Dr. Tasnim Adatya, ND
www.dradatya .com Phone: 604-224-2124 Fax: 604-515-7861

CONFIDENTIAL PATIENT INTRODUCTION

Welcome to our clinic. Please complete the following so that we may help you achieve your optimal level of health! Thank you.

Date _____

☐ Female
☐ Male _____ BIRTH DATE ____/____/____ AGE _____
First Name Middle Name Last Name D M Y

HOME ADDRESS _____
Street City / Province Postal Code

HOME PHONE _____ BUSINESS PHONE _____ OCCUPATION _____

EMPLOYED BY _____ BUSINESS ADDRESS _____

NAME OF SPOUSE _____ # OF CHILDREN AND AGES _____

CHECK ONE: ☐MARRIED ☐SINGLE ☐ WIDOWED ☐DIVORCED ☐SEPARATED

NEAREST RELATIVE OR NEXT OF KIN NOT LIVING WITH YOU _____
Name Relationship

REFERRED BY _____ _____
Address Phone

E- MAIL ADDRESS: _____

IF PATIENT IS UNDER 18 YEARS, NAME AND RELATIONSHIP OF PERSON LEGALLY RESPONSIBLE (Parent, Guardian)

_____

CARECARD NUMBER _____ FAMILY M.D. _____

CURRENT HEALTH CONDITION:

1) **WHAT IS YOUR MAIN REASON FOR COMING IN TODAY?** IF YOU HAVE A SPECIFIC CONDITION PLEASE DESCRIBE IN DETAIL. WHEN DID YOU FIRST NOTICE YOUR CONDITION? CAREFULLY DESCRIBE ANY FACTORS WHICH MAY HAVE PLAYED A ROLE IT'S ASSET OR
CONTINUATION_____

_____

2) HAS ANYTHING RECENTLY CHANGED OR BECOME WORSE? LIST IN ORDER.

_____

_____

3) ARE YOU BEING HEALED BY ANOTHER PHYSICIAN OR PRACTITIONER PRESENTLY? (ND? MD?)_____

CURRENT MEDICATIONS:

PLEASE LIST ALL OF YOUR PRESCRIPTION MEDICATIONS (SLEEPING PILLS, BIRTH CONTROL PILLS), NON-PRESCRIPTION MEDICATIONS (ASPIRIN, ANTACIDS), VITAMINS, HERBS, ETC.

_____

CURRENT NON PRESCRIPTION /SUPPLEMENTS: _____

KNOWN ALLERGIES: SUCH AS MEDICATIONS, POLLENS, FOODS: _____

_____

HOSPITALISATIONS, SURGERIES OR SERIOUS INJURIES:

DATE AND DESCRIBE: _____

HEALTH HISTORY: THE GENERAL STATE OF MY HEALTH IS: EXCELLENT_____ GOOD_____ AVERAGE _____ FAIR _____ POOR _____

ENERGY: ______/10 (10 BEING EXCELLENT, 0 BEING VERY POOR)

HEIGHT: __________ CURRENT WEIGHT: ________ lbs. 1 YEAR AGO: _______lbs. MAX WEIGHT: ________ WHEN? __________

SMOKER: ☐ Yes ☐ No SMOKED: __________ YEARS AMOUNT/DAY: __________ YEAR STOPPED: ________________________

ALCOHOL USE: ☐ Yes ☐ No TYPE: ____ FREQUENCY: __________________________

RECREATIONAL DRUG USE: ☐ Yes ☐ No TYPE: _____________________________ FREQUENCY: __________________________

COFFEE: ☐ Yes ☐ No __________ CUPS/DAY TEA: ☐ Yes ☐ No __________ CUPS/DAY

DIET: ANY FOOD GROUPS THAT YOU AVOID: ☐ Yes ☐ No ____

REGULAR EXERCISE: ☐ Yes ☐ No TYPE: ________________ DURATION: ___________ FREQUENCY: _______________________

DO YOU CURRENTLY TAKE ANY VITAMINS OR MINERALS? ☐ Yes ☐ No

DO YOU THINK THAT YOU MAY NEED TO TAKE VITAMINS OR MINERALS? ☐ Yes ☐ No

WOMEN: ARE YOU CURRENTLY PREGNANT? ☐ Yes ☐ No ☐ Not sure DATE OF LAST PERIOD: _________ LENGTH OF CYCLE: _______

MEN: HOW OFTEN DO YOU GET UP AT NIGHT TO URINATE? ________ AS THIS INCREASED RECENTLY? ☐ Yes ☐ No

ANY PROBLEMS IN SEX DRIVE? ☐ Yes ☐ No IMPOTENCY? ☐ Yes ☐ No DATE OF LAST PROSTATE EXAM: ______________________

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MEDICAL HISTORY: Please check only those that pertain to YOU personally.

- ☐ Alcohol abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding problems
- ☐ Blood pressure/ Stroke
- ☐ Breast pain or lumps
- ☐ Cancer
- ☐ Car accidents
- ☐ Colitis
- ☐ Cold, flu, sore throat
- ☐ Diabetes
- ☐ Digestive disturbances
- ☐ Ear problems
- ☐ Eating disorders
- ☐ Edema
- ☐ Epilepsy
- ☐ Fatigue, Chronic
- ☐ Female gynecological problems
- ☐ Fever
- ☐ Hair loss
- ☐ Hayfever
- ☐ Headaches
- ☐ Heart disorders
- ☐ Hepatitis
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Joint problems
- ☐ Lung problems
- ☐ Kidney problems
- ☐ Occupational exposure to toxic substances
- ☐ Parasites
- ☐ Psychological difficulties / suicide / depression
- ☐ Sexually transmitted diseases
- ☐ Skin problems
- ☐ Sports injuries
- ☐ Thyroid problems
- ☐ Tremors
- ☐

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FAMILY MEDICAL HISTORY: Blood relatives NOT including yourself.

- ☐ Asthma
- ☐ Arthritis
- ☐ Bleeding problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Eating disorders
- ☐ Epilepsy
- ☐ Gout
- ☐ Hayfever, allergies
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Mental disorders
- ☐ Obesity
- ☐ Stroke
- ☐ Substance abuse
- ☐ Tuberculosis
- ☐ Thyroid problems

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OFFICE POLICY REGARDING FEES AND INSURANCE COVERAGE

Our fee policy is a reflection of the specialised procedures incorporated in this office and allows us to give what we feel to be the highest quality of naturopathic care.

FEES

Payment for naturopathic services is expected at the time of treatment.

B.C. MEDICAL

B.C. Medical Insurance has removed MSP coverage for naturopathic services. This means that BC residents will no longer receive a partial reimbursement from the government.

EXTENDED MEDICAL

Your medical insurance policy is a contract between you and your insurance company. This office does not collect payment directly from insurance companies.

CANCELLATION AND MISSED APPOINTMENTS

This office requires a minimum of forty-eight (48) hours notice to cancel any appointment. Any missed or rescheduled appointment with insufficient notice will be billed 50% of the appointment cost.

BC RESIDENTS ARE REQUIRED TO SIGN THE AGREEMENT BELOW

I HAVE READ AND FULLY UNDERSTAND THE OFFICE POLICIES AS STATED ABOVE.

_____

Date PATIENT'S SIGNATURE
parent or guardian