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	____	____	Belching	____	____	Heart palpitations
____	____	Nausea	____	____	Vomiting	____	____	Swelling/ankles
____	____	Rectal pain	____	____	Constipation	____	____	Appetite changes

____ ____ Diarrhea	____ ____ Intestinal gas	____ ____ Rectal bleeding
____ ____ Blood in urine	____ ____ Genital pain	____ ____ Painful urination
____ ____ Muscle pain	____ ____ Joint pain	____ ____ Frequent urination
____ ____ Back pain	____ ____ Skin eruptions	____ ____ Genital discharge
____ ____ Itching	____ ____ Weight change	____ ____ 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
_____
_____
_____

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I agree:_____

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

I agree: _____