PROACTIVE HEALTH GROUP
PROFESSIONAL HEALTH CARE FOR THE ACTIVE INDIVIDUAL

Date _____

Name _____ / _____ / _____
last first middle initial

Personal Health # _____ - _____ Male ☐ Female ☐

Home Address _____

City _____Postal Code_____Home Telephone #_____

Business Telephone # _____Cell #_____

E-Mail Address_____

Best way to contact you: ☐ Home # ☐ Work # ☐ Cell # ☐ Email

Birth Date _____/____/____ Marital Status ☐ M ☐ S ☐ W ☐ D
Y M D

Emergency Contact Name, Address, Phone#_____

_____

Occupation & Company Name _____

Physician's (G.P) Name, Address, Phone#_____

_____

Date of last physical examination _____/____/_____
Y M D

On occasion, our practitioners will communicate your clinical condition with your Physician.

Do you have health insurance other than Alberta Health Care? Yes ☐ No ☐

How did you first find out about the clinic?

☐ Patient Referral * ☐ Health Care Event ☐ Internet Search ☐ Physician Referral *

☐ Walk In ☐ Sport Team Referral * ☐ Trainer Referral * ☐ Website ☐ Other *

* Please specify the name of the person referring you: _____

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Dr. Michael Hoffmann, B.Sc., N.D.
Naturopathic Physician

GENERAL CONTACT INFORMATION

Child's Name:_____ Date:___/___/___
(Last name) (First name) dd/mm/yyyy

Age: _____ Sex: ☐ Female ☐ Male Date of Birth:___/___/___
dd/mm/yyyy

Address: _____
(Street/PO box)

_____
(City) (Province/Sate) (Postal code/Zip)

_____
(Home number) (Work) (Mobile)

_____
(Email) (Fax)

Parent/Guardian Name:_____

May we leave messages on your phone line? Y / N Preference: Home / Work / Cell

How did you hear about this clinic?_____

Emergency Contact: _____
(Name) (Relationship)

_____
(Home phone) (Work) (Mobile)

Primary physician?_____ Last physical exam?_____
(Name) (Telephone) (Month/year)

PLEASE COMPLETE THE FOLLOWING QUESTIONS

What are your child's main health concerns? List as many as you can in order of importance.

1. _____
2. _____
3. _____
4. _____

MEDICAL HISTORY

How is your child's health in general? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please indicate any serious conditions, illnesses, injuries, and hospitalizations, along with dates:

1. _____
2. _____
3. _____
4. _____

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking, the dosage and the reasons for taking them:

1. _____
2. _____
3. _____
4. _____

Is your child hypersensitive or allergic to any of the following (please list):

Drugs? _____

Foods? _____

Environmental? (e.g. pollen, dust, perfume) _____

_____

Has your child ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc) while at home or traveling? Y N

Does your child live near power lines or refinery? Y N

Does your child have mercury dental fillings? Y N

Does your child have any surgical implants (medical)? Y N

Does your child have any body piercings? Y N

Has your child ever had any organ transplants? Y N

Has there been an event or sickness that your child has never fully recovered from? Please indicate below

_____

_____

Please indicate what immunization your child has had:

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis A
☐ MMR (measles, mumps, rubella) ☐ "Flu" ☐ Hepatitis B
☐ Smallpox ☐ Polio
☐ Other: _____

Please describe any adverse reaction: _____

FAMILY HISTORY

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		High blood pressure	
Alcoholism		Kidney disease	
Asthma		Mental illness	
Arthritis		Mononucleosis	
Cancer (type)		Multiple Sclerosis	
Chronic Bronchitis		Osteoporosis	
Diabetes		Rheumatic Fever	
Depression		Skin diseases	
Drug abuse		Strep throat	
Emphysema		Stroke	
Hepatitis		Tuberculosis	
Heart disease		Other	

☐ I don't know my family medical history

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverage: _____

Cravings: _____

Aversions: _____

Does your child drink pop? Y N How much?_____

Does your child have any dietary restrictions?_____

GENERAL

Weight:_____ Height:_____

Does your child suffer from allergies? If yes, please explain:_____

_____

Has your child had any specific allergy testing? If yes, please explain:_____

_____

Roughly how many times has your child been on antibiotics?_____

SYMPTOM CHECKLIST

Please take a moment to circle the following symptoms and childhood illnesses which your child may have experienced either in the past or presently.

Symptom Checklist	Childhood Illnesses
Appetite change	Measles
Bad Breath	Chicken Pox
Bed Wetting	Rubella
Burning Urination	Mumps
Constipation	Pneumonia
Cough	Tonsillitis
Cries Easily	Recurrent Ear Infections
Diarrhea	Frequent Colds
Dizziness	Allergies
Easy Bruising	Fevers
Eczema	Impetigo
Fatigue	Rheumatic Fever
Hair Loss	Anemia
Hearing Loss	Sinusitis
Indigestion	Acute Epiglottitis
Insomnia	Whooping Cough
Nervousness	Scarlet Fever
Night Sweats	Mononucleosis
Sore Throat	Asthma
Stomach Aches	Other:_____
Urinary Frequency	
Visual Disturbances	
Vomiting	
Wheezing	
Other:_____	

HEALTH HISTORY FROM BIRTH

Birth mother's illnesses during pregnancy (circle):

Hypertension	Gestational Diabetes	Pre-eclampsia
Bleeding	Excessive vomiting	Anemia
Trauma	Other:_____	

Substances used during pregnancy by birth mother (circle):

Tobacco	Alcohol	Caffeine
Medications	Other:_____	

Type of labor (circle)	Spontaneous	Induced
Type of delivery (circle)	Vaginal	C-section

Complications after delivery (circle):

Jaundice	Rash	Colic	Seizures
Respiratory Distress	Birth Defects	Bleeding	Fever
Other:_____			

Breast Fed: Y N How long:_____

Bottle Fed: Y N How long:_____

Introduction of Solid Foods: When?_____

First foods in order of introduction (specify if bottled or fresh)

_____

_____

Where there any reactions to the foods listed above? (colic, constipation, congestion, etc)

_____

_____

LIFESTYLE PATTERNS

Does your child sleep well?	Y	N	Does your child wet the bed?	Y	N
Does your child go to daycare?	Y	N	Does your child crave junk food?	Y	N

DEVELOPMENTAL MILESTONES

At what age did your child:

Crawl_____ Walk_____ Talk_____ Toilet train_____

*Thank you for taking the time to complete this form***Dr. Michael Hoffmann, B.Sc., N.D.**
Naturopathic Physician

Dr. Michael Hoffmann, B.Sc., N.D.
Naturopathic Physician

CONSENT FOR TREATMENT

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your naturopath will take a thorough case history, do a screening physical examination that may include a breast exam, blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important therefore that you inform your ND immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your ND immediately.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture, acupuncture, prolothreapy, neuralthreapy or mesotherapy
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa
- Muscle strains and sprains, disc injures from spinal manipulation

_____ Initials I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____ Initials I understand that the Naturopathic Doctor will answer any questions that I have to the best of his ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications.

_____ Initials I understand that charges are to be paid at the time of the visit. Payment for all dispensary items is due at the time of the visit.

_____ Initials I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or late cancellations (less than 24 hours).

As the patient, you are responsible for the total charges incurred for each visit including costs of supplements. If I have coverage for naturopathic medicine, it is my responsibility to bill my insurance company. I understand that most insurance companies do not cover the cost of supplements. I have read and understood the above stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (Please Print) _____

Signature of Patient or Guardian: _____ Date:_____