physician licensed and registered in the province of British Columbia, Canada to practice Naturopathic Medicine and that ND's apply primarily natural, non-invasive methods of assessment and treatment.
- 2) I understand that any advice given to me as a patient under the care of Dr. Tamara Browne is mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another care provider.
- 3) I understand that I am at liberty to seek, or continue medical care from another qualified health care provider.
- 4) I understand that the Naturopathic Physician reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.
- 5) I understand that I am accepting or rejecting this care of my own free will.
- 6) I understand that no employee or physician at the Natural Family Health Clinic Ltd is suggesting to me to refrain from seeking the advice of another health care provider.
- 7) I understand that the services offered at the Natural Family Health Clinic are not covered by MSP, and that the fees are payable at the time of appointment, including fees for services, prescriptions, and laboratory tests.
- 8) I understand that 24 hours notice is required for appointment cancellations; otherwise, I will be responsible for a cancellation fee.
- 9) I understand that any therapies recommended will be explained to me in full by my physician, and that I will give consent to treatment based on informed consent.
- 10) I understand that I am under no obligation to purchase any therapeutics, supplements, injections, or anything else from this clinic and it is my choice to purchase products from the source of my choice.
- 11) While I understand that there have been no warranties, assurances or guarantees of successful treatment made to me, I consent to undergo this care after having considered the information contained in this document, the information provided to me through my conversations with my treating physician and through materials provided to me through the office to educate me about the treatment. I acknowledge that I have had the opportunity to ask any questions of my physician with respect to the proposed therapy and the procedures to be utilized and all of my questions have been answered to my full satisfaction.

I \_\_\_\_\_ have read, understood, and agree to the above statements.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_