



Medical History			
What is the main reason for your visit today?			
List in order of importance other health problems that are troubling you?			
1.	How long?		
2.	How long?		
3.	How long?		
Current Medications / Nutritional Supplements / Herbal Preparations (please list dosages)			
1.	6.		
2.	7.		
3.	8.		
4.	9.		
5.	10.		
Sleep habits			
How many hours of sleep/night? <input type="checkbox"/> 0 - 3 <input type="checkbox"/> 4 - 6 <input type="checkbox"/> 6 - 8 <input type="checkbox"/> 8 - 10 <input type="checkbox"/> 10+			
Difficulty falling asleep <input type="checkbox"/>		Frequent dreaming <input type="checkbox"/>	
Frequent waking in night <input type="checkbox"/>		Night sweats <input type="checkbox"/>	
Sleep during the day? <input type="checkbox"/>		Feel rested on waking? <input type="checkbox"/>	
Quality of sleep? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
Sexual/Reproductive Health			
Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No		Sexual orientation:	
WOMEN	Age of first menses?		Date of last period?
	Regular pap tests? <input type="checkbox"/> Yes <input type="checkbox"/> No		Abnormal results?
	Changes in sexual desire?		Fertility issues? <input type="checkbox"/> Yes <input type="checkbox"/> No
	# Pregnancies:	# Live births	# Miscarriages: # Terminations:
	Have you ever had? <input type="checkbox"/> Hysterectomy		<input type="checkbox"/> Endometriosis



Sexual/Reproductive Health cont'd...			
MEN	Difficulty achieving erections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty maintaining erections? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you get up at night to urinate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency?
	Have you ever had a prostate exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lifestyle/Habits			
Which of the following do you currently use? (Details/Dosage/Frequency)			
<input type="checkbox"/> Alcohol			
<input type="checkbox"/> Tobacco			
<input type="checkbox"/> Coffee			
<input type="checkbox"/> Hormones			
<input type="checkbox"/> Sedatives			
<input type="checkbox"/> Antacids			
<input type="checkbox"/> Laxatives			
<input type="checkbox"/> Cortisone			
<input type="checkbox"/> Recreational Drugs _____			
Do you exercise?		<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?
What do you do?			
Past Medical History (please check all that apply) :			
	Present	Past	Never
Frequent tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Present	Past	Never
Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	Present	Past	Never		Present	Past	Never
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STI/STD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gas/bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Traumas / Surgeries / Major Illnesses

Falls / Accidents (please list with dates, if possible)

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Surgeries (please list with dates, if possible)

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Family History

	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Other/Details
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Anything else you think I should know?

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Marketing Data Collection:

How did you hear about our clinic: Friend _____

Phone book Sign Other

Please remember - It takes time to get better.

Frequently, our patients have spent many years with chronic medical problems unsolved by conventional medicine. Some are currently receiving positive and necessary treatment from one or more medical doctors or other health-care providers. Some are simply not feeling well and want to improve their general health. Whichever scenario applies to you, it is important to realize that it takes time to heal using naturopathic medical principles and techniques.

As a general rule, it takes about 2 months of treatment for every year you've experienced the condition to feel momentous improvements in your wellbeing. Certainly, our goal is for patients to be able to notice positive change within 1 – 2 visits, but this is not always realistic. We ask you to be patient as a patient! If you have concerns as to your speed of progress, please discuss them with your attending physician.

We are here to serve you!

If you have any questions or concerns regarding your treatment, please contact Dr. Eriksen via email at dr.teriksen@gmail.com.

Sincerely,

Dr. Tamara Eriksen, ND

**** Please read and sign the consent form on the reverse of this page. ****



RISK DISCLOSURE

It is very important that you inform your ND immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking.

Please advise your ND if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

There are some potential health risks associated with treatment by naturopathic medicine. These may include but are not limited to:

- Some patients experience allergic reactions to certain supplements and herbs. Please advise your ND if you have any allergies.
- Pain, bruising or injury from injections, blood draws, acupuncture or IV therapy.
- Fainting during injections, blood draws, acupuncture or IV therapy.
- Puncturing of an organ with acupuncture needles. (*EXTREMELY RARE*)
- Accidental burning or bruising of the skin from the use of moxa and/or during cupping.
- Muscle strains and sprains from spinal manipulation.

The attending ND is trained to handle emergencies should the need arise.

PERSONAL INFORMATION – PATIENT CONSENT FOR COLLECTION, USE & DISCLOSURE

We value your privacy! Dr. Eriksen and the staff at Tailor Made Wellness Clinic commit to being open and transparent about the way we handle your personal information. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They have signed confidentiality agreements and are trained in the appropriate use and protection of your personal information.

- *We only share your information with your consent;*
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the College of Naturopathic Doctors of Alberta.

PATIENT CONSENT

I have reviewed the above information and I understand:

- ***The clinic may collect, use and disclose personal information as set out above.***
- ***The clinic does not guarantee treatment results.***
- ***My ND will explain to me the exact nature of any treatment provided, discuss side effects and possible adverse reaction and answer any questions I may have.***
- ***I am free to expressly withdraw my consent for any individual treatment and/or to discontinue treatment in full at any time.***
- ***I may, from time to time, receive emails regarding upcoming events, courses and seminars (if email address is provided on form.)***
- ***I understand that Dr. Eriksen has a 24-hour cancellation policy and the clinic reserves the right to bill for missed appointments and same-day cancellations.***

Patient's Name (print)

Patient's Signature

Date