



**East liberty
Medical Centre**

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libertymd.ca
Cara MacMullin Bsc ND

Naturopathy New Patient Registration Form

Date: _____

Name _____

Age _____ Birthday ____/____/____ (m/day/yr)

Address _____ City _____

Province _____ Postal Code _____

Phone (home) (____) _____ (work) (____) _____

Email address: _____

Occupation _____ Circle one: Full Time / Part Time / Retired / Student

Marital Status: Married / Separated / Divorced / Widowed / Single / Partner

If patient is a child, please indicate the following:

Mother's name _____ Age _____

Father's name _____ Age _____

Name and Address of Relatives/Friends in case of Emergency:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

How did you hear about our office?

Name and phone number of family doctor:

Main reason for visit:

Please list **in order of importance** any other health problems that are of concern to you:

- 1) _____ how long? _____
- 2) _____ how long? _____
- 3) _____ how long? _____
- 4) _____ how long? _____

Have you seen health practitioners for these concerns? Please state which health practitioners and the treatment prescribed:

FAMILY HISTORY and PERSONAL HEALTH HISTORY

Please indicate if you or anyone in your immediate family presently have or have had any of the following conditions. Please indicate whether it was you or a family member who was affected, as well as the outcome.

- Severe Allergies (anaphylaxis) requiring the use of an EpiPen**
- Heart Disease (heart attacks, strokes, arrhythmia, hypertension, etc)**
- High Blood Pressure**
- Tuberculosis**
- SARS**
- Emphysema**
- Asthma**
- Hemophilia/Blood Disorder**
- Cancer** – please specify type of cancer: _____
- HIV/AIDS**
- Hepatitis**
- Epilepsy**
- Suicidal Tendencies**
- Glaucoma**
- Thyroid Disease**
- Schizophrenia**
- Diabetes**
- Alcoholism/Drug Addiction**
- Genetic Disease (please specify)** _____
- Other** _____

Are you **allergic** to any medicines or other substances? If so, please indicate:

Have you ever had any kind of **surgery** or been **hospitalized**? If so, please indicate when and for what reason:

Please indicate which **medicines** you are presently taking, **including supplements, herbs, vitamins and other nonprescription items** – include brand and dosage were applicable

Do you now, or have you ever smoked cigarettes? _____

How much alcohol do you consume/week? _____

Do you use recreational drugs? If yes, which ones, and how often? _____

Do you exercise? If yes, list type, how often and duration

EMOTIONAL HEALTH (please circle appropriate response)

Have you ever received professional counseling? Yes No

Please rate your emotional health via the following scale: (1=unstable, difficulty coping; 10=happy, stable)

1 2 3 4 5 6 7 8 9 10 (please circle)

How stressful is your day to day life (1=stress-free; 10=extremely stressful)

1 2 3 4 5 6 7 8 9 10 (please circle)

Are you able to find joy in some/all aspects of your life? Yes No

Do you often feel anxious or depressed? Yes No If yes, how long has this been going on?

Please provide a brief explanation of your home life, and your general emotional state

Is there any information, not included on this form, that you would like to discuss? Please explain.

REVIEW OF SYSTEMS QUESTIONNAIRE

General/Constitutional Information

General state of health	Excellent	Good	Average	Poor
Sense of well-being	Excellent	Good	Average	Poor
Strength	Excellent	Good	Average	Poor
Ability to conduct usual activities	Excellent	Good	Average	Poor
Exercise tolerance	Excellent	Good	Average	Poor
Emotional well-being	Excellent	Good	Average	Poor

Average weight _____ Height _____

Recent/Past Weight loss or gain _____

Put a check mark beside any condition you are **presently experiencing**. If the symptom was in the **past**, please indicate by placing a **“P”** beside the check mark.

Eyes/Ears/Nose/Mouth/Throat

Headaches	Double vision	Nose bleeding	Dental problems/decay
Vertigo	Tearing	Frequent colds	Bleeding gums
Lightheaded	Blind spots	Nasal discharge	Root Canals (#)
Neck stiffness	Eye pain	Ringing in ears	Multiple fillings (3 +)
Neck Pain/Tenderness		Cataracts	Lumps/masses in neck

Other (please specify):

Cardiovascular System

- | | |
|--------------------------------------|---|
| Chest pain | High blood pressure |
| Palpitations | Heart murmurs |
| Fainting | Varicose veins |
| Shortness of breath on exertion | Hypertension/High Blood Pressure |
| Shortness of breath while lying down | Leg pain worse with exercise and relieved by rest |
| Shortness of breath at night | Cyanosis (bluish tone to skin) |
| Swelling of ankles or hands | Other cardiovascular problems |
| Family history of heart disease | |

Last ECG/echo/cardiac testing: _____

Other cardiovascular concerns (please specify): _____

Respiratory System

- | | | |
|---------------------------|-------------------------|-----------------------|
| Chest pain when breathing | Environmental allergies | Coughing up blood |
| Shortness of breath | Sinus infections | Persistent cough |
| Wheezing | Chronic nasal discharge | Bronchitis/Infections |
| Fever or night sweats | Asthma | Tuberculosis/Exposure |

Last chest X-Ray and/or TB test _____

Other respiratory/chest/breathing concerns (please specify): _____

Gastrointestinal System

- | | |
|-----------------------------------|--|
| Change in appetite | Jaundice (yellowing of the skin or eyes) |
| Difficulty swallowing | Frequent vomiting |
| Frequent indigestion | Hemorrhoids |
| Frequent abdominal pain | Frequent nausea |
| Recent change in bowel habits | Blood in stool |
| Frequent constipation | Vomiting blood |
| Frequent diarrhea | Abdominal pain after eating |
| Frequent flatulence (passing gas) | |
| Frequent heartburn | |

Other gastrointestinal concerns (please specify): _____

Genitourinary System

Urinary urgency	Unusual (or change in) color of urine	Change in libido
Frequent urination	Kidney stones	Impotency
Pain on urination	Frequent bladder/kidney infections	Infertility
Urination at night	Nephritis	Genital discharge
Blood in the urine	Dribbling of urine	STI
Urinary Incontinence		

Females Only: Age of onset of menses _____
 Length of cycle and duration of bleeding _____
 Last menstrual period _____

Number of pregnancies _____ Number of live births _____

Do you experience (please check): menstrual cramping/pain Mid-cycle bleeding
 heavy menstrual bleeding missed periods vaginal discharge
 post-menopausal bleeding pain during intercourse
 breast lumps/cysts breast tenderness nipple discharge
 PMS (list symptoms): _____

Are you presently or have you ever been on the birth control pill? _____
 Which one and for how long? _____

Date of onset of menopause/menopausal symptoms: _____

Other urinary or genital concerns (please specify):

Skin

Frequent/chronic rashes	Acne (vulgaris/rosacea)
Change in texture of skin	Hair loss/alopecia/androgenic/changes in hair growth
Skin itching	Nail changes (breaking, chipping, lines, pitting)
Skin discoloration	Changes in moles, freckles, birth marks
Excessive moisture or dryness of skin	

Other skin concerns (please specify):

Vaccinations Please list what you are currently vaccinated for and any recent vaccinations you have received:

Musculoskeletal System

- | | |
|--|-------------------|
| Muscular pain or swelling | Muscular weakness |
| Redness or heat of muscles and/or joints | Muscle wasting |
| Restricted movement | Muscle cramps |
| Decreased flexibility | Bone pains |
| Joint pains | |

Other muscular or bone concerns (please specify):

Neurological/Psychological

- | | | |
|--|---------------------------|---------------------|
| Convulsions | Nervousness | Unusual perceptions |
| Paralysis | Emotional problems | Hallucinations |
| Tremor | Anxiety | |
| Loss of coordination | Panic attacks | |
| Memory changes | Depression | |
| Speech Difficulties | Previous psychiatric care | |
| Unusual sensation (pins & needles, numbness, heightened sensation) | | |

Other neurological/psychological concerns (please specify):

Hematological/Immune/Lymphatic/Endocrine Systems

- Life threatening allergies: _____
- Reactions to drugs, food, insects _____
- Blood Type: _____
- Local or general lymph node enlargement or tenderness
 - Increased thirst
 - Hormone therapy (thyroid medication,HRT, birth control pill, diabetic medications)
 - Intolerance to heat or cold
 - Previous transfusions
 - Bleeding tendency
 - Anemia

Other blood-related, immune, lymphatic or hormonal concerns (please specify):

Is there anything else you feel the doctor should be aware of?

Cara MacMullin, B.Sc., N.D.
Naturopathic Doctor

FEE SCHEDULE

Naturopathic Services: East Liberty Medical Centre

Initial 60-75 Minute Visit and Assessment: \$175.00 + GST
60 Minute Follow-up: \$130.00 + GST
45 Minute Follow-up: \$110.00 +GST
30 minute Follow-up: \$80.00 + GST

Phone Consultations – in office rates apply

24 hours notice is required for cancellations.

Appointments cancelled within 24 hours will be charged.

Fees for naturopathic services are due when services are rendered.

Payment may be made by **cash, cheque, credit card, and debit** Please ensure that you have the appropriate method of payment available when you visit the clinic.

We respectfully request **a minimum of 24 hours notice for cancellation of appointments**, or you will be charged for 50% of the missed appointment fee. The amount of time scheduled for each naturopathic visit is significant, and abrupt cancellations make it difficult to run an efficient clinic. Certainly there are unforeseen events which may arise and these will of course be taken into consideration.

It is of utmost importance to the staff of this clinic to remain on time for all scheduled appointments, out of respect and convenience for our patients. Please note that if you arrive late for your appointment, we will try to accommodate you as much as possible, however only the balance of time that was booked may be available to you.

I have read and understand the naturopathic fee schedule and agree to its conditions.

Signature of Patient or Guardian _____

**Cara MacMullin BSc ND
Naturopathic Doctor**

INFORMED CONSENT TO NATUROPATHIC TREATMENT

Naturopathic medicine is a form of primary health care which focuses on the diagnosis, treatment and prevention of disease. Naturopathic therapies are based on the following principles:

1. **First, do no harm.** This means offering competent, effective health care with the least risk for all patients.
2. **Co-operate with the healing powers of nature.** The human body has an amazing capacity to for self-healing. Naturopathic doctors have a deep respect for this ability, with the goal being to augment this ability using gentle therapies.
3. **Treat the cause.** Many conventional therapies focus on treating the symptoms of certain diseases. Naturopathic doctors focus on the cause, such that if the cause is successfully treated, the symptoms may be permanently removed.
4. **Doctor as teacher.** The goal is to educate patients, such that they have a solid understanding of the disease process, and are empowered to take control of their health and get well.
5. **Treat the whole person.** This means that naturopathic doctors take the whole person into account when developing a treatment protocol. Each person is unique and the factors contributing to their health concerns are therefore unique as well. This includes emotional, spiritual and physical aspects of each individual.
6. **Preventative medicine.** Naturopathic medicine incorporates prevention into all aspect of treatment. Teaching patients about a healthy lifestyle and self-responsibility in preventing disease is a cornerstone of this form of health care.

The primary therapies/modalities utilized within the scope of naturopathic medicine are as follows:

- *Clinical Nutrition, Supplementation and Lifestyle Counseling
- *Botanical (Herbal) Medicine
- *Homeopathy
- *Acupuncture and Traditional Chinese Medicine
- *Spinal and Soft Tissue Manipulation
- *Hydrotherapy

As a patient of East Liberty Medical Centre, I recognize that even the gentlest forms of treatment potentially have their complications. Although rare, these complications may arise in certain physiological conditions, as well as in very young children, the elderly, pregnant women, or individuals on multiple medications. These complications may include, but are not limited to: exacerbation of present symptoms, allergic reactions to naturopathic prescriptions, interactions with prescription medications, pain, fainting, bruising, muscle strains and sprains.

I am willing to provide Cara MacMullin, Naturopathic Doctor, with all information relevant to my health. I understand that this information will be used only for the purposes of my naturopathic treatment, in order for Cara MacMullin to fully understand my symptoms, my health history, and my health goals. I will provide this information voluntarily with the purpose of obtaining naturopathic care. I also understand that this information will remain completely confidential, unless I have given my explicit written consent for disclosure. I acknowledge that my name, address and phone number will also be used for billing purposes and to book and confirm appointments.

I do hereby acknowledge that I have been informed of and understand the recommended naturopathic procedures, and I am aware that I have the choice to accept or reject this naturopathic care of my own free will, at any time during treatment. I further acknowledge and confirm that I have been informed of and understand the naturopathic procedures with respect to the financial costs, expected benefits, potential risks and side effects. I have also been informed of the likely consequences of not following the recommended naturopathic procedures, as well as what alternative course(s) of action are available to me. I further understand that naturopathic medicine, like other forms of medicine, does have its limits as a healing agent.

I confirm that I have been informed of and understand the naturopathic procedures with respect to financial costs, expected benefits, potential risks, and side effects.

Date: _____

Patient's Name: _____

Patient's Signature: _____

Cara MacMullin, ND: _____

