



**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.drtamarabrowne.ca
email: 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 _____ Gender Female 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 _____

How did you find the 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 _____ |
| ☐ Surgeries | _____ | |

Family Medical History: please check if any family member has/had the following

- | | | |
|-----------------------------------|--|--|
| ☐ 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 | ☐ Clots | ☐ Vaginal sores |
| ☐ Hysterectomy | | ☐ 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: _____