REJUV-INNATE
NATUROPATHIC
CLINIC

Section A: Contact Information

Full Name: _____Today's Date: _____
(Last) (First)

Date of Birth: _____Year _____Month ____Day Age: ____ Sex: ___ Male ____Female

Height: _____ Weight: _____ Marital Status: _____

Occupation:
_____

Address_____ City_____ Prov. _____

Postal Code _____

Telephone: Home _____ Work _____ Cell _____

Would you like to sign up for our E-Newsletter _____Yes _____ No Initial: ____

Email Address:
_____

Do you have extended health benefits: _____Yes _____ No

Are you here from an injury from car or work related accident? _____ Yes _____No

Work related Injury: _____ Car Accident: _____

Are you involved in an ICBC or WCB claim? ____Yes ____No _____

Date of accident/injury: _____

Please give dates of missed work due to the accident or injury:
_____

_____

Emergency Contact Name: _____ Relationship:

_____ Telephone: Home_____ Work

_____ Cell _____

How did you hear about Rejuv-Innate Naturopathic Clinic?

_____ Referred by: _____

Section B: Current Health Condition

What are your health concerns, in order of importance?

1.

2.

3.

When did these conditions begin?

_____

List all prescribed medications including (Dose, Frequency, and duration):

_____

List any medication allergies_____

Have you been on antibiotics in the last year? ___Yes ___ No Number of times if yes _____

Please list your medications:

_____

How many days a week do you exercise? _____

Do you have any food allergies or intolerances? ____ Yes ____No

If yes, please list

_____

Do you have any dietary restrictions (Dairy/ Wheat/Vegetarian/ Vegan etc.)?

_____

How stressful is work or other aspects of your life? _____

_____

Section C: Past Health History

List any major operations:

_____

List any major accidents/falls:

_____

Hospitalization (other than above):

_____

Have you been treated for any major health condition in the last year: _____ Yes _____ No

If yes, please explain:

_____

_____

Does anyone else in your family have the same or similar conditions? ____Yes _____No

Check any of the following that apply to you:

☐ Pneumonia	☐ Small Pox	☐ Mumps	☐ Hepatitis	☐ Rheumatic Fever
☐ Pleurisy	☐ Polio	☐ Arthritis	☐ Chicken Pox	☐ Diabetes
☐ Tuberculosis	☐ Whooping Cough		☐ Thyroid	☐ Influenza
☐ Lumbago	☐ Measles			

GENERAL HEALTH	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent Severe
Fatigue, lack of energy, lack of stamina	□ 0	□ 1	□ 2	□ 3
Need to decrease or alter activities of daily living due to Fatigue, pain, or illness	□ 0	□ 1	□ 2	□ 3
Insomnia, lack of sleep	□ 0	□ 1	□ 2	□ 3
Excessive tiredness and increased need for sleep	□ 0	□ 1	□ 2	□ 3
Tired and/or not hungry after waking	□ 0	□ 1	□ 2	□ 3
Pain at night, night sweats	□ 0	□ 1	□ 2	□ 3
Enlarged Lymph lodes	□ 0	□ 1	□ 2	□ 3
Frequent infections	□ 0	□ 1	□ 2	□ 3
Undesired weight loss	□ 0	□ 1	□ 2	□ 3
Undesired weight gain, difficulty losing weight	□ 0	□ 1	□ 2	□ 3
Cold hands or feet	□ 0	□ 1	□ 2	□ 3
Compulsive/binge eating, increased appetite	□ 0	□ 1	□ 2	□ 3
Decreased appetite	□ 0	□ 1	□ 2	□ 3
Hypoglycemia, low blood sugar	□ 0	□ 1	□ 2	□ 3
Allergies to food or environment	□ 0	□ 1	□ 2	□ 3
Sensitivity to fumes, chemicals, odors, exhaust	□ 0	□ 1	□ 2	□ 3
Have you been tested for iron disorders?	□ **NO**	□ **YES**		
Past diagnosis of serious illness or chronic health Condition such a systemic disease, cancer, HIV, mental condition, heart disease, infection, kidney problems, or other condition	□ **NO**	□ **YES**		
MUSCLES AND JOINTS	**Very rare-None**	**Occasional-Mild**	**Intermittent-Moderate**	**Frequent Severe**
Pain, swelling, or limited motion in joint(s)	□ 0	□ 1	□ 2	□ 3
Pain, swelling, or weakness in muscles(s)	□ 0	□ 1	□ 2	□ 3
Cramps in muscles, grind teeth at night?	□ 0	□ 1	□ 2	□ 3
Other problem, concerns, or questions in this area?	□ 0	□ 1	□ 2	□ 3
HEAD AND MIND	**Very rare-None**	**Occasional-Mild**	**Intermittent-Moderate**	**Frequent Severe**
Headaches	□ 0	□ 1	□ 2	□ 3
Feeling or pressure inside head	□ 0	□ 1	□ 2	□ 3
Faintness, loss of consciousness	□ 0	□ 1	□ 2	□ 3
Dizziness	□ 0	□ 1	□ 2	□ 3
Seizure, epilepsy	□ 0	□ 1	□ 2	□ 3

Difficulty thinking or processing information; confusion	□ 0	□ 1	□ 2	□ 3
Difficulty with concentrating or maintaining attention	□ 0	□ 1	□ 2	□ 3
Poor memory	□ 0	□ 1	□ 2	□ 3
Difficulty speaking or talking, slurred speech	□ 0	□ 1	□ 2	□ 3
Hyperactivity	□ 0	□ 1	□ 2	□ 3
Learning difficulties, dyslexia	□ 0	□ 1	□ 2	□ 3
Other problem, concern, or question in this area?	□ **NO**	□ **YES**		
Additional notes or comments:				
EMOTIONS AND SOCIAL HEALTH	**Very rare-None**	**Occasional-Mild**	**Intermittent-Moderate**	**Frequent Severe**
Depression, sadness	□ 0	□ 1	□ 2	□ 3
Anger, irritability, sadness	□ 0	□ 1	□ 2	□ 3
Stressful situations	□ 0	□ 1	□ 2	□ 3
Apathy, lack of interest or concern	□ 0	□ 1	□ 2	□ 3
Use of alcohol, herbs, drugs or medications to help manage emotions				
Isolation, few friends, distant family	□ 0	□ 1	□ 2	□ 3
Problems with employer(s) or coworkers(s)	□ 0	□ 1	□ 2	□ 3
Sadness or recurrent problems from childhood or past events	□ 0	□ 1	□ 2	□ 3
Recent or current thoughts of suicide?	□ **NO**	□ **YES**		
Diagnosed mental condition such as bipolar, schizophrenia, or other condition	□ **NO**	□ **YES**		
Other problem, concern, or question in this area?	□ **NO**	□ **YES**		
EYES	**Very rare-None**	**Occasional-Mild**	**Intermittent-Moderate**	**Frequent Severe**
Watery, red, or itchy eyes	□ 0	□ 1	□ 2	□ 3
Dark circles under eyes	□ 0	□ 1	□ 2	□ 3
Decrease or loss of vision; cataracts, or glaucoma	□ 0	□ 1	□ 2	□ 3
Poor night vision, night blindness	□ 0	□ 1	□ 2	□ 3
Pain in eye(s)	□ 0	□ 1	□ 2	□ 3
Pain near or behind eye(s)	□ 0	□ 1	□ 2	□ 3
Other problem, concern or question in this area?	□ **NO**	□ **YES**		

MOUTH, NOSE AND THROAT	Very rare-None	Occasional-Mild	Intermittent-Moderate	Frequent Severe
Swollen or tender tongue or gums	□ 0	□ 1	□ 2	□ 3
Decreased sense of taste or smell	□ 0	□ 1	□ 2	□ 3
Stuffy nose, nasal congestion	□ 0	□ 1	□ 2	□ 3
Sinus infections, sinus pain	□ 0	□ 1	□ 2	□ 3
Nasal Polyps	□ 0	□ 1	□ 2	□ 3
Ulcers or sores in mouth or lips, oral herpes	□ 0	□ 1	□ 2	□ 3
Allergies/sneezing, sinus pain	□ 0	□ 1	□ 2	□ 3
Excessive mucus formation	□ 0	□ 1	□ 2	□ 3
Drainage to back of throat	□ 0	□ 1	□ 2	□ 3
Sore throat	□ 0	□ 1	□ 2	□ 3
Cough or wheeze	□ 0	□ 1	□ 2	□ 3
Change in voice	□ 0	□ 1	□ 2	□ 3
Hoarseness, loss of voice	□ 0	□ 1	□ 2	□ 3
Other problem, concern or question in this area?	□ NO	□ YES		
LUNGS AND HEART	**Very rare-None**	**Occasional-Mild**	**Intermittent-Moderate**	**Frequent Severe**
Pain in left arm and/or left side or neck of face	□ 0	□ 1	□ 2	□ 3
Shortness of breath, difficulty breathing	□ 0	□ 1	□ 2	□ 3
Irregular heartbeat	□ 0	□ 1	□ 2	□ 3
Rapid or pounding heartbeat	□ 0	□ 1	□ 2	□ 3
Chest congestion, bronchitis	□ 0	□ 1	□ 2	□ 3
Asthma	□ 0	□ 1	□ 2	□ 3
Medications for lungs or heart	□ 0	□ 1	□ 2	□ 3
Current or past cigarette smoking or tobacco use	□ 0	□ 1	□ 2	□ 3
Pain in Chest	□ NO	□ YES		
High blood pressure, high cholesterol, or high Triglycerides?	□ NO	□ YES		
Other problem, concern, or question in this area?	□ NO	□ YES		
SKIN, HAIR AND NAILS	**Very rare-None**	**Occasional-Mild**	**Intermittent-Moderate**	**Frequent Severe**
Acne	□ 0	□ 1	□ 2	□ 3
Eczema	□ 0	□ 1	□ 2	□ 3
Psoriasis	□ 0	□ 1	□ 2	□ 3
Dry Skin	□ 0	□ 1	□ 2	□ 3
Oily Skin	□ 0	□ 1	□ 2	□ 3
Flushing, hot flashes	□ 0	□ 1	□ 2	□ 3
Itchy skin (with or without redness) or hives	□ 0	□ 1	□ 2	□ 3
Decrease in body or facial hair	□ 0	□ 1	□ 2	□ 3

Decrease in head hair (not male pattern baldness)	□ 0	□ 1	□ 2	□ 3
Increase in body or facial hair	□ 0	□ 1	□ 2	□ 3
Excessive sweating	□ 0	□ 1	□ 2	□ 3
Insufficient sweating when hot or active	□ 0	□ 1	□ 2	□ 3
Area(s) of numbness	□ 0	□ 1	□ 2	□ 3
Area(s) of pain	□ 0	□ 1	□ 2	□ 3
Area(s) of tingling	□ 0	□ 1	□ 2	□ 3
Area(s) of pain	□ 0	□ 1	□ 2	□ 3
Weak or ridged fingernails	□ 0	□ 1	□ 2	□ 3
Change in skin color or pigmentation, vitiligo	□ 0	□ 1	□ 2	□ 3
Small rough bumps on back of upper arms	□ 0	□ 1	□ 2	□ 3
Other problem, concerns, or questions in this area?	□ **NO**	□ **YES**		
STOMACH AND DIGESTIVE TRACT	**Very rare-None**	**Occasional-Mild**	**Intermittent-Moderate**	**Frequent Severe**
Heartburn	□ 0	□ 1	□ 2	□ 3
Poor digestion	□ 0	□ 1	□ 2	□ 3
Nausea	□ 0	□ 1	□ 2	□ 3
Vomiting	□ 0	□ 1	□ 2	□ 3
Diarrhea	□ 0	□ 1	□ 2	□ 3
Constipation	□ 0	□ 1	□ 2	□ 3
Belching, intestinal bloating, gas or flatulence	□ 0	□ 1	□ 2	□ 3
Pain in stomach, intestines, colon	□ 0	□ 1	□ 2	□ 3
Rectal itching, pain, or bleeding	□ 0	□ 1	□ 2	□ 3
Hemorrhoids	□ 0	□ 1	□ 2	□ 3
Loss of bowel control, incontinence	□ 0	□ 1	□ 2	□ 3
Other problem, concern, or question in this area?	□ **NO**	□ **YES**		
KIDNEYS AND GENITALS	**Very rare-None**	**Occasional-Mild**	**Intermittent-Moderate**	**Frequent Severe**
Kidney Stones	□ 0	□ 1	□ 2	□ 3
Other kidney problems	□ 0	□ 1	□ 2	□ 3
Difficulty controlling urination, incontinence	□ 0	□ 1	□ 2	□ 3
Bladder problems (other than infections)	□ 0	□ 1	□ 2	□ 3
Frequent urination	□ 0	□ 1	□ 2	□ 3
Pain or burning with urination	□ 0	□ 1	□ 2	□ 3
Discharge or blood in urine	□ 0	□ 1	□ 2	□ 3
Urinary tract (kidney, bladder, urethra) infection(s)	□ 0	□ 1	□ 2	□ 3

Sexually transmitted disease(s)	□ 0	□ 1	□ 2	□ 3
Genital herpes	□ 0	□ 1	□ 2	□ 3
Low sex drive, low libido	□ 0	□ 1	□ 2	□ 3
Have you been tested for HIV?	□ Negative	□ Positive	□ Not tested	
Other problem, concern, or question in this area?	□ **NO**	□ **YES**		
FOR WOMEN ONLY	**Very rare-None**	**Occasional-Mild**	**Intermittent-Moderate**	**Frequent Severe**
Irregular menses	□ 0	□ 1	□ 2	□ 3
Painful menses	□ 0	□ 1	□ 2	□ 3
Pain between menses	□ 0	□ 1	□ 2	□ 3
Painful, swollen, or fibrocystic breasts	□ 0	□ 1	□ 2	□ 3
Water retention	□ 0	□ 1	□ 2	□ 3
Premenstrual syndrome	□ 0	□ 1	□ 2	□ 3
Excessive bleeding	□ 0	□ 1	□ 2	□ 3
Abnormal uterine/vaginal bleeding	□ **NO**	□ **YES**		
Missed menses	□ 0	□ 1	□ 2	□ 3
Vaginal dryness, irritation, painful intercourse	□ 0	□ 1	□ 2	□ 3
Yeast infections	□ 0	□ 1	□ 2	□ 3
Uterine fibroids	□ **NO**	□ **YES**		
Menopausal symptoms or concerns	□ **NO**	□ **YES**		
Infertility	□ **NO**	□ **YES**		
Annual pap smear, breast examination, and health checkup?	□ **NO**	□ **YES**		
Family history of breast, uterine, or ovarian cancer	□ **NO**	□ **YES**		
FOR MEN ONLY	**Very rare-None**	**Occasional-Mild**	**Intermittent-Moderate**	**Frequent Severe**
Pain or difficulty obtaining or maintaining erection	□ 0	□ 1	□ 2	□ 3
Pain or difficulty with ejaculation	□ 0	□ 1	□ 2	□ 3
Pain or mass in testicles	□ 0	□ 1	□ 2	□ 3
Slow stream of urine or frequent urination	□ 0	□ 1	□ 2	□ 3
Undescended testis, testis in abdomen or pelvis	□ **NO**	□ **YES**		
Men over 50: annual PSA test and prostate exam?	□ **NO**	□ **YES**		
Family history or prostate cancer	□ **NO**	□ **YES**		
Other problem, injury, concern in this area?	□ **NO**	□ **YES**		

Please Answer the Following Questions:

1. **What Are Your Main Reasons for Choosing a Naturopathic Approach?**

   ☐ to assist with your overall healing process in conjunction with other health care practitioners;

   ☐ to incorporate naturopathic medicine as part of your ongoing health lifestyle choice;

   ☐ to heal from an injury/illness as quickly as possible; or

   ☐ other

2. **How Committed Are You to Seeing Your Naturopathic Physician Over the Course of Your Treatment?**

   ☐ once a week

   ☐ every two weeks

   ☐ once a month

   ☐ less than once a month

   ☐ as frequently as recommended by your doctor

3. **What Do You Consider a Reasonable Course of Supplementation for the Treatment of Your Current Health Complaints and/or Optimal Health?**

   ☐ 1 - 3 supplements is all I am willing to take, even if it means that results will be comprised.

   ☐ 3 - 5 supplements

   ☐ Number of supplements that is most likely to have success in my treatment.

4. **Are You Interested in Becoming as Healthy as Possible or Are You Only Concerned With Your Current Symptoms?**

_____

_____

_____

FEES:

Initial Appointment	$154.00
20 min Sub Appointment	$ 80.00
40 min Sub Appointment	$130.00
Naturopathic Visit with Neural Therapy	$112.00
Prolotherapy 5 cc	$134.00
Prolotherapy 10 cc	$175.00
Immune Boosting Shot	$ 46.00
Vitamin B Shot	$ 30.00
Acupuncture	$ 62.00
Level I Adjustment	$ 28.00
Standard Adjustment	$ 48.00
Comprehensive Avatar Screening	$104.00
Total Body Modification (TBM)	$130.00

***All remedies/supplements are additional**

Please note that we require a credit card number on file for all missed appointments. Should you need to reschedule or cancel there is a mandatory 24 hour notice period. Failure to do so will result in a $50.00 charge. Thank you for your cooperation.

Patient signature: _____

Print name: _____

Date: _____

Doctor's Signature _____

Dr. Gallant, ND