Dr. Kelly Brown drkbrownnd@gmail.com

Birch Wellness Center

34 Carlton Street, Winnipeg, Manitoba R3C 1N9

204 505 0325 (f) 204 505 0327

Full Legal Name: (Last, First) _____/_____

Preferred Name:_____Date of Birth:_____Age:_____

Gender: Female □ Male □ Other□_____ E-mail Address: _____

Address: _____

Telephone: home_____/work_____/cell_____

Occupation: _____Full Time □ Part time □ Student □ Retired□

Emergency Contact:_____

Names of other Healthcare Providers:

Medical Doctor _____ Naturopathic Doctor_____

Chiropractor_____ Others _____

Your Main Health Concerns

Why are you seeing the Naturopath today? _____

What are your most important health concerns? Please list in order of importance:

1. _____

2._____

3. _____

Please list vitamin/mineral/herbal supplements you are taking:

Supplement/Brand	Dose	How long have you been taking this supplement?

Please list all current medications:

Medication	Dose	How long have you been taking this medication?

Check each that you currently use:

Laxatives □	Pain relievers □	Antacids □	Cortisone □
Antibiotics □	Heart/Blood medication □	Allergy medication □	Thyroid medication □
Sleeping pills □	Anti-depressants □	Birth control pills □	Hormones □

Please list any past medications:

Your past medical history: (Please list any surgeries or illnesses)

Family Medical History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Age (if living)							
Current Health							
Age at death							
Cause of death							

Social History:

How many cigarettes do you smoke a day? _____

How much alcohol do you drink per week? _____

Do you take recreational drugs? (Please list) _____

Are you exposed to any toxins or chemicals in your home or at work (mold, chemicals, etc)? _____

Have you been vaccinated? _____ Which vaccines? _____

Have you travelled recently and to where (Please include Manitoba/North America)? _____

_____

How often do you exercise? What type of exercise do you do?

Diet: (Please complete One week diet diary attached to this form)

Are you or have you ever been on a restricted diet? If so, what kind? _____

How much water do you drink/day? _____

What else do you drink? (Tea, juice, coffee, soda, etc.)/day? _____

How frequently do you move your bowels? _____ Per day/week

Diet Diary- attached to back of intake

Please check boxes that apply, if symptoms are current or past recurring problem:

GENERAL

Fatigue □	Change in appetite □	Change in thirst □	Cravings □
Weight gain □	Weight loss □	Poor sleep □	Chills or fever □
Night sweats □	Allergies □	Cancer □	Diabetes □

SKIN AND HAIR

Dryness □	Eczema □	Psoriasis □	Acne □
Recent moles □	Hives/allergic reactions □	Loss of hair □	Thinning of hair □
Dandruff □			

EYES, EARS, NOSE, AND THROAT

Eye pain □	Eye strain □	Blurry vision □	Impaired vision □
Cataracts □	Ear aches □	Ear infections □	Ringing in ears □
Vertigo/dizziness □	Sinus infections □	Nasal obstruction □	Post nasal drip □
Nosebleeds □	Loss of smell/taste □	Sores in mouth □	Mercury fillings □
Jaw pain or clicks □	Recurrent sore throat □	Tonsillitis □	Enlarged glands □
Enlarged thyroid □	Facial pain/tics □	Headaches □	

CARDIOVASCULAR

Chest pain □	Palpitations □	High/low blood pressure □	Heart Attack □
Irregular heartbeat □	Pacemaker □	Congestive heart failure □	Artificial heart valve □
Stroke □	Fainting □	Varicose veins □	Deep leg pain □
Swelling of limbs □	Low iron □	Easy bruising □	

RESPIRATORY

Difficulty breathing □	Shortness of breath □	Chronic cough □	Bronchitis □
Emphysema □	Asthma □	Wheezing □	Coughing blood/phlegm □

MUSCLES, BONES, AND JOINTS

Neck/Back pain □	Arthritis □	Bursitis □	Joint pain/stiffness □
Artificial joint □	Muscle pain □	Muscle weakness □	

GASTROINTESTINAL

Nausea□	Vomiting □	Vomiting blood □	Reflux or heartburn □
Constant hunger □	Ulcers □	Abdominal pain/cramping □	Bloating □
Gallbladder stones □	Liver disease □	Intestinal parasites □	Gas □
Constipation □	Diarrhea □	Chronic laxative use □	Rectal pain/burning □
Hemorrhoids □	Blood in stool □		

NEUROLOGICAL

Anxiety □	Depression □	Irritability □	Emotional problems □
Loss of balance □	Poor memory □	Dizziness □	Seizures/epilepsy □
Concussions □	Lack of coordination □	Extremity numbness □	Extremity tingling □
Paralysis □			

INFECTIONS

Strep throat □ Mononucleosis (Mono) □ Tuberculosis □ Hepatitis □

HIV/AIDS □ Sexually transmitted Infections □

URINARY

Frequent urination □ Urgency to urinate □ Incontinence □ Pain on urination □

Waking at night to urinate □ Urinary tract infection □ Blood in urine □

Kidney stones □

MALE REPRODUCTIVE

Prostate problems □ Impotence □ Sores on genitals □ Discharge□

Testicular mass □ Testicular pain□ Hernia □ Infertility/low sperm □

FEMALE REPRODUCTIVE

Irregular Periods □ Heavy, light, clots (please circle)

Painful periods □ PMS □ Sore breast with period□

Infertility □ Vaginal sores □ Vaginal discharge □

Date of last Pap:_____

Have you had an irregular pap?_____ If yes, what was the date? _____

Age at first menses (period):_____ Age at last menses (If menopausal):_____

Are you menopausal Y/N

Currently pregnant or trying Y/N

Currently breast feeding Y/N

Do you practice birth control Y/N If yes, what type? _____

Number of:

Pregnancies _____

Abortions _____

Miscarriages_____

Births _____

Breasts

Lumps □ Tenderness □ Nipple discharge □

Do you do self breast exams? Y/N

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Breakfast							
Lunch							
Dinner							
Other/ Snacks							

Consent Form

Full Legal Name: (Last, First, Middle Initial):_____

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

-Potential allergic reaction to supplements or herbs,

-Some aggravation of pre-existing symptoms as a part of healing when using homeopathic remedies

I understand the Naturopathic Doctor will answer any of my questions that I have, to the best of their ability.

I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to treatment by my naturopath. I understand this consent form will cover the entire course of treatment. I understand I am free to withdraw their consent and discontinue participation in these procedures at any time.

Signature of Patient/Guardian:_____

Date:_____