BETA
WELLNESS CENTRE

Contact and Medical Information Form

Today's Date_____
DD / MM / YY

Please complete and return to front desk or e-mail back

Name _____M ☐ F ☐ Date of Birth (Day/Month/Year) ____/____/____ PHN _____

Address _____ City _____ Postal Code _____

Phone_____ Alternate Phone_____

Email _____

☐ I would like to receive appointment reminders by email ☐ I would like to receive appointment reminders by telephone

☐ Please email me about new therapies, upcoming events, and office closures.

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 ☐ Beta Wellness Centre website
☐ Doctor's referral_____ ☐ RGCC USA ☐ ACAM Website ☐ 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: ☐HIV ☐Hepatitis ☐Tuberculosis ☐Cancer ☐Heart Disease ☐Stroke ☐High/Low Blood Pressure
☐Diabetes ☐Autoimmune disease ☐Rheumatic Fever ☐Seizures ☐Mental illness
☐Thyroid Disease ☐Kidney or bladder disease ☐Venereal Disease ☐Nursing ☐Pregnant (or planning to be)
☐Other: _____

☐Exposure to harmful chemicals, radioactivity, fumes or other health hazards? _____

☐ Hospitalizations, Surgeries, Implants etc. including dates: _____

_____

Describe stress in your life, e.g. schooling, residence, finances, relationships, etc.

_____

Current weight_____ Your **weight 1 year ago**_____ __**Ideal weight**_____

Tobacco # of cigarettes /d_____

EXERCISE Days per week_____Duration: _____ minutes Describe_____

DIET

☐ Mixed food diet ☐ Vegetarian ☐ Vegan

☐ Amount of Water per day_____# of pop/week_____☐ Alcohol # of drinks/week_____Caffeine #6 oz coffee/d_____

Restrictions:

☐ Dairy ☐ Wheat ☐ Eggs ☐ Soy ☐ All gluten ☐ Salt ☐ Caffeine

EATING HABITS:

☐ Skip meals ☐ Eat on the run ☐ Small frequent meal ☐Increased/decreased appetite ☐ Cravings for:_____

FAMILY MEDICAL HISTORY (Parents and Siblings)

☐ Arthritis ☐Alcoholism ☐ Alzheimer's disease ☐ Depression ☐ Asthma ☐ Diabetes ☐ Cancer ☐ Addiction

☐ Glaucoma ☐Genetic disorder ☐Heart Disease ☐ Infertility ☐ Mental illness ☐ Migraine ☐ Obesity ☐ Thyroid Disorders

GENERAL

☐ Fatigue/Time of Day_____ ☐ Poor sleep ☐ Bleed or bruise easily ☐ Cold hands or feet

☐ Cold hands or feet ☐Sweat easily ☐ Fevers ☐Dizziness ☐Strong thirst

MUSCULOSKELETAL

☐Whiplash ☐Osteoarthritis ☐Osteoporosis ☐Rheumatoid Arthritis ☐Re-occurring Sprains/Strains ☐Tendonitis

☐Bursitis ☐Dislocations ☐Fracture

SKIN AND HAIR

☐ Sensitive Skin ☐ Ulcerations ☐ Itching ☐ Rashes

☐ Hives ☐ Eczema ☐ Acne ☐ Dandruff ☐ Warts

☐ Hair Loss ☐ Suspicious Moles or Lesions

HEAD, EYES, EARS, NOSE AND THROAT

☐ Headache ☐ Concussions ☐ Migraines

☐ Eye pain ☐ Eye strain ☐ Poor vision

☐ Glasses/contact lenses ☐Blurry vision

☐ Cataracts ☐ Spots in front of eyes

☐Night blindness

☐ Earaches or infections ☐ Ringing in ears

☐ Poor hearing ☐ Sinus Problems

☐ Recurrent sore throats ☐ Nosebleeds

☐ Grinding teeth ☐ Jaw clicks ☐ Teeth problem

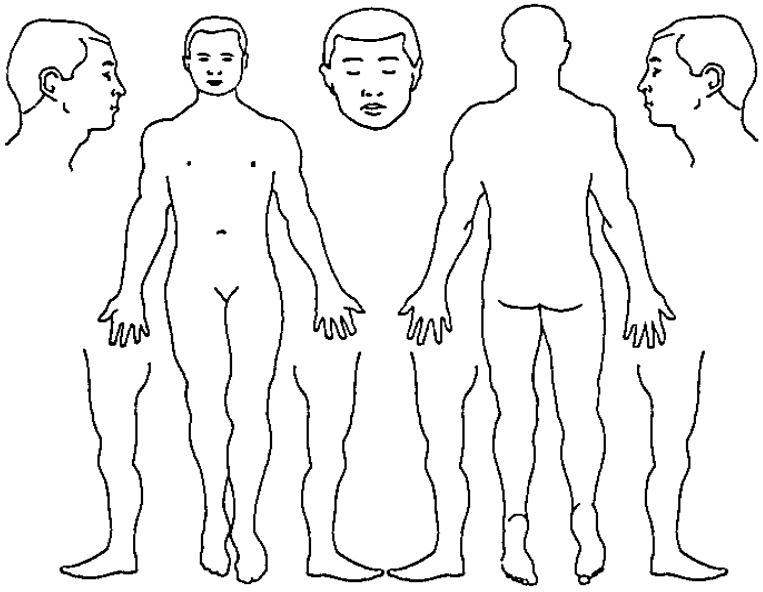
☐ Dental amalgam fillings (Mercury/Silver) #_____

☐ Sores on lips or tongue

S

X – sharp/intense pain
/- radiating pain
S- area of surgery

O- dull/ aching
N- numbness/ tingling
W-Weakness



CARDIOVASCULAR

☐ Fainting ☐ Chest pain ☐ Phlebitis ☐ Congestive Heart Failure
☐ High blood pressure ☐ Low blood pressure ☐ Irregular heartbeat ☐ Swelling of hands/ feet
☐ Blood clotting disorders ☐ Heart valve disease ☐ Varicose veins ☐ Raynaud's phenomenon

RESPIRATORY

Frequent cols/flu ☐ Cough ☐ Bronchitis ☐ Pneumonia
☐ Shortness of Breath ☐ Phlegm color_____ ☐ Asthma ☐ Emphysema

GASTROINTESTINAL

☐ Bad breath ☐ Heartburn/Reflux ☐ Indigestion ☐ Belching
☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting
☐ Abdominal pain or cramps ☐ Rectal pain ☐ Blood in stools ☐ Hemorrhoids
☐ Hemorrhoids ☐ 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 ☐ Decreased urine flow ☐ Sores on genitals ☐ Do you wake to urinate (how often)? _____

WOMEN'S HEALTH

☐ Menstrual Irregularities ☐ Light/Heavy ☐ Clots ☐ Painful periods ☐ Premenstrual Syndrome
☐ Endometriosis ☐ Infertility ☐ Fibrocystic Breasts ☐ Breast cancer ☐ Ovarian cysts
☐ Pelvic Inflammatory Disease ☐ Menopause since_____ ☐ Decreased sex drive ☐ Vaginal dryness
☐ Vaginal infections ☐ Oral contraception, type: _____ ☐ IUD, type:_____
☐ # of children:_____ ☐ #of pregnancies:_____ ☐ Date of last PAP exam_____
☐ Date of last mammogram: _____ ☐ Last Menstruation_____ ☐ 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 causing difficulty losing weight such as adrenal and thyroid function, estrogen/testosterone
☐ Salivary hormone assessments for estrogen, progesterone, DHEA, DHT, etc.
☐ Metabolic/genetic assessment for nutritional status, i.e. body requirements for vitamins, minerals, amino acids, essential oils.
☐ Food and/or environmental sensitivity/allergy testing; ☐ Assessment of digestive system function
☐ Aesthetic/antiaging medicine: ☐ Facial Rejuvenation with concentrated GF ☐ Facial Acupuncture ☐ Bio-facial ☐ 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.

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 Program, special order 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)