Delbrook Naturopathic Medical Centre Inc.

Dr. D. Bayley BSc.K, ND

Confidential Medical History

CARE CARD #:_____________________________ BIRTHDATE:________________________

INSURANCE CLAIMS
ICBC# __________________WCB# ________________________ DOI: ___________________
ADJUSTER: _____________________________ PHONE: ______________________

FULL NAME: ____ DATE: _________________
ADDRESS: ____POSTAL CODE: ____________

HOME PHONE: ___________________WORK: _________________ CELL PHONE: ______________________
EMAIL: ____
APPOINTMENT REMINDERS: How would you like us to contact you? Email, text, or phone?_____________

AGE: ____ SEX: ____ MARITAL STATUS: ____ OCCUPATION: _____________________________________
NEXT OF KIN: _________________________ DID SOMEONE REFER YOU? ___________________________

HAVE YOU SEEN OTHER PHYSICIANS OR THERAPISTS IN THE PAST YEAR? IF SO, PLEASE LIST THE NAME AND TYPE: ____
____

PRESENT COMPLAINT(S) OR ILLNESS(ES) IS/ARE: ____
____
____

WHAT IS THE CAUSE? (if known) ____
____
DURATION: ____

SYMPTOMS: Please mark (1) = **MILD**, (2) = **MODERATE**, (3) = **SEVERE** next to the following symptoms which apply to you NOW or in the PAST.

NOW	PAST		NOW	PAST		NOW	PAST	
____	____	Headache	____	____	Dizziness	____	____	Memory loss
____	____	Nervousness	____	____	Unconsciousness	____	____	Paralysis
____	____	Vision change	____	____	Blurred vision	____	____	Ringing ears
____	____	Ear pain	____	____	Ear discharge	____	____	Impaired hearing
____	____	Nose bleeds	____	____	Sinus pains	____	____	Sore throat
____	____	Cough	____	____	Expectoration	____	____	Shortness of breath
____	____	Pain in chest	____	____	Indigestion	____	____	Spitting of blood

____ ____ Abdominal pain
____ ____ Nausea
____ ____ Rectal pain
____ ____ Diarrhea
____ ____ Blood in urine
____ ____ Muscle pain
____ ____ Back pain
____ ____ Itching

____ ____ Belching
____ ____ Vomiting
____ ____ Constipation
____ ____ Intestinal gas
____ ____ Genital pain
____ ____ Joint pain
____ ____ Skin eruptions
____ ____ Weight change

____ ____ Heart palpitations
____ ____ Swelling/ankles
____ ____ Appetite changes
____ ____ Rectal bleeding
____ ____ Painful urination
____ ____ Frequent urination
____ ____ Genital discharge
____ ____ Numbness/tingling

PREVIOUS HISTORY: have you had?
Measles ____ Mumps ____ Chicken Pox ____ German Measles (rubella) ____ Hepatitis ____
Whooping Cough ____ Scarlett Fever ____ Venereal Disease ____

FAMILY HISTORY: has anybody in your extended family (blood related) had the following:
Diabetes ____ Cancer ____ Asthma ____ Heart disease ____ Arthritis ____ T.B. ____
Kidney Disease ____ Ulcers ____ Mental disorders ____ Other ____________________

OPERATIONS: what and when
____
____

Please mark your consumption per day/week (on average)

Coffee ____ Tea ____ Tobacco ____ Alcohol ____ Laxatives ____ Work ____ Sleep ____
Exercise ____ Other ____

Do you have any known allergies? (drugs, foods, chemicals, inhalants, etc.)
____
____

Please list all your current medications/supplements

____
____
____
____

CANCELLATION POLICY

Life happens, so you may need to cancel or re-schedule your appointment. Please call us at least 24 hours in advance. A cancellation with less than 24 hours notice (or no-show) will result in charges to your account.
Less than 24 hours notice cancellation or re-schedule is $42.00.
Missed appointments are subject to a fee of $85.00

I agree to the above policy __________________________ (Please sign)