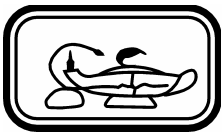

Complimentary Question Form

Naturopathic and Allergy Clinic

Telephone (416) 207-0207, Telefax (416) 207-0272, www.4162070207.ca

Confidential Patient Question

Dear Patient: This form was specifically designed by our **Naturopathic Doctor, the clinic director Fateh Srajeldin ND,** to help our medical team evaluate your question and give you the best possible answer for best results.
Please complete this health questionnaire to the best of your knowledge.
Your answers will help us determine in what ways we can help you restore your health. **Thank you.**

Personal information

***Last name**: _____ ***First name**: _____ **Middle name**: _____
***Date of birth**: MM. DD. YY. Sex: ❑ **Male**, ❑ **Female**, **Height**: _____ **Weight**: _____ **Last physical date**: _____

***I have been unwell for**: _____ **Yrs., Physician's name who treated me was**: _____
I was treated by a ❑ **Medical Dr.,** ❑ **Chiropractor,** ❑ **Naturopath Dr.,** ❑ **Psychiatrist,** ❑ **Hospital,** ❑ **Homeopath,** ❑ **Herbs.**
Was treatment terminated..? : ❑ **Yes,** ❑ **No, Did treatment achieve its goal % (explain)**: _____

***I was treated for**: _____
***I am currently suffering from and need treatment for**: _____

***My home address**: _____ **Suite**: _____ **City**: _____ **Province**: _____ **PC code**: _____
***My home telephone ( ):** _____ ***My office telephone ( ):** _____ **Ext.** _____
***My Cellular number ( ):** _____ ***My email**: _____ **@** _____

***Who referred you to this Clinic :** _____
❑ **Yellow pages,** ❑ **Internet,** ❑ **Alternative health Directory,** ❑ **Office sign,** ❑ **Web Site,** ❑ **Surfing the Net,** ❑ **Office Pamphlet,** ❑ **TV Interview,**

Dear Patient:

General Questions	Write your question here
C… ☑ symptoms are present daily or **F… ☑ symptoms come and go frequently every few days, every week or every month or** **O…☑ symptoms appear every several months or every season.**	Write down your health question and symptoms then list all your medication:

Please answer the following Questions

O	F	C	
❑	❑	❑	Were you breast fed,
❑	❑	❑	Were you treated with Anti-Biotics.?
❑	❑	❑	Do you have constipation..?
❑	❑	❑	Do you have heart burn..?
❑	❑	❑	Do you have hypertension..?
❑	❑	❑	Do you have diabetes..?
❑	❑	❑	Do you have exhaustion..?
❑	❑	❑	Do you drink coffee every day..?
❑	❑	❑	Do you consume dairy products, Milk, cheese, yogurt, butter, cream?
❑	❑	❑	Do you have any colon trouble..?
❑	❑	❑	Do you smoke..?
❑	❑	❑	Do you have allergies, name_____ .
❑	❑	❑	Do you sleep well..?

For Females :

❑	❑	❑	Is your cycle regular..?
❑	❑	❑	Do you use the pill..?
❑	❑	❑	Do you have any vaginal discharge?
❑	❑	❑	Are you pregnant..?