Contact and Medical Information Form

Double Sided

Please complete and return to front desk, or email to office@mvwc.ca

Name ________________________________ M ☐ F ☐ Date of Birth (Mo/Day/Year) ____/____/____ PHN ______________________
Address ____ City ______________________ Postal Code ___________________
Phone____ Alternate Phone ____
Email ____
☐ Please email me about new therapies, upcoming events, office closures, our magazine Metanoia
If the above is a child: Parent(s)/Guardian(s) names ____
Family Physician (MD) ____ Phone ____
Emergency Contact name _________________________ Relationship ___________________ Number ___________________________
Children's names and ages____
How did you hear about our clinic? ☐ Yellow Pages ☐ BCNA ☐ Choices Markets ☐ Friend/colleague/family ☐ Sign ☐ Newspaper ad
☐ Talk/Presentation ☐ Chamber of Commerce ☐ Organic Grocer ☐ Local business ☐ ACAM Website ☐ Magazine ad ☐ RGCC USA
☐ Mountainview Wellness Centre website ☐ Doctor's referral____________________ ☐ Other:_________________________

Occupation/Previous Occupation____

Allergies/Sensitivities____

Medications/Supplements (photocopying available):____
____

Health Concern(s)/Diagnosis (please include date of onset)
____
____
____
____

Have you had any lab work done or special studies (CT, MRI, Echocardiogram)?_______________________________________
What treatments have you tried and what were the outcomes____
____

Medical History: ☐ Autoimmune disease ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Hepatitis ☐ HIV
☐ High/Low Blood Pressure ☐ Rheumatic Fever ☐ Seizures ☐ Tuberculosis ☐ Stroke ☐ Pregnant (or planning to be)
☐ Kidney or bladder disease ☐ Venereal Disease ☐ Thyroid Disease ☐ Mental illness ☐ Nursing
☐ Other: ____
☐ Exposure to harmful chemicals, radioactivity, fumes or other health hazards? Describe: ______________________________
Any Hospitalizations, Surgeries, Implants etc. including date____
Describe stress in your life, e.g. schooling, residence, finances, relationships, etc. ______________________________

Current weight_________________________ **Weight 1 year ago**__________________________ **Ideal weight** ___________________
Tobacco # of cigarettes /d ________ Alcohol # of drinks/week_________Caffeine #6 oz coffee/d______________________
EXERCISE Days per week _______ Duration: _______ minutes Describe:____

DIET
Amount of Water per day_________ # of pop/week_________
☐ Mixed food diet ☐ Vegetarian ☐ Salt restriction
☐ Vegan Restrictions: ☐ Dairy ☐ Wheat ☐ Eggs ☐ Soy
☐ All gluten

EATING HABITS: ☐ Skip meals ☐ Eat on the run
☐ Small frequent meals ☐ Cravings for:_________________

FAMILY MEDICAL HISTORY (Parents and Siblings)
☐ Arthritis ☐ Alcoholism ☐ Alzheimer's disease
☐ Depression ☐ Asthma ☐ Diabetes ☐ Cancer
☐ Drug Addiction ☐ Glaucoma ☐ Genetic disorder
☐ Heart Disease ☐ Infertility ☐ Mental illness
☐ Migraine ☐ Obesity ☐ Thyroid Disorders

GENERAL
☐ Fatigue/Time of Day_________________ ☐ Poor sleep
☐ Bleed or bruise easily ☐ Poor appetite ☐ Fevers
☐ Increased appetite ☐ Chills ☐ Tremors
☐ Cravings ☐ Sweat easily ☐ Dizziness
☐ Cold hands or feet ☐ Strong thirst

MUSCULOSKELETAL
☐ Whiplash ☐ Osteoarthritis ☐ Osteoporosis
☐ Rheumatoid Arthritis ☐ Re-occurring Sprains/Strains
☐ Tendonitis ☐ Bursitis ☐ Dislocations ☐ Fracture

INDICATE PAINFUL OR DISTRESSED AREAS
X – sharp/intense pain
/- radiating pain
S- area of surgery
O- dull/ aching
N- numbness/ tingling
W-Weakness

SKIN AND HAIR
☐ Sensitive Skin ☐ Ulcerations ☐ Hives ☐ Itching
☐ Eczema ☐ Acne ☐ Dandruff ☐ Warts
☐ Hair Loss ☐ Suspicious Moles or Lesions ☐ Rashes

HEAD, EYES, EARS, NOSE AND THROAT
☐ Concussions ☐ Migraines ☐ Eye pain ☐ Glasses or contact lenses ☐ Eye strain ☐ Cataracts ☐ Poor vision
☐Night blindness ☐Blurry vision ☐ Spots in front of eyes ☐ Earaches or infections ☐ Ringing in ears ☐ Poor hearing ☐ Sinus Problems
☐ Recurrent sore throats ☐ Nosebleeds ☐ Grinding teeth ☐ Sores on lips or tongue ☐ Jaw clicks ☐ Teeth problems
☐ Headaches ______# of amalgam fillings (Mercury/Silver)

CARDIOVASCULAR
☐ Fainting ☐ Chest pain ☐ Phlebitis ☐ Congestive Heart Failure ☐ High/Low blood pressure ☐ Irregular heartbeat
☐ Swelling of hands/ feet ☐ Blood clotting disorders ☐ Varicose veins

RESPIRATORY
☐ Cough ☐ Asthma ☐ Emphysema ☐ Bronchitis ☐ Pneumonia ☐ Shortness of Breath ☐ Phlegm (what color)?

GASTROINTESTINAL
☐ Nausea ☐ Heartburn/Reflux ☐ Indigestion ☐ Vomiting ☐ Belching ☐ Blood in stools ☐ Constipation
☐ Gas ☐ Rectal pain ☐ Diarrhea ☐ Bad breath ☐ Hemorrhoids ☐ Abdominal pain or cramps
☐ Chronic laxative use ☐ Black stools ☐ Ulcers/Gastritis

GENITO-URINARY
☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate ☐ Unable to hold urine
☐ Kidney stones ☐ Decrease in flow ☐ Erectile Dysfunction ☐ Sores on genitals ☐ Do you wake to urinate (how often)?

WOMEN'S HEALTH
☐ Menstrual Irregularities ☐ Light/Heavy ☐ Clots ☐ Painful periods ☐ Endometriosis ☐ Premenstrual Syndrome
☐ Fibrocystic Breasts ☐ Breast cancer ☐ Ovarian cysts ☐ Pelvic Inflammatory Disease ☐ Decreased sex drive
☐ Menopause ☐ Infertility ☐ Vaginal infections ☐ Oral contraception, type: ___________________________
# of children:___________ #of pregnancies:__________ Date of last PAP exam___________________
Date of last mammogram: ________________ Date of last Menstrual Period_______________ Date of Last Thermography_______________

MEN'S HEALTH
☐ Benign prostatic enlargement ☐ Prostate Cancer ☐ Decreased sex drive ☐ Erectile Dysfunction

NEUROPSYCHOLOGICAL
☐ Seizures ☐ Panic Attacks ☐ Lack of coordination ☐ Poor memory ☐ Depression ☐ Anxiety ☐ Quick temper / irritability

I am also interested in:
☐ Modifiable Genetic Risk factors for diseases such as cancer, cardiovascular disease and osteoporosis
☐ Heavy metal testing for mercury, cadmium, lead, arsenic, and other common toxic metals
☐ Determining underlying factors that cause difficult weight loss such as cortisol, thyroid function, serotonin, estrogen and testosterone
☐ Salivary hormone assessments for estrogen, progesterone, DHEA, DHT, etc.
☐ Metabolic assessment for nutritional status i.e. need for certain vitamins, minerals, essential fats
☐ Food and/or environmental sensitivity and allergy testing; Gastrointestinal assessment
☐ Aesthetic treatments such as facial rejuvenation, acupuncture, bio facial, and mesotherapy

PAYMENT POLICY
Payment is due in full at the end of your visit for any applicable visit fees, lab work, treatments, or medications. 2.5% compounded monthly interest charged on overdue accounts. All medications are GST applicable. A Menu of Services and Tests is provided for your convenience.

RETURN POLICY
Unopened and undamaged naturopathic medication purchased may be returned only for credit on your account, with receipt, within 15 days of purchase. Lab tests, Rapid Weight Loss programs, special order items, refrigerated and in-house compounded items are Final Sale. Returns on the remainder of prepaid treatment packages will void any discount on treatments already provided.

Please ensure the information that you provide is accurate and complete. If you are here to for an initial visit, please complete entire form.
All information collected is considered confidential and is kept in accordance with the College of Naturopathic Physicians of BC.

____ ____________________________________
(Signature of Patient, Parent or Legal Guardian) (Date)