

Naturopathic Intake Form

Dr. Kim McKenzie, ND, DC

Please return these completed forms a week before your appointment via fax, mail or you can drop it off at the Centre. This allows Dr. McKenzie to review them thoroughly before your appointment, so that you can make the most of your time with him. Our mailing address and fax number is shown below, but if you received this form via e-mail, please note that you will not be able to reply to the e-mail that was used to send this. If you have any questions please feel free to call our office at any time.

Please note: We review the information on these forms very carefully, and need the time to do so. If they are submitted late, it places strains on our time, efforts and administrative procedures. Because of this, there is a \$25.00 rushed processing fee applied to submissions received later than 2 business days prior to your scheduled appointment time.

Patient Information

Name: _____ Referred by: _____

Address: _____ Occupation: _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: (M): _____ (D): _____ (Y): _____ Age: _____ Sex: _____

Phone (home): _____ Phone (business): _____

Phone (mobile): _____ e-mail: _____

Marital Status (circle) Single Married Separated Divorced Widowed

Number of children: _____ Ages of children: _____

If the patient is a child:

Mother's name: _____ Father's name _____

Parent's Occupations: Mother _____ Father _____

Mother's Employer: _____ Father's _____

Have you received **naturopathic** care previously? Y /N

If so, when? _____ Name of Practitioner: _____

For what reason? _____

Have you received **chiropractic** care previously? Y /N

If so, when? _____ Name of Practitioner: _____

For what reason? _____

Are you currently under the care of a medical doctor or other health care practitioner? Y/N

If yes, please name practitioner: _____

For what reason? _____

Statement of Acknowledgement

The health care system in Ontario is under scrutiny. In order to clarify our position as health care practitioners, and our mutual responsibilities in your health care, we ask for your cooperation in signing this statement of acknowledgement.

1. That you understand that Naturopathic and/or Chiropractic practitioners are not Medical Doctors; that we use non-invasive, natural methods of assessment and treatment of body dysfunctions.
2. That you understand that the methods utilized in this practice have a proven clinical foundation, yet may not be accepted practice by standard (allopathic) medicine.
3. That you understand that we are required by our licensing boards 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 accepted by the attending practitioner.
4. That you understand that treatment and/or referral to other health practitioners is based upon the assessment of your health revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation.
5. That you understand that the practitioner reserves the right to determine which cases fall outside their scope of practice, in which event an appropriate referral will be recommended.
6. That you are not an agent of any private or governmental agency attempting to gather information without so stating your intentions.
7. That you are accepting or rejecting this care of your own free will.
8. That you understand that the ultimate responsibility for your health care is your own, and that we are here to support you in this. We reserve the right to discontinue our services where it is apparent that your expectations and what we provide are not in agreement.
9. That you understand that fees are payable at the time of the appointment by the patient or guardian. There is a fee for completion of any insurance forms. 24 hours notice is required for appointment cancellation, otherwise you will be responsible for the full fee. Any special financial agreement may be made with your practitioner.

I, _____ have read, understood and acknowledge the above.
(print name)

Signature: _____ Date: _____
(guardian if applicable)

Naturopathic Informed Consent for Care by Dr. Kim McKenzie

Naturopathic and medical physicians, chiropractors, dentists and other primary care health practitioners are required to advise patients that there are or may be some risks associated with their treatments.

Naturopathic Medicine addresses the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration the physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used to stimulate the body's inherent healing capacity.

A number of different approaches are used by Dr. McKenzie which are in harmony with naturopathic principals. These include but may not be limited to: dietary guidance and nutritional supplementation, botanical or herbal medicines, homeopathy, oriental medicine and acupuncture, bio-energetic medicine, hydrotherapy, physical medicine and exercise recommendation and lifestyle counseling.

There are some health risks with treatment from Naturopathic Medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms and conditions from re-activation of the body's corrective healing capacities by homeopathic and energetic medicines.
- Allergic or hypersensitive reactions to herbs or supplements.
- Pain, bruising or other injury from venipuncture, intramuscular injections, soft tissue therapy or acupuncture needling.
- Fainting from acupuncture or accidental burning of the skin from the use of moxa.
- Rib dislocations or fractures or muscle and ligament sprains and strains following spinal adjustments.
- Injury to a vertebral artery following cervical (neck) spinal adjustments. Such injuries may cause a stroke, sometimes with serious neurological impairment or other serious injury. The chances of this happening are extremely remote-evaluated at less than 1 incident per 1 million treatment sessions.

It is now the policy of the Licensing Board of Drugless Therapy - Naturopathy requiring all Naturopaths to obtain this signed consent form from their patients. Please read and sign the following:

I request and consent to the performance of naturopathic procedures and therapies as found appropriate by Dr. McKenzie except for (please list any exceptions you want):

- I have discussed or have had the opportunity to discuss with Dr. McKenzie the nature and purpose of my naturopathic care and I consent to this care offered me.
- I do not expect Dr. McKenzie to be able to anticipate and explain all risks and complications and I rely on him to exercise good judgment during the carrying out of this care.
- I authorize Dr. McKenzie to treat my condition through the use of Naturopathic methods and I understand that the results of this approach treatment are not guaranteed.

I have read the above and consent. I have had the opportunity to ask questions about its content to my satisfaction. I intend this consent form to cover the entire course of my care from Dr. McKenzie. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Print name of Client

Signature of Client or Guardian

Print Name of Witness

Signature of Witness

Date

Confidential Health and Lifestyle Questionnaire

Please complete this questionnaire with care. Your answers will help us determine the most effective mode of care for you. Please print clearly throughout. Thank you.

Health History

- What is your main reason for being here?
- If there is a specific condition, how long has it been occurring? _____
- Have you had similar problems before? _____ If so, please explain below:

- Do you have any relatives with similar problems? _____ If so, who? _____
List any practitioners seen for this reason

- List diagnoses, types of treatments, medications, etc.

- List any medications you are presently taking and doses

- Have you had any x-rays in the last 3 years? _____ If so, please list areas

- Have you lost any days of work recently? _____ Please list dates

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

- When did you last feel well? _____
- Please indicate the occurrence of the following and give details and dates:
 - Hospitalization _____
 - Surgery _____
 - Accidents _____
 - Major illness _____
 - Loss of consciousness _____
 - Seizures _____

Lifestyle

- Birth date _____ Weight _____ Height _____ Blood type _____
- Are you satisfied with your present weight? _____
- Have you ever had a weight problem? _____
- Are you constipated? _____ Number of bowel movements a day _____
- Do you exercise regularly? _____ How often? _____
What type of program? _____
- What are the things which you find stressful?

- Do you meditate or use any relaxation exercise? _____
- Do you have regular sleeping habits? _____ How many hours per night? _____
Early riser? _____ Difficulty falling asleep? _____ Nightmares? _____
- Do you drink coffee? _____ No./Day _____ Black Tea? _____ No./ Day _____
- Do you smoke? _____ If yes, how long? _____ No./ Day _____ Inhale? _____
- Do you drink alcohol? _____ Daily amount _____ Weekly amount _____ Special occasions _____
What types? _____
- Do you have any hobbies? _____ If yes, please list _____

Family History

Is there a history of any of the following in your family? Please circle and then list relationship of family member.

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

Systems Survey

Please check the appropriate box for any of the following symptoms which you now have, or have had previously. We need as many facts as possible about your health to assist us in your care.

Occasional/Mild
Frequent/Moderate
Constant / Severe

- General**
- Alcoholism
 - Allergy
 - Cancer
 - Chills
 - Convulsions
 - Dizziness
 - Diabetes
 - Epilepsy
 - Fainting
 - Fatigue
 - Headache
 - Hyperactivity
 - Learning Disabilities
 - Loss of Sleep
 - Loss of Weight
 - Mental Disorders
 - Nervous/Depression
 - Neuralgia
 - Numbness
 - Sweats
 - Tremors

- Genito-Urinary**
- Bed-wetting
 - Blood in urine
 - Frequent urination
 - Inability to control Kidneys
 - Kidney Infection
 - Kidney Stones
 - Painful Urination
 - Prostate Trouble
 - Pus in Urine
 - Venereal Disease

- Women Only**
- Congested Breasts
 - Cramps of Backache
 - Excessive Menstrual Flow
 - Hot Flashes
 - Irregular Cycle
 - Lumps in Breast
 - Menopausal Symptoms
 - Painful Menstruation
 - Pre-Menstrual Tension
 - Vaginal Discharge
 - Yeast Infection

- Muscle & Joint**
- Arthritis
 - Bursitis
 - Foot Trouble
 - Hernia
 - Low Back Pain
 - Lumbago
 - Neck Pain/Stiffness
 - Pain Between Shoulders
 - Pain / Numbness in:
 - Shoulders
 - Arms
 - Elbows
 - Hands
 - Hips
 - Legs
 - Knees
 - Feet
 - Painful Tailbone
 - Poor Posture
 - Sciatica
 - Spinal Curvature
 - Swollen Joints

- Eyes, Ears, Nose & Throat**
- Asthma
 - Colds
 - Crossed Eyes
 - Deafness
 - Dental Decay
 - Earache
 - Ear Discharge
 - Ear Noises (clicking, ringing)
 - Enlarged Glands
 - Enlarged Thyroid
 - Eye Pain
 - Failing Vision
 - Far Sightedness
 - Gum Trouble
 - Hay Fever
 - Hoarseness
 - Nasal Obstruction
 - Near Sightedness
 - Nosebleeds
 - Sinus Infection
 - Sore Throat
 - Tonsillitis

- Cardiovascular**
- Hardening of Arteries
 - High Blood Pressure
 - Low Blood Pressure
 - Pain Over Heart
 - Poor Circulation
 - Rapid Heart Beat
 - Slow Heart Beat
 - Stroke
 - Swelling of Ankles

- Respiratory**
- Chest Pain
 - Chronic Cough
 - Difficult Breathing
 - Spitting-up Blood
 - Spitting-up Phlegm
 - Wheezing

- Gastro-Intestinal**
- Belching or Gas
 - Colitis
 - Colon Trouble
 - Constipation
 - Diarrhea
 - Difficult Digestion
 - Distension of Abdomen
 - Excessive Hunger
 - Gall Bladder Trouble
 - Hemorrhoids
 - Hepatitis
 - Intestinal Worms
 - Liver Trouble
 - Nausea
 - Pain Over Stomach
 - Poor Appetite
 - Ulcers
 - Vomiting
 - Vomiting of Blood

- Skin**
- Boils
 - Bruise Easily
 - Dryness
 - Hives or Allergy
 - Itching
 - Skin Eruptions/Rash
 - Varicose Veins

Day 3 Date: _____

Time	Food/Beverage	Symptoms

Day 4 Date: _____

Time	Food/Beverage	Symptoms

Day 5 Date: _____

Time	Food/Beverage	Symptoms

Day 6 Date: _____

Time	Food/Beverage	Symptoms

HEALTH APPRAISAL QUESTIONNAIRE

Name _____

Date _____

DIRECTIONS

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

0 = No or Rarely—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

1 = Occasionally—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = Often—Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Some questions require a YES or NO response: 0 = NO 8 = YES

PART I					
	No/Rarely	Occasionally	Often	Frequently	
SECTION A					
1. Indigestion, food repeats on you after you eat	0	1	4	8	
2. Excessive burping, belching and/or bloating following meals	0	1	4	8	
3. Stomach spasms and cramping during or after eating	0	1	4	8	
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	0	1	4	8	
5. Bad taste in your mouth	0	1	4	8	
6. Small amounts of food fill you up immediately	0	1	4	8	
7. Skip meals or eat erratically because you have no appetite	0	1	4	8	
Total points					
SECTION B					
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	0	1	4	8	
2. Feel hungry an hour or two after eating a good-sized meal	0	1	4	8	
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	0	1	4	8	
4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids	0	1	4	8	
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	0	1	4	8	
6. Digestive problems that subside with rest and relaxation	(0)No			(8)Yes	
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	0	1	4	8	
8. Feel a sense of nausea when you eat	0	1	4	8	
9. Difficulty or pain when swallowing food or beverage	0	1	4	8	
Total points					
SECTION C					
1. When massaging under your rib cage on your left side, there is pain, tenderness or soreness	0	1	4	8	
2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	0	1	4	8	
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	0	1	4	8	
4. Specific foods/beverages aggravate indigestion	0	1	4	8	
5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day	0	1	4	8	
PART II					
SECTION C (cont.)					
6. Stool odor is embarrassing	0	1	4	8	
7. Undigested food in your stool	0	1	4	8	
8. Three or more large bowel movements daily	0	1	4	8	
9. Diarrhea (frequent loose, watery stool)	0	1	4	8	
10. Bowel movement shortly after eating (within 1 hour)	0	1	4	8	
Total points					
SECTION D					
1. Discomfort, pain or cramps in your colon (lower abdominal area)	0	1	4	8	
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	0	1	4	8	
3. Generally constipated (or straining during bowel movements)	0	1	4	8	
4. Stool is small, hard and dry	0	1	4	8	
5. Pass mucus in your stool	0	1	4	8	
6. Alternate between constipation and diarrhea	0	1	4	8	
7. Rectal pain, itching or cramping	0	1	4	8	
8. No urge to have a bowel movement	(0)No			(8)Yes	
9. An almost continual need to have a bowel movement	(0)No			(8)Yes	
Total points					
SECTION D (cont.)					
1. When massaging under your rib cage on your right side, there is pain, tenderness or soreness	0	1	4	8	
2. Abdominal pain worsens with deep breathing	0	1	4	8	
3. Pain at night that may move to your back or right shoulder	0	1	4	8	
4. Bitter fluid repeats after eating	0	1	4	8	
5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods	0	1	4	8	
6. Throbbing temples and/or dull pain in forehead associated with overeating	0	1	4	8	
7. Unexplained itchy skin that's worse at night	0	1	4	8	
8. Stool color alternates from clay colored to normal brown	0	1	4	8	
9. General feeling of poor health	0	1	4	8	

PART II		No/Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise		0	1	4	8
11. Retain fluid and feel swollen around the abdominal area		0	1	4	8
12. Reddened skin, especially palms		0	1	4	8
13. Very strong body odor		0	1	4	8
14. Are you embarrassed by your breath?		0	1	4	8
15. Bruise easily	(0)No (8)Yes				
16. Yellowish cast to eyes	(0)No (8)Yes				
Total points					

PART III		No/Rarely	Occasionally	Often	Frequently
SECTION A					
1. Feel cold or chilled—hands, feet or all over—for no apparent reason		0	1	4	8
2. Your upper eyelids look swollen		0	1	4	8
3. Muscles are weak, cramp and/or tremble		0	1	4	8
4. Are you forgetful?		0	1	4	8
5. Do you feel like your heart beats slowly?		0	1	4	8
6. Reaction time seems slowed down		0	1	4	8
7. In general, are you disinterested in sex because your desire is low?		0	1	4	8
8. Feel slow-moving, sluggish		0	1	4	8
9. Constipation		0	1	4	8
10. Dryness, discoloration of skin and/or hair	(0)No (8)Yes				
11. Have you noticed recently that your voice is deepening?	(0)No (8)Yes				
12. Thick, brittle nails	(0)No (8)Yes				
13. Weight gain for no apparent reason	(0)No (8)Yes				
14. Outer third of your eyebrow is thinning or disappearing	(0)No (8)Yes				
15. Swelling of the neck	(0)No (8)Yes				
Total points					

SECTION B					
1. Lingering mild fatigue after exertion or stress		0	1	4	8
2. Do you find that you get tired and exhaust easily?		0	1	4	8
3. Craving for salty foods		0	1	4	8
4. Sensitive to minor changes in weather and surroundings		0	1	4	8
5. Dizzy when rising or standing up from a kneeling position		0	1	4	8
6. Dark bluish or black circles under your eyes		0	1	4	8
7. Have bouts of nausea with or without vomiting		0	1	4	8
8. Catch colds or infections easily	(0)No (8)Yes				
9. Wounds heal slowly	(0)No (8)Yes				
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful		0	1	4	8
11. Feel puffy and swollen all over your body		0	1	4	8
12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements	(0)No (8)Yes				
Total points					

PART IV		No/Rarely	Occasionally	Often	Frequently
SECTION A					
When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?					
1. A sense of weakness		0	1	4	8
2. A sudden sense of anxiety when you get hungry		0	1	4	8
3. Tingling sensation in your hands		0	1	4	8
4. A sensation of your heart beating too quickly or forcefully		0	1	4	8
5. Shaky, jittery, hands trembling		0	1	4	8
6. Sudden profuse sweating and/or your skin feels clammy		0	1	4	8
7. Nightmares possibly associated with going to bed on an empty stomach		0	1	4	8
8. Wake up at night feeling restless		0	1	4	8
9. Agitation, easily upset, nervous		0	1	4	8
10. Poor memory, forgetful		0	1	4	8
11. Confused or disoriented		0	1	4	8
12. Dizzy, faint		0	1	4	8
13. Cold or numb		0	1	4	8
14. Mild headaches or head pounding		0	1	4	8
15. Blurred vision or double vision		0	1	4	8
16. Feel clumsy and uncoordinated		0	1	4	8
Total points					

SECTION B					
1. Frequent urination during the day and night		0	1	4	8
2. Unusual thirst—feeling like you can't drink enough water		0	1	4	8
3. Unusual hunger—eating all the time		0	1	4	8
4. Vision blurs		0	1	4	8
5. Feel itchy all over		0	1	4	8
6. Tingling or numbness in your feet		0	1	4	8
7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping		0	1	4	8
8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing weight	(0)No (8)Yes				
9. Sores heal slowly	(0)No (8)Yes				
10. Loss of hair on your legs	(0)No (8)Yes				
Total points					

PART V		No/Rarely	Occasionally	Often	Frequently
SECTION A					
1. Feel jittery		0	1	4	8
2. First effort of the day causes pain, pressure, tightness or heaviness around the chest		0	1	4	8
3. Exhaustion with minor exertion		0	1	4	8
4. Heavy sweating (no exertion, no hot flashes)		0	1	4	8
5. Difficulty catching breath, especially during exercise		0	1	4	8
6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly		0	1	4	8
7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason		0	1	4	8
Total points					

PART V (cont.)		No/Rarely	Occasionally	Often	Frequently
SECTION B					
1. Muscle pain at rest	0	1	4	8	
2. Cramp-like pains in your ankles, calves or legs	0	1	4	8	
3. Numbness, tingling and prickling sensation in hands and feet	0	1	4	8	
4. Cold feet and/or toes appear blue	0	1	4	8	
5. Brief moments of hearing loss	0	1	4	8	
6. Nausea comes and goes quickly (unrelated to eating)	0	1	4	8	
7. Feel worse standing: legs get heavy and fatigued	0	1	4	8	
8. Leg discomfort or fatigue relieved by elevating legs	0	1	4	8	
9. Fingers and toes get numb in cold weather even when protected	0	1	4	8	
10. Notice changes in your ability to feel pain or differentiate between sensations of hot or cold	(0)No		(8)Yes		
11. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared	(0)No		(8)Yes		
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?	(0)No		(8)Yes		
Total points					
PART VI					
SECTION A					
1. Family, friends, work, hobbies or activities you hold dear are no longer of interest	0	1	4	8	
2. Do you cry?	0	1	4	8	
3. Does life look entirely hopeless?	0	1	4	8	
4. Would you describe yourself as feeling miserable and sad, unhappy or blue?	0	1	4	8	
5. Do you find it hard to make the best of difficult situations?	0	1	4	8	
6. Sleep problems—too much or too little sleep	0	1	4	8	
7. Changes in your appetite and weight	(0)No		(8)Yes		
8. Lately you've noticed an inability to think clearly or concentrate	(0)No		(8)Yes		
9. Difficulty making decisions and/or clarifying and achieving your goals	(0)No		(8)Yes		
Total points					
SECTION B					
1. Does worrying get you down?	0	1	4	8	
2. Does every little thing get on your nerves and wear you out?	0	1	4	8	
3. Would you consider yourself a nervous person?	0	1	4	8	
4. Do you feel easily agitated?	0	1	4	8	
5. Do you shake and tremble?	0	1	4	8	
6. Are you keyed up and jittery?	0	1	4	8	
7. Do you tremble or feel weak when someone shouts at you?	0	1	4	8	
8. Do you become scared at sudden movements or noises at night?	0	1	4	8	
9. Do you find yourself sighing a lot?	0	1	4	8	
10. Are you awakened out of your sleep by frightening dreams?	0	1	4	8	
11. Do frightening thoughts keep coming back in your mind?	0	1	4	8	
PART VII					
SECTION B (cont.)					
12. Do you become suddenly scared for no reason?	0	1	4	8	
13. Do you break out in a cold sweat?	0	1	4	8	
14. "Butterflies in your stomach," nausea and/or diarrhea	0	1	4	8	
Total points					
SECTION C					
1. Do you feel pent up and ready to explode?	0	1	4	8	
2. Are you prone to noisy and emotional outbursts?	0	1	4	8	
3. Do you do things on impulse?	0	1	4	8	
4. Are you easily upset or irritated?	0	1	4	8	
5. Do you go to pieces if you don't control yourself?	0	1	4	8	
6. Do little annoyances get on your nerves and make you angry?	0	1	4	8	
7. Does it make you angry to have anyone tell you what to do?	0	1	4	8	
8. Do you flare up in anger if you can't have what you want right away?	0	1	4	8	
Total points					
SECTION A					
1. Eyes water or tear	0	1	4	8	
2. Mucus discharge from the eyes	0	1	4	8	
3. Ears ache, itch, feel congested or sore	0	1	4	8	
4. Discharge from ears	0	1	4	8	
5. Is your nose continually congested?	0	1	4	8	
6. Are you prone to loud snoring?	(0)No		(8)Yes		
7. Does your nose run?	0	1	4	8	
8. Nosebleeds	(0)No		(8)Yes		
9. Hoarse voice	0	1	4	8	
10. Do you have to clear your throat?	0	1	4	8	
11. Do you feel a choking lump in your throat?	0	1	4	8	
12. Do you suffer from severe colds?	(0)No		(8)Yes		
13. Do frequent colds keep you miserable all winter?	(0)No		(8)Yes		
14. Flu symptoms last longer than 5 days	(0)No		(8)Yes		
15. Do infections settle in your lungs?	(0)No		(8)Yes		
16. Chest discomfort or pain	0	1	4	8	
17. Do you experience sudden breathing difficulties?	0	1	4	8	
18. Do you struggle with shortness of breath?	0	1	4	8	
19. Difficulty exhaling (breathing out)	0	1	4	8	
20. Breathlessness followed by coughing during exertion, no matter how slight	0	1	4	8	
21. Inability to breathe comfortably while lying down	0	1	4	8	
22. Do you cough up lots of phlegm?	0	1	4	8	
23. Can you hear noisy rattling sounds when breathing in and out?	0	1	4	8	
24. Are you troubled with coughing?	0	1	4	8	
25. Do you wheeze?	0	1	4	8	
26. Do you have severe soaking sweats at night?	0	1	4	8	
27. Do your lips and/or nails have a bluish hue?	0	1	4	8	
28. Are you sleepy during the day?	0	1	4	8	

PART VII (cont.)		No/Rarely	Occasionally Often	Frequently
29. Do you have difficulty concentrating?		0	1 4	8
30. Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products	(0)No (8)Yes			
31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal changes	(0)No (8)Yes			
Total points				

PART VIII		No/Rarely	Occasionally Often	Frequently
1. Involuntary loss of urine when you cough, lift something or strain during an activity		0	1 4	8
2. Mild lower back ache or pain		0	1 4	8
3. Abdominal achiness or pain		0	1 4	8
4. Pain or burning when urinating		0	1 4	8
5. Rarely feel the urge to urinate		0	1 4	8
6. Feel the need to urinate less than every two hours during the day or night		0	1 4	8
7. Strong smelling urine		0	1 4	8
8. Back or leg pains are associated with dripping after urination		0	1 4	8
9. Sore or painful genitals		0	1 4	8
10. Urine is a rose color		0	1 4	8
11. Sudden urge to void causes involuntary loss of urine		0	1 4	8
12. Generalized sense of water retention throughout your body		0	1 4	8
Total points				

PART IX		No/Rarely	Occasionally Often	Frequently
SECTION A				
1. Bones throughout your entire body ache, feel tender or sore		0	1 4	8
2. Localized bone pain		0	1 4	8
3. Hands, feet or throat get tight, spasm or feel numb		0	1 4	8
4. Difficulty sitting straight		0	1 4	8
5. Upper back pain		0	1 4	8
6. Lower back pain		0	1 4	8
7. Pain when sitting down or walking		0	1 4	8
8. Find yourself limping or favoring one leg		0	1 4	8
9. Shins hurt during or after exercise		0	1 4	8
Total points				

SECTION B				
1. Are you stiff in the morning when you wake up?		0	1 4	8
2. Difficulty bending down and picking up clothing or anything from the floor		0	1 4	8
3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees or ankles)		0	1 4	8
4. Joints hurt when moving or when carrying weight		0	1 4	8
5. A routine exercise program, like daily walking, causes your knees to swell or hurt		0	1 4	8
6. Difficulty opening jars that were previously easy to open		0	1 4	8
7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm		0	1 4	8

SECTION B (cont.)		No/Rarely	Occasionally Often	Frequently
8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder		0	1 4	8
9. Difficulty chewing food or opening mouth		0	1 4	8
10. Difficulty standing up from a sitting position		0	1 4	8
11. Shooting, aching, tingling pain down the back of leg		0	1 4	8
12. Is it difficult to reach up and get a 5-pound object like a bag of flour from just above your head?	(0)No (8)Yes			
13. Injure, strain or sprain easily	(0)No (8)Yes			
Total points				

SECTION C		No/Rarely	Occasionally Often	Frequently
1. Muscles stiff, sore, tense and/or achy		0	1 4	8
2. Burning, throbbing, shooting or stabbing muscle pain		0	1 4	8
3. Muscle cramps or spasms (involuntary or after exertion/exercise)		0	1 4	8
4. Is muscle pain or stiffness greater in the morning than other times of the day?		0	1 4	8
5. Specific points on body feel sore when pressed		0	1 4	8
6. Feel unrefreshed upon awakening		0	1 4	8
7. Headaches		0	1 4	8
8. Pain at the sides of your head or in your face especially when awakening		0	1 4	8
9. Your jaw clicks or pops		0	1 4	8
10. Muscle twitch or tremor—eyelids, thumb, calf muscle		0	1 4	8
11. Irresistible urge to move legs		0	1 4	8
12. Legs move during sleep		0	1 4	8
13. Unpleasant crawling sensation inside calves when lying down		0	1 4	8
14. Hand and wrist numbness or pain (e.g., interferes with writing or with buttoning or unbuttoning your clothes)		0	1 4	8
15. Feeling of "pins and needles" in your thumb and first three fingers		0	1 4	8
16. Pain in forearm and sometimes in shoulder		0	1 4	8
Total points				

PART X		No/Rarely	Occasionally Often	Frequently
SECTION A				
1. Head feels heavy		0	1 4	8
2. Dizziness		0	1 4	8
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side		0	1 4	8
4. Your hands tremble, ever so slightly, for no apparent reason		0	1 4	8
5. You feel like you're wearing heavy weights on your feet when walking		0	1 4	8
6. Bump into things, trip, stumble and feel clumsy		0	1 4	8
7. Difficulty breathing		0	1 4	8
8. Difficulty swallowing		0	1 4	8
9. People tell you to speak up because they have trouble hearing you		0	1 4	8
10. Speaking and forming words does not feel automatic		0	1 4	8
11. Need 10-12 hours of sleep to feel rested		0	1 4	8

PART X (cont.)

SECTION A (cont.)

	No/Rarely	Occasionally	Often	Frequently
12. Lack strength (your grip is weak, holding your head or picking your arms up takes effort)	0	1	4	8
13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be	(0)No	(8)Yes		
14. Muscles in arms and legs seem softer and smaller	(0)No	(8)Yes		
15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be?	(0)No	(8)Yes		
16. Do you find yourself moving slower than you used to?	(0)No	(8)Yes		

Total points

SECTION B

1. Difficulty absorbing new information	0	1	4	8
2. Tend to forget things	0	1	4	8
3. Trouble thinking or concentrating	0	1	4	8
4. Easily distracted	0	1	4	8
5. Do you have a tendency to become frustrated quickly?	0	1	4	8
6. Inability to sit still for any length of time, even at mealtime	0	1	4	8
7. Finishing tasks is easier said than done	0	1	4	8
8. Do you have more trouble solving problems or managing your time than usual?	0	1	4	8
9. Low tolerance for stress and otherwise ordinary problems	0	1	4	8

Total points

PART XI

Men Only

1. Sensation of not emptying your bladder completely	0	1	4	8
2. Need to urinate less than 2 hours after you have finished urinating	0	1	4	8
3. Find yourself needing to stop and start again several times while urinating	0	1	4	8
4. Find it difficult to postpone urination	0	1	4	8
5. Have a weak urinary stream	0	1	4	8
6. Need to push or strain to begin urinating	0	1	4	8
7. Dripping after urination	0	1	4	8
8. Urge to urinate several times a night	0	1	4	8

Total points

PART XII

Women Only

(Menopausal women should skip to Sections E and F)

SECTION A

Do you persistently experience any of these symptoms within three days to two weeks prior to menstruation?

[A]

1. Anxious, irritable or restless	(0)No	(8)Yes		
2. Numbness, tingling in hands and feet	(0)No	(8)Yes		
3. Easy to anger, resentful	(0)No	(8)Yes		
4. Aggressive or hostile toward family/friends	(0)No	(8)Yes		

Total points

SECTION A (cont.)

[B]

5. Abdominal bloating, feeling swollen (e.g., feet)	(0)No	(8)Yes		
6. Temporary weight gain	(0)No	(8)Yes		
7. Breast tenderness, swelling	(0)No	(8)Yes		
8. Appearance of breast lumps	(0)No	(8)Yes		
9. Discharge from nipples	(0)No	(8)Yes		
10. Nausea and/or vomiting	(0)No	(8)Yes		
11. Diarrhea or constipation	(0)No	(8)Yes		
12. Aches and pains (back, joints, etc.)	(0)No	(8)Yes		

[C]

13. Craving for sweets	(0)No	(8)Yes		
14. Increased appetite or binge eating	(0)No	(8)Yes		
15. Headaches	(0)No	(8)Yes		
16. Being easily overwhelmed, shaky or clumsy	(0)No	(8)Yes		
17. Heart pounding	(0)No	(8)Yes		
18. Dizziness or fainting	(0)No	(8)Yes		

[D]

19. Confused and forgetful to the point that work suffers	(0)No	(8)Yes		
20. Overwhelmed with feelings of sadness and worthlessness	(0)No	(8)Yes		
21. Difficulty sleeping or falling asleep	(0)No	(8)Yes		
22. Engaging in self-destructive behavior	(0)No	(8)Yes		

Total points

SECTION B

Do you experience any of these symptoms during your period?

1. Cramping in lower abdomen or pelvic area	(0)No	(8)Yes		
2. Lower abdominal pain is sharp and/or dull or intermittent	(0)No	(8)Yes		
3. Bloating and sense of abdominal fullness	(0)No	(8)Yes		
4. Diarrhea or constipation	(0)No	(8)Yes		
5. Nausea and/or vomiting	(0)No	(8)Yes		
6. Low back and/or legs ache	(0)No	(8)Yes		
7. Headaches	(0)No	(8)Yes		
8. Unusual fatigue (take naps) resulting in missed work	(0)No	(8)Yes		
9. Painful and/or swollen breasts	(0)No	(8)Yes		
10. Scanty blood flow	(0)No	(8)Yes		

Total points

SECTION C

1. Painful or difficult sexual intercourse	0	1	4	8
2. Low abdominal, back and vaginal pain throughout the month	0	1	4	8
3. Pelvic pressure or pain while sitting down or standing up, relieved by lying down	0	1	4	8
4. Vaginal bleeding other than during your period	0	1	4	8
5. Painful bowel movements	0	1	4	8
6. Difficult (straining) urination	0	1	4	8
7. Abnormal vaginal discharge	0	1	4	8
8. Offensive vaginal discharge	0	1	4	8
9. Vaginal itching or burning with or without intercourse	0	1	4	8
10. Pain during periods is getting progressively worse	(0)No	(8)Yes		
11. Profuse or prolonged menstrual bleeding	(0)No	(8)Yes		
12. Unable to get pregnant	(0)No	(8)Yes		

Total points

PART XII (cont.)

SECTION D

	No/Rarely	Occasionally	Often	Frequently
1. Absence of periods for six months or longer	(0)No			(8)Yes
2. Periods occur irregularly (e.g., 3 to 6 times a year)	(0)No			(8)Yes
3. Profuse heavy bleeding during periods	0	1	4	8
4. Menstrual blood contains clots and tissue	0	1	4	8
5. Bleeding between periods can occur anytime	0	1	4	8
6. Periods occur greater than every 35 days	(0)No			(8)Yes
7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)	0	1	4	8
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)	0	1	4	8
9. Monthly abdominal pain without bleeding	0	1	4	8
10. Abundant cervical mucus	0	1	4	8
11. Acne and/or oily skin	0	1	4	8
12. Overwhelming urges for sexual intercourse	0	1	4	8
13. Aggressive feelings	0	1	4	8
14. Increased growth of dark facial and/or body hair	(0)No			(8)Yes
15. Poor sense of smell	(0)No			(8)Yes
16. Voice is becoming deeper	(0)No			(8)Yes
17. Breasts seem to be getting smaller	(0)No			(8)Yes
18. Receding hairline	(0)No			(8)Yes

Total points

SECTION E

1. Vaginal discharge	0	1	4	8
2. Vaginal secretions are watery and thin	0	1	4	8
3. Vaginal dryness	0	1	4	8
4. Sexual intercourse is uncomfortable	0	1	4	8

SECTION E (cont.)

	No/Rarely	Occasionally	Often	Frequently
5. Interest in having sex is low	0	1	4	8
6. Engorged breasts	0	1	4	8
7. Breast tenderness, soreness	0	1	4	8
8. Difficulty with orgasm	0	1	4	8
9. Vaginal bleeding after sexual intercourse	0	1	4	8
10. Do you skip periods?	(0)No			(8)Yes
11. The length (number of days) of your period varies month to month, with the number of days of bleeding getting fewer	(0)No			(8)Yes

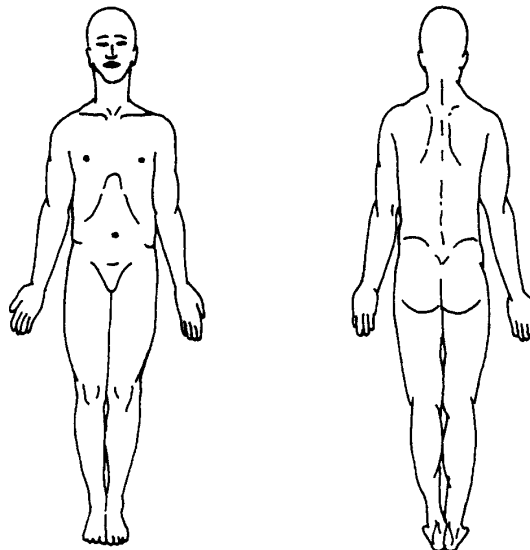
Total points

SECTION F

1. Sense of well-being fluctuates throughout the day for no apparent reason	0	1	4	8
2. Sudden hot flashes	0	1	4	8
3. Spontaneous sweating	0	1	4	8
4. Chills	0	1	4	8
5. Cold hands and feet	0	1	4	8
6. Heart beats rapidly or feels like it is fluttering	0	1	4	8
7. Numbness, tingling or prickling sensations	0	1	4	8
8. Dizziness	0	1	4	8
9. Mental foginess, forgetful or distracted	0	1	4	8
10. Inability to concentrate	0	1	4	8
11. Depression, anxiety, nervousness and/or irritability	0	1	4	8
12. Difficulty sleeping	0	1	4	8
13. Conscious of new feelings of anger and frustration	0	1	4	8
14. Skin, hair, vagina and/or eyes feel dry	0	1	4	8
15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding	(0)No			(8)Yes

Total points

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.



A Few Things to Know Before Visiting Us

(Please detach these last 3 sheets and keep for your own reference)

Chemical Allergies

Many people who visit (and work at) the West End Health Centre have chemical allergies. These allergies can be triggered by perfume, cologne, hand cream, after-shave, cigarette smoke, hairspray etc. These reactions can range from mild to very severe. We ask that you avoid wearing any products that may cause an allergic reaction when you are at the centre. This includes clothing items that have perfume or cologne on them, that was applied days before your visit without being washed. We thank you for helping us to make the Centre a safe environment for everyone.

Footwear at the Centre

Everyone visiting the Centre is asked to remove their outdoor footwear upon entering. This helps us to minimize outdoor pollutants and grime in the office. You will be allowed to walk around the centre in your socks, but bare feet are not allowed. We will provide you with clean “booties” if you arrive in footwear that does not require socks (such as sandals) or you can bring along your own pair of socks if you wish.

Parking

Metered parking can be found on the streets around the Centre, including Dundas St. directly in front of the Centre. The cost is very reasonable. There is also a metered parking lot located on the East side of Keele St. just South of Dundas St. (across from the Fire Station).

Directions and Map

See next page for 2 maps showing the location of the Centre.

Directions from 401

Take 401 to the Black Creek Drive exit (near Hwy. 400). Continue South on Black Creek Drive until you reach Weston Rd. (approximately 5 km). Turn left onto Weston Rd. After about 1.5 km, the name of the road changes to Keele St. Continue along Keele St. approximately 1 km until you reach Dundas St. Turn left on Dundas and you will find the Health Centre on the left-hand side a few hundred feet from the corner of Dundas and Keele. The address is 2826 Dundas St. and our phone number is (416) 763-3211.

Directions from QEW/Gardiner Expressway Eastbound

Take the QEW/Gardiner and exit onto Lakeshore Blvd./Hwy. 2. Continue along Lakeshore Blvd. until you get to Parkside Drive. Drive North on Parkside Drive. After about 2 km, Parkside Drive's name changes to Keele St. (at Bloor) Continue North along Keele St. for approximately 1.25 km until you reach Dundas St. Turn right on Dundas St. and you will find the Health Centre on the left-hand side a few hundred feet from the corner of Dundas and Keele. The address is 2826 Dundas St. and our phone number is (416) 763-3211.

Directions from QEW/Gardiner Expressway Westbound

Take the Gardiner Expressway and exit onto Dunn St., go up the ramp to Lakeshore Blvd and continue along Lakeshore Blvd. until you get to Parkside Drive. Drive North on Parkside Drive. After about 2km, Parkside Road's name changes to Keele St. (at Bloor) Continue North along Keele St. for approximately 1.25 km until you reach Dundas St. Turn right on Dundas St. and you will find the Health Centre on the left-hand side a few hundred feet from the corner of Dundas and Keele. The address is 2826 Dundas St. and our phone number is (416) 763-3211.

Appointment Fees ⁽¹⁾ (Effective July 1, 2010)

Initial Consultation & Examination	# of time units*	Fee (including HST)
Naturopathic ⁽²⁾	6 units	\$334.50+\$43.50 = \$378.00
Report of Findings ⁽³⁾	3 units	\$184.50 + \$24.00 = \$208.50
Chiropractic	2 units	\$130.00 (HST exempt)

Subsequent Visits	# of time units*	Fee (including HST)
Naturopathic	1 unit	\$61.50 + 8.00 = \$69.50
	2 units	\$123.00 + \$16.00 = \$139.00
	3 units	\$184.50 + 24.00 = \$208.50
	4 units	\$246.00 + \$32.00 = \$278.00
Naturopathic Extended ⁽⁴⁾	1 unit	\$79.65 + 10.35 = \$90.00
Chiropractic	1 unit	\$61.50
	2 units	\$123.00

Additional Services	# of time units*	Fee (including HST)
Remedies		Priced Individually
Computerized Microcurrent	1 unit	\$25.00
Far Infrared Therapy	1 unit	\$10.00
Energy Balancing/Detox Footbath		\$35.00 each or a series of 10 for \$285.00
Body Composition Analysis		\$15.00
Hair Mineral Analysis, Elisa Allergy Testing and other outsourced blood, saliva, hormone etc. tests		Priced Individually

* 1 unit is booked per 15 minute interval.

(1) Certain extended health insurance plans contribute to these fees. Please enquire at your place of work. Please note that all of our fees, where applicable, have the HST included. Chiropractic services are exempt from HST.

(2) Initial naturopathic visit includes: Consultation, physical examination, assessments with applied kinesiology (muscle testing), traditional oriental medicine, N.E.S. reading and iridology. Blood type testing can be done if this is an unknown.

(3) Naturopathic report of findings includes review of all findings and assessments, urine analysis, and the initiation of recommendations and therapies.

(4) Extended visits include: Additional time requirements or services added beyond the scheduled visit (such as reading other lab or x-ray reports or internet review)

Payment

Payment is due at the end of each appointment. For your convenience, you may pay using Cash, Interac, Visa, MasterCard or personal cheque. Please discuss any special financial circumstances with Dr. McKenzie.

Please note: Chiropractic fees are no longer covered by OHIP effective December 1st, 2004.