the Natural Family Health Clinic
& Chelation Centre

Preventing illness-optimizing health, naturally

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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__ Today's Date_____
Your care card number_____ Birthdate_____
Home Address (mailing)
_____

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_____

Who referred you to this clinic?_____

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

Your main Health Concern
Why are you coming to the clinic today?

When did your problem(s) begin?

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

__Cancer	__Significant trauma	__Hepatitis
__High blood pressure	__Kidney disease	__Thyroid disease
__Heart Disease	__Diabetes	__Seizures
__Rheumatic fever	__Allergies. To what?	__Asthma
__Autoimmune Disease	_____	__COPD
__Liver disease		
	_____	__Other_____

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

___Cancer	___High blood pressure	___Asthma or lung disease
___Diabetes	___Heart disease	___Allergies
___Seizures	___Stroke	___Kidney or liver disease

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

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

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

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

_____
_____
_____
_____

How many cigarettes do you smoke a day?_____
How much coffee, tea, cola, or alcohol do you drink per day?_____
_____

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

General

__Poor appetite __Night sweats __Weight gain
__Poor sleep __Sweat easily __Weight loss
__Fatigue __Change in appetite __Sudden energy drop (time?)
__Chills __Cravings __Bleed or bruise easily
__Fevers __Strong thirst __Peculiar tastes or smells

Skin and hair

__Rashes __Change in hair or skin texture __Recent moles
__Itching __Loss of hair __Ulcerations
__Eczema __Dandruff __Other hair or skin problems?
__Pimples

Head, Eyes, Ears, Nose, and Throat

__Headaches __Color blindness __Sinus problems
__Head and neck problems __Blurry vision __Nose bleeds
__Concussions __Cataracts __Teeth problems
__Eye strain __Earaches __Jaw clicks
__Glasses __Poor hearing __Facial pain
__Night blindness __Ringing in the ears __Recurrent sore throats
__Eye pain __Sores on lips or tongue

Cardiovascular

__High blood pressure __Fainting __Cold hands or feet
__Low blood pressure __Chest pain __Swelling of hands
__Irregular heart beat __Varicose veins __Swelling of feet
__Dizziness __Blood clots

_____

Respiratory

__Difficult breathing __Asthma __Coughing blood
__Cough __Pain with a deep breath __Pneumonia
__Bronchitis __Production of phlegm __Other problems

Gastrointestinal

__Indigestion __Abdominal pain or cramps __Rectal pain
__Gas __Nausea __Hemorrhoids
__Bad breath __Vomiting __Blood in stool
__Constipation __Chronic laxative use __Diarrhea

Genitourinary

__Frequent urination __Unable to hold urine __Kidney stones
__Urgency to urinate __Decrease in flow __Impotency
__Pain on urination __Any particular color __Sores on genitals
__Do you wake to urinate? __Blood in urine __Other problems

Women only: Gynecology and Pregnancy

__Age of first menses __Unusual menses __Irregular periods
__Duration of menses __Heavy __Painful periods
__Days between menses __Light __Vaginal discharge
__Date of start of last menses __Clotts __Vaginal sores
__Breast lumps
__Change in body or emotions prior to menstruation?
__Do you practice birth control?_____ What type and for how long?_____

Musculoskeletal

__Neck pain __Knee pain __Muscle pain
__Back pain __Foot/Ankle pain __Muscle weakness
__Hand/Wrist pain __Hip pain
__Shoulder pain __Other joint or bone problems?_____

Neuropsychological

__Loss of balance __Depression __Concussion
__Quick temper/Irritable __Susceptible to stress __Seizure
__Poor memory __Dizziness __Areas of numbness
__Anxiety __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:_____