2917 Lake Shore Blvd, West.
Toronto, Ontario. M8V 1J3
647-748-2917 | PHYSIOINTHESIX.COM

All information will be held in strict confidence.

Last Name_____ First Name_____ Initial_____

Date of Birth (*dd/mm/yyyy*) ____/____/_____ Occupation_____

Address_____ City_____ Postal Code_____

Email_____

Home Phone_____ Work Phone_____ Cell Phone _____

Height_____ Weight_____ Blood Type _____

Marital Status _____ Children (circle) YES / NO If Yes, How Many_____

Direct Billing Information: Insurance Company_____

Policy Holder Last Name_____ Policy No._____

Policy Holder First Name_____ ID/Certificate No._____

Family Physician

Name_____

Address_____

Phone_____

Fax _____

How did you hear about us?

Doctor ___ Friend ___ Media____ Walk-In____

Insurance Company____ Family Member_____ Other_____

Referral Source's Name (*Optional*)

_____

Contact in case of Emergency

Name_____ Relationship_____

Home Phone_____ Work Phone_____

SERVICE	TOTAL FEE
Naturopathic Assessment	**$180.00**
Naturopathic Treatment per unit	**$90.00**
Naturopathic Re-assessment ***greater than six months since last assessment or new complaint**	**$ 150.00**

N.B. Fees are subject to change. 01/09/2018

****Our cancellation policy requires 24 hours notice or you will be charged 100% of the fee****

This signed form and photocopies of this signed form will serve as authorization to the Physio In The Six Inc. Clinic to obtain/release medical information pertaining to myself from/to my family physician and to other Physio In The Six Inc. Clinic practitioners. It also serves as an agreement to provide payment to Physio In The Six Inc. Clinic, at the time of each visit, and later claim through any extended health benefits plan, as appropriate. The undersigned has read and understands the cancellation policy.

Signature_____ **Date (*dd/mm/yyyy*)** ____/____/_____

Physio In The Six Inc.
Health and Lifestyle

What are your major health concerns?

1) _____

2) _____

3) _____

4) _____

5) _____

Describe a typical day's diet:

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

Liquids:

_____

Exercise Activity:
(Type & Frequency)

_____

_____

**Patient's Name: _____
**Date of Birth: (*dd/mm/yyyy*) ____/____/_____

Physio In The Six Inc.
Health and Lifestyle Assessment

Name:_____ D.O.B.: (*dd/mm/yyyy*) ____/____/_____

Rate your average energy level: (lowest) 1 2 3 4 5 6 7 8 9 10 (highest)

Rate your usual stress level: (lowest) 1 2 3 4 5 6 7 8 9 10 (highest)

How well do you sleep? _____

How would you describe your emotional life? _____

How would you describe your diet? _____

Do you have any food reactions/allergies (circle)? YES / NO

If yes, please specify: _____

How do you feel after eating? _____

How is your appetite? _____

Do you tend to have constipation/diarrhea (circle)? YES / NO

If yes, how often: _____

Are you/have you been a smoker (circle)? YES / NO

How often do you consume:

Coffee/Tea? _____

Alcoholic Beverages? _____

Tobacco Products? _____

Do you use recreational drugs (circle)? YES / NO

Do you have frequent infections (circle)? YES / NO

Do you feel your health is getting better/worse? _____

Are you satisfied with your relationships? YES / NO

Are you satisfied with your career/work? YES / NO

Physio In The Six Inc.
REVIEW OF SYSTEMS - CONFIDENTIAL HEALTH PROFILE (PART 1)

Name:_____ D.O.B.: (*dd/mm/yyyy*) ____/____/_____

If you have now or <u>have had</u> any of the following, please complete by checking the boxes that apply to you

GENERAL

- Insomnia ❒
- Fatigue ❒
- Weight loss/gain ❒
- Allergies ❒

HEAD

- Headache/Migraines ❒
- Dizziness ❒
- Head trauma ❒
- Fainting ❒
- Blacking out ❒

EYES

- Itching/redness ❒
- Change in vision ❒
- Cataracts ❒
- Light sensitivity ❒
- Flashes in vision ❒
- Spots in vision ❒
- Glaucoma ❒

EARS

- Ringing/tinnitus ❒
- Impaired hearing ❒
- Earache ❒
- Dizziness ❒
- Discharge ❒

MOUTH & THROAT

- Bleeding gums ❒
- Cold sores ❒
- Sore throat ❒
- Jaw/TMJ Problems ❒
- Hoarseness ❒
- Swollen glands ❒
- Goiter ❒

NOSE

- Hayfever ❒
- Loss of smell ❒
- Nosebleeds ❒
- Sinus Problems ❒

LUNGS

- Difficulty breathing ❒
- Shortness of breath ❒
- Persistent cough ❒
- Coughing phlegm ❒
- Coughing blood ❒
- Asthma ❒
- Pneumonia ❒
- Emphysema ❒
- Bronchitis ❒
- Infections (please state) ❒

VASCULAR

- Angina ❒
- Murmurs ❒
- Heart disease ❒
- Chest pain ❒
- Palpitations ❒
- Ankle swelling ❒
- Cold feet/hands ❒
- Leg cramps ❒
- Calf pain ❒
- Varicose veins ❒
- Low/high blood pressure ❒

GASTROINTESTINAL

- Bloating/gas ❒
- Heartburn ❒
- Ulcers ❒
- Liver disease ❒
- Gall stones/bladder ❒
- Vomiting/nausea ❒
- Abdominal pain ❒
- Diarrhea ❒
- Constipation ❒
- Blood in stool ❒
- Hemorrhoids ❒
- Hernias ❒

SKIN

- Rash ❒
- Itching/hives ❒
- Warts ❒
- Psoriasis ❒
- Eczema ❒

URINARY

- Difficulty/pain urinating ❒
- Kidney Disease ❒
- Blood in urine ❒
- Bed-wetting ❒
- Urinary urgency ❒
- Frequent urination ❒
- Frequent infections ❒
- Kidney stones ❒

NEUROLOGICAL

- Seizures/epilepsy ❒
- Strokes ❒
- Tingling sensation ❒
- Muscle weakness ❒
- Difficulty walking ❒
- Poor coordination ❒
- Paralysis ❒
- Speech problems ❒
- Loss of memory ❒

MUSCLE & BONE

- Joint pain ❒
- Stiffness ❒
- Muscle ache ❒
- Arthritis ❒
- Fractures ❒
- Dislocations ❒

ENDOCRINE

- Diabetes ❒
- Hypoglycemia ❒
- Hormone therapy ❒
- Thyroid problems ❒
- Heat/cold intolerance ❒
- Night sweats ❒

EMOTIONAL

- Depression ❒
- Mood swings ❒
- Anxiety/nervousness ❒
- Tension ❒
- Phobias ❒
- Alcohol/drug abuse ❒

CONDITIONS/OTHER

- AIDS/HIV ❒
- Eating disorders ❒
- Rheumatic arthritis ❒
- Leukemia ❒
- Rheumatic fever ❒
- Alcoholism ❒
- Cancer/tumor ❒
- Polio ❒
- Parkinson's ❒
- Multiple Sclerosis ❒
- Gout ❒
- Anemia ❒
- Osteoporosis ❒
- High/low cholesterol ❒
- Fibromyalgia ❒
- Chronic fatigue ❒
- Hepatitis ❒
- Herpes Genitalia ❒
- Abscesses ❒
- Gonorrhea ❒
- Syphilis ❒
- Chicken pox ❒
- Tuberculosis ❒
- Worms ❒
- Venereal Warts ❒
- Tonsillitis ❒
- Strep Throat ❒
- Mumps ❒
- Measles ❒
- Parasites ❒
- Worms ❒
- Rubella ❒
- Mononucleosis ❒
- Prostatitis ❒
- Stroke ❒
- Hepatitis ❒
- Pleurisy ❒
- Malaria ❒
- Miscarriage ❒

FEVERS AND FLUS

- Influenza ❒
- Hay ❒
- Rheumatic ❒
- Yellow ❒
- Scarlet ❒

Physio In The Six Inc.
REVIEW OF SYSTEMS - CONFIDENTIAL HEALTH PROFILE (PART 2)

Name:_____ D.O.B.: (*dd/mm/yyyy*) ____/____/_____

Are there any conditions checked previously in which you have never felt totally well again? Please state:

_____

Please list all major traumas in your life (i.e. accidents/factures/surgeries/emotional traumas/deaths, etc.)
(If possible please provide location & date) where necessary)

1) _____

2) _____

3) _____

4) _____

5) _____

Medications *(List all prescription, over the counter and supplements you are currently taking)*

Medication/Supplement	Strength (i.e. 400 mg)	Amount Per Day (i.e. one)	Time (AM/PM)	Since how long? (i.e. starting 1 yr ago)

Physio In the Six Inc.
WOMEN'S/MEN'S HEALTH PROFILE AND FAMILY HISTORY

Women's Health (if this does not apply please proceed to the Men's Health directly below)

Symptom	Often	Sometimes	Never	Symptom	Often	Sometimes	Never
Hot flashes				Mood changes			
Night sweats				Irritability			
Depression				Forgetfulness			
Fatigue				Difficulty Concentrating			
Acne				Vaginal Dryness			
Hair Thinning/Loss				Painful Intercourse			
Headaches/Migraines				Decreased Sex Drive			
Sleep Disorders				Breast Tenderness			
PMS				Urinary Tract Infections			
Bloating				Yeast Infections			
Weight Gain				Joint Tenderness			

Do you perform monthly self-breast examinations? YES / NO

Age of first menses: _____ Age of last menses: _____

Still menstruating? YES / NO Are your periods regular? YES / NO Duration of Cycle _____ Days

Number of pregnancies: _____ Number of Live Births: _____

Birth Control? YES / NO Premarin/Prempro? YES / NO Date Discontinued _____

Men's Health (if this does not apply please proceed to the Women's Health directly above)

Symptom	Often	Sometimes	Never	Symptom	Often	Sometimes	Never
Loss of Libido				Mood Changes			
Stamina Decrease				Irritability			
Weight Gain				Forgetfulness			
Muscle Building Difficulty				Difficulty Concentrating			
Acne				Joint Tenderness			
Hair Thinning/Loss				Frequent Urination			
Headaches/Migraines				Urinary Tract Infections			
Sleep Disorders				Erectile Dysfunction			
Fatigue				Other (please list below)			

Family History *(Please complete to the best of your ability)*

Relation	Age (if alive)	State of Health	Age at Death & Cause	Check and Designate if They Had
Mother				❒ Tuberculosis
Father				❒ High Blood Pressure
Maternal Grandmother				❒ Heart Disease
Maternal Grandfather				❒ Migraine
Paternal Grandmother				❒ Strokes
Paternal Grandfather				❒ Cancer
Sibling (M / F)				❒ Allergies/Asthma
Sibling (M / F)				❒ Arthritis
Sibling (M / F)				❒ Kidney Disease
Sibling (M / F)				❒ Diabetes
				❒Nervous Troubles

****Patient's Initials_____**

Physio In The Six Inc.

NAUTUROPATHIC MEDICINE - CONSENT TO TREATMENT AND PRIVACY POLICY

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent capacity/

I hereby consent to the assessment and treatment performed by the Registered Naturopathic Doctor named below.

I understand that treatment may include treatments for therapeutic, preventative, palliative, diagnostic, cosmetic, or other health related purposes. Treatment modalities include dietary modification and nutritional supplementation, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counseling. Bowen therapy may also be used, as well as bio-identical hormones.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or in those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform your Naturopath immediately of any disease process that you are suffering from or if you are on any medication or over-the-counter drugs. If you are pregnant, suspect that you are pregnant or are breast-feeding, please advise your Naturopath immediately.

There are some slight health risks to treatment by Naturopathic Medicine. These can include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture

Supplements may be prescribed by your Naturopathic Doctor, these can be purchased at the clinic or at other local health stores. Please note: extended health insurance companies may not cover the supplements prescribed to you.

I understand that I may rescind or amend this consent in writing.

I further understand that the clinical, psychological and any other information which is gathered during the course of my treatment is confidential, but may be shared with my insuring agents, third party payers and/or physician(s) upon request.

Privacy and protecting your personal information is something we take very seriously. All personal information gathered adheres to the privacy legislation and standards of the College of Naturopaths of Ontario (CONO).

I have read the above consent, and I have had the opportunity to ask questions about its content. This consent will cover the naturopathic assessment and entire course of treatment.

_____
Patient's Name (*Please print*)

Date of Birth: (*dd/mm/yyyy*) ____/____/_____

_____
Signature of Patient

_____
Date Signed

_____MARY GALIC_____
Doctor's Name (*Please print*)

The Health Information Custodian of this chart is Physio In The Six Inc.

Physio In The Six Inc.
2917 Lake Shore Blvd West
Toronto, ON
M8V 1J3