Dr. Laura Stark BKin ND
Thrive Naturopathic ~ Medicine to Nourish Your Soul

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors 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 Naturopathic Doctor will take a thorough case history, perform a physical exam and may employ specific diagnostic testing, if it is deemed necessary, which will be discussed in your visit. If your case requires, the physical may include more specific examinations such as breast, gynecological, rectal, prostate or genital exams. It is very important that you inform your Naturopathic Doctor of any disease process that you are suffering from, and 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 Naturopathic Doctor immediately.

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

- Possible aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles
- Muscle strains and sprains, disc injures from spinal manipulation

Statement of Acknowledgement

As a patient of Thrive Naturopathic, I _____ have read the information and understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. 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 unless so directed by myself in writing or unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

The information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs.

With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: _____.

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.

I also confirm that I have the ability to accept or reject this care of my own free will and choice.

I accept full responsibility for any fees incurred during care and treatment.

Patient Name (Please Print): _____

Signature: _____ Date: _____

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Patient Information:

Full Name: _____ M / F

Birthdate (dd/mon/year): _____ Age: _____ Height: _____ Weight: _____

Full Address: _____

_____

Telephone: (home) _____ (cell) _____ (work) _____

Email Address: _____

Would you like to receive quarterly clinic newsletters and events by email? □ yes □ no

Emergency Contact: _____ Relation: _____ Phone: _____

Relationship Status: □ single □ dating □ common-law □ married □ separated/divorced □ widowed

Number of children & ages? _____

Occupation: _____

Are you currently seeing a Medical Doctor? Y / N

Who is your Primary Care Provider? □ Medical Dr. _____ or □ Dr. Stark

Other healthcare providers you are seeing:

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
(_____)_____	(_____)_____	(_____)_____
(_____)_____	(_____)_____	(_____)_____

How did you find Dr. Stark?
□ Online search
□ Referred. By whom? _____
□ Yellow pages
□ Other _____

Extended Health Care Carrier (if applicable): _____

What is the extent of your coverage? _____

Office use only: If you would like to keep payment information on file for over-the-phone payments

Credit Card Number: _____ Expiry Date: _____

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Adult Patient Health History:

Full Name: _____ M / F

Birthdate (dd/mon/year): _____ Age: _____ Height: _____ Weight: _____

Other healthcare providers you are seeing:

1. _____ 2. _____ 3. _____

_____ _____ _____

_____ _____ _____

(_____)_____ (_____)_____ (_____)_____

(_____)_____ (_____)_____ (_____)_____

Please fill out the following pages as best you can.

PRIMARY CONCERN: _____

Other health concerns: _____ _____

_____ _____

_____ _____

Any allergies or sensitivities: □ hay fever □ skin reactions □ foods □ medications (please list, indicating severity)

_____

_____

Please list any past traumatic injuries, hospitalizations and surgeries (with dates):

_____ _____

_____ _____

_____ _____

Please list your medication and supplement use over the last 2 years:

Drug/vitamin/herb/etc.	Dosage	Reason for taking/Any side-effects

# of times on Antibiotics? _____ Corticosteroids? Topical _____ Oral _____

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Health Screening and Maintenance:

When was your last:	Date	Results
Full physical exam	_____	_____
Screening lab tests	_____	_____
Dental exam	_____	_____
Hearing test	_____	_____
Eye exam	_____	_____
STI screening	_____	_____
Fecal Occult Blood test	_____	_____
Colonoscopy (age 50+)	_____	_____
Bone density test	_____	_____
Breast exam	_____	_____

Do you do regular self-exams? _____ Any concerns? _____

Women:

PAP test	_____	_____
Mammogram	_____	_____

Men:

Prostate (DRE) exam	_____	_____
Testicular exam	_____	_____

Do you do regular self-exams? _____ Any concerns? _____

Health and Lifestyle Habits:

Please indicate your use of the following:

Water: ☐ Never ☐ Occasionally ☐ _____ /day

Coffee: ☐ Never ☐ Occasionally ☐ _____ /day or wk

Soda pop: ☐ Never ☐ Occasionally ☐ _____ /day or wk

Alcohol: ☐ Never ☐ Occasionally ☐ _____ /day or wk

Tobacco: ☐ Never ☐ Occasionally ☐ _____ /day or wk Have you ever been a smoker? _____

Recreational drugs: ☐ Never ☐ Occasionally ☐ _____ /day or wk What kind(s)? _____

Do you have a regular exercise program? _____

Type(s): _____ Amount per week: _____

Where do you live? ☐ city ☐ small town ☐ rural/farm

Who do you live with? _____

Please list any chemicals, toxins, or other environmental factors that may be affecting your health:

☐ pesticides ☐ herbicides ☐ asbestos ☐ solvents ☐ gas fumes ☐ cigarette smoke ☐ other: _____

_____

_____

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Diet:

What do you typically eat for…

Breakfast ?	Lunch?	Dinner?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What do you snack on (and when)? _____

_____

How often do you eat out? _____ /wk What types of restaurants? _____

Family Health History:

Please indicate whether any blood relatives (mother, father, siblings, grandparents, children) have had any of the following. Circle if on maternal (M) or paternal (P) side.

M/P Cancer (type)	_____	M/P Kidney disease	_____
M/P Heart disease	_____	M/P Crohn's/Colitis	_____
M/P High blood pressure	_____	M/P Osteoporosis	_____
M/P High Cholesterol	_____	M/P Bleeding disorders	_____
M/P Stroke	_____	M/P Sickle Cell disease	_____
M/P Diabetes	_____	M/P Epilepsy/seizures	_____
M/P Obesity	_____	M/P Substance abuse	_____
M/P Tuberculosis	_____	M/P Depression	_____
M/P Glaucoma	_____	M/P Mental illness	_____

Any other diseases that run in your family? _____

Personal Health History:

Prenatal influences: □ alcohol □ coffee □ cigarettes □ drugs □ stress □ other: _____

Nature of birth: □ trauma □ forceps □ c-section □ medicated □ natural □ other: _____

Were you breast fed (if so, for how many months)? _____

Vaccinations: □ none □ all scheduled □ other (please specify): _____

Any complications? _____

How was your health as a baby? _____

_____

How was your health as a child? _____

_____

How was your health as a teenager? _____

_____

_____

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Adult illnesses: Age How Severe (hospitalized?)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

When did you notice changes to your health? _____

_____

Psychosocial History:

Please list any important life experiences in chronological order, especially traumatic events:

Age Event Comment

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Has there been a significant event in your life that changed you forever? _____

Have you ever had a nervous breakdown? □ yes □ no If yes, please describe the circumstance: _____

_____

_____

Religious or spiritual beliefs: _____

_____

What is your view of the present and your outlook for the future? _____

_____

How do you feel about yourself? _____

_____

Do you have a supportive environment (work/home) for making lifestyle changes? _____

Summary and Health Goals:

Do you have a preference for the type of naturopathic treatments used? _____

_____

What are your short-term health goals? _____

_____

What are your long-term health goals? _____

_____

Is there any information you would like to add? _____

_____

_____

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Review of Body Systems:

Please place a " **X** " by any symptoms you have **currently**. Place a " **P** " by any you have had in the **past**.

General:
___ fatigue
___ night sweats
___ hot person
___ chilly person

Infections:
___ HIV/AIDS
___ Hepatitis
___ Tuberculosis
___ Chicken pox
___ Mononucleosis
___ Whooping cough
___ Scarlet fever
___ Mumps
___ Measles
___ Malaria
___ Rheumatic fever
___ Typhoid fever

Blood:
___ bleeding disorder
___ bruise easily
___ anemia
___ iron deficiency/excess

Skin:
___ acne
___ open sore/ulcer
___ hives
___ itching
___ warts
___ eczema/dermatitis
___ psoriasis
___ rashes
___ colour changes
___ changes in moles
___ skin cancer
___ nail problems

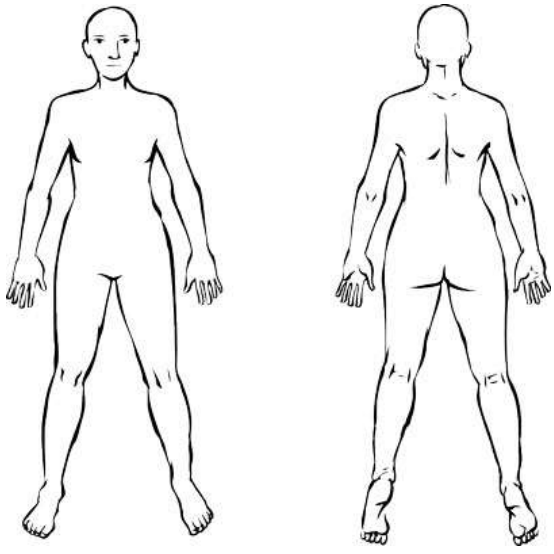
Eyes:
___ vision problems
___ glasses/contacts
___ sensitive to light/sun
___ eye infections
___ excess tearing
___ dry eyes
___ floaters
___ cataracts
___ glaucoma

Head & Hair:
___ headaches
___ migraines
___ hair loss (excessive)
___ hair growth (excessive)
___ head injury/concussion
___ dizziness/vertigo

Mouth & Throat:
___ tooth problems
___ mercury fillings
___ dentures
___ gum problems/bleeding
___ cold/canker sores
___ hoarse voice
___ frequent sore throat
___ tonsils removed
___ loss of taste
___ bad taste in mouth

Nose & Sinuses:
___ frequent colds
___ hay fever/allergies
___ frequent nose bleeds
___ congestion

Please indicate on the body map the location and type of symptoms you are experiencing currently. (eg. Pains, rashes, etc.)



Musculoskeletal:
___ chronic pain
___ joint problems
___ arthritis
___ gout
___ muscle pain/cramps
___ jaw pain/clicking
___ broken bones
___ specific injury

Nervous System:
___ seizures
___ stroke
___ paralysis
___ local weakness
___ tremors
___ numbness/tingling
___ fainting/blackouts
___ memory problems
___ learning difficulties
___ ADD/ADHD

Ears:
___ hearing loss
___ ringing in ears
___ excess wax
___ frequent infections
___ ear aches

Respiratory:
___ chronic cough
___ sputum/excess mucous
___ difficulty breathing
___ short of breath (SOB)
___ SOB lying down
___ SOB on exertion
___ wheezing
___ asthma
___ frequent lung infections
___ COPD/emphysema
___ pneumonia

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Please place a " **X** " by any symptoms you have **currently**. Place a " **P** " by any you have had in the **past**.

Gastrointestinal:
___ difficulty swallowing
___ heartburn/acid reflux
___ nausea
___ appetite up or down
___ persistent vomiting
___ indigestion
___ excess bloating
___ excess belching
___ excess passing gas
___ abdominal pain
___ stomach ulcer
___ jaundice
___ gallstones
___ gallbladder removed
___ fatty food intolerance
___ constipation
___ diarrhea
___ pale stool
___ black stool
___ blood in stool
___ irritable bowel syndrome

Endocrine:
___ diabetes
___ hypoglycemia
___ excessive thirst
___ excessive sweating
___ thyroid problems
___ heat/cold intolerance
___ recent weight gain
___ recent weight loss

Urinary:
___ wake up to urinate
___ kidney infections
___ kidney stones
___ bladder infections
___ excessive urination
___ frequent urination
___ urgency
___ painful urination
___ slow/difficult stream
___ dribbling
___ incontinence

Cardiovascular:
___ high or low blood pressure
___ high or low cholesterol
___ heart murmur
___ chest pain
___ angina
___ palpitations
___ irregular heart beat
___ pacemaker
___ heart surgery

Peripheral Vascular:
___ bruise/bleed easily
___ cold hands/feet
___ Raynaud's syndrome
___ cyanosis (blue lips, skin)
___ deep leg pain/cramps
___ extremity skin ulcers
___ wounds slow to heal
___ swollen ankles
___ varicose veins
___ hemorrhoids

Female Reproductive:
___ age of first period?
___ irregular cycles
___ excessive flow
___ bleeding between periods
___ clots
___ PMS mood changes
___ cramping/painful periods
___ birth control pill?
___ bleeding after intercourse
___ vaginal discharge
___ itch
___ yeast infections
___ endometriosis
___ fibroids
___ ovarian cysts
___ cervical dysplasia
___ difficulty conceiving
___ # of pregnancies
___ # of deliveries
___ # of miscarriages
___ # of abortions
___ problems during pregnancy
___ problems during delivery
___ tubal ligation
___ hysterectomy
___ menopause
___ vaginal dryness
___ hot flashes

Male Reproductive:
___ enlarged prostate
___ hernia
___ testicular pain
___ testicular lump
___ sores on penis
___ discharge from penis
___ jock itch
___ infertility

Breast (male & female):
___ breast tenderness
___ breast lumps
___ fibrocystic breasts
___ nipple discharge

Sexual:
___ sexually active
___ increased libido
___ decreased libido
___ painful intercourse
___ sexual difficulties
___ sexually transmitted infection
___ birth control methods?
_____

Mind & Mood:
___ diagnosed mental illness
___ depression/excess sadness
___ seasonal depression
___ anxiety/nervousness
___ tension
___ mood swings
___ mania/hyperactivity
___ panic attacks
___ excess anger/irritability
___ difficulty expressing emotions
___ lack of concentration
___ foggy thinking

Thank you for taking the time to fill out these health history forms.
I look forward to working with you on your healing journey!

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