Christine Slonetsky, MSW, ND
Health Questionnaire

Welcome. It is our hope that we can assist you with your current and future health concerns. Our focus is: health improvement, maintenance, prevention and education. Any current health problems may be indicators of underlying imbalances. Part of our job will be to explore your overall health status and to advise you on measures to ensure optimal well being.

During the course of you examination and treatments, please feel free to comment, ask questions, and provide us with feedback. We feel that the more you know about yourself, the more active a role you can play in restoring and maintaining your own health. Together, we can form a team on the side of a healthy future.

PATIENT INFORMATION

Name: ____

Phone H: (_____)_________________________ B: (_____)_____________________________

Address: ____ Apt:________________

City: ________________________________ Postal Code:______________________________

Age:________ Birthdate: Day:____ Mo:____Yr:_________ Sex: M F

How did you hear about Dr Christine? **Please check all that apply;**

____ Current Client of Clinic ___ Building Sign ___ Business Cards/Flyer ___Yellow Pages

Internet: _____Canada 411 ____Yellow Pages.ca ______ Google _____Yahoo ____ Bing

____ Referral (Who?) _______________________ Other (Explain) _________________________

Place of Birth:_______________ Marital Status: S M Sep Wid

Number of Children:_______ Ages: ________________________

If the patient is a child, give the parents name: Mother: ______________ Father:______________

Occupation: ______________________ Employer: ____

Have you received naturopathic care previously? Yes No If yes, when? ________________

Name of Practitioner(s): _________________________For what reasons? ______________________

Medical Doctor _______________________________ (phone) _______________________________

Are you under the care of any other health care practitioner? Yes No

Name(s)________________________________ For What Reason? _____________________________

Confidential Health and Lifestyle Questionnaire

Dear Patient:
Please complete this questionnaire with care. Your answers will help us to determine the most effective health care for you. Please print throughout. Thank you.

What are your chief reasons for being here in order of importance to you?
____

____

____

How long have these problems occurred?
____

Have you had similar problems before? Yes No Explain:
____

____

Do you have any relatives with similar problems? Yes No Who?
____

List any practitioners seen for the above conditions:
____

List diagnosis, type of treatments, for these conditions:
____

____

List any medications you are presently taking & doses:
____

What do you feel is causing any health problems you may have?____

____

When did you last feel well?
____

What do you hope to achieve from participating in naturopathic care?
____

____

Please indicate the occurrence of the following and give details and dates:

Surgery: ____________________________________ Hospitalization: _______________________________
____________________________________ _______________________________

Accidents: ___________________________________ Major Illnesses: _______________________________
___________________________________ _______________________________

Loss of Consciousness: _______________________ Seizures: _______________________________
___________________________________ _______________________________

Weight: ______ Height:______ Blood Type: _______

Are you satisfied with your current weight? Yes No Have you ever had a weight problem? Yes No

Are you constipated: Yes No Number of bowel movements per day? ____________________________

Do you exercise regularly? Yes No How often? ____

What type of program? ____

What type of things do you find stressful? ____

Do you meditate or use any type of relaxation exercise? Yes No

Do you have regular sleep habits? Yes No How many Hours? _________________________________

Early riser? Yes No Difficulty falling asleep? Yes No Nightmares? Yes No

Do you drink coffee? Yes No No./day: _________ Black tea: Yes No No./day: __________

Do you smoke? Yes No If yes, how long? __________ No./day?

Do you drink alcohol? Yes No Daily Am't? _______Weekly Am't? ______ Special Occasions?_____

What types? ____

Do you have any hobbies? Yes No If yes, please list: ____

Is there a history of any of the following in your family? (Please circle and state relationship of family member):

Alcoholism	Cancer	Heart Disease	Schizophrenia
Allergies	Cataracts	Hyperactivity	Stomach Ulcers
Arteriosclerosis	Celiac	Kidney Disease	Stroke
Arthritis	Colitis	Learning Disability	Tuberculosis
Asthma	Depression	Mental Disease	Yeast Infections
Bed Wetting	Diabetes	Muscular Dystrophy	Venereal Disease
Candida Albicans	Epilepsy	Multiple Sclerosis	

Circle any of the following medications you are taking:

Antacids	Antibiotic/Antifungal	Antidepressants	Antidiabetic/Insulin
Aspirin/Tylenol	Chemotherapy	Cortisone/Anti-Inflammatory	Heart Medications
High Blood Pressure	Hormones	Laxatives	Lithium
Oral Contraceptives	Radiation	Relaxants/Sleeping Pills	Thyroid
Ulcer Medication			

Recreational Drugs: specify: ____

Other specific: ____

Circle if you eat, drink, or use:

Alcohol	Candy	Carbonated beverages	Cigarettes
Fast Foods (regularly)	Fried Foods	Margarine	Luncheon Meats
Refined Sugars	Saccharine (Sweet & Low)	Chew Tobacco	Coffee
Distilled Water	Aspartame (Nutrasweet)	Relaxants/Sleeping Pills	

Vitamins and/or Minerals: specify; ____

Circle if you:

Diet Often	Do Not Exercise Regularly	Salt Food without Tasting
Are Under Excessive Stress	Are Exposed To Chemicals at Work	Are Exposed to Cigarette Smoke

INFORMED CONSENT STATEMENT

THIS FORM MUST BE SIGNED BEFORE ANY TREAMENT WILL BE RENDERED
Naturopathic medicine uses non–invasive methods of assessing the bodily functions and the use of natural therapeutic for correction. The methods used by Christine Slonetsky, N.D. include homeopathy, clinical nutrition, botanical medicine, traditional Chinese medicine and acupuncture, counselling, and various modes of physical therapy.

The current health care system in Ontario is under scrutiny. In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I, Christine Slonetsky, N.D., ask for your cooperation in signing this statement of acknowledgement, in so doing:

1. That you understand that I am a Naturopathic Doctor, and not a conventional medical doctor, that I use non-invasive, natural methods as assessment and treatment of body dysfunctions. That any treatment you receive is not mutually exclusive from any treatment or advice you may now be receiving or may receive in the future from another licensed health care provider.

2. That you understand the methods that I may use have proven clinical foundation, yet may not be accepted by standard (allopathic) medicine.

3. That you understand that I am required by my licensing board to perform a physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is deemed acceptable.

4. That you understand that treatment and/or referral to other health practitioners is based on the assessment of your health revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.

5. That you understand I reserve the right to determine which cases fall outside my scope of practice, in which event the appropriate referral will be recommended.

6. That you are not an agent of any private or government agency attempting to gather information without so stating your intentions.

7. That while changes in dietary habits are not an absolute pre-requisite for treatment, that you understand that failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.

8. That you are accepting or rejecting this care of your own free will.

9. That you understand that the ultimate responsibility for your health care is your own, and that I am here to support you in this. I reserve the right to discontinue my services where it is apparent that your expectation and what I can provide are not in agreement.

10. That you understand that all fees for services and supplements are payable at the time of the appointment by the patient or the guardian. That there is a fee for telephone consultations of greater than 10 minutes. Notice of 24 hours is require for appointment cancellation, otherwise you will be charged an administrative fee for $35. Any special financial arrangements may be made clear in advance.

I, ____ have read, understood and acknowledge the above statements.

Signature: ____ Date: ______________________________