FREDA TAM, BSCH, ND
NATUROPATHIC DOCTOR
138 Courtland Cres. • East Gwillimbury, ON • L9N 0B2 • Tel: (416) 723-3336
www.FredaTamND.com • fredatam.nd@gmail.com

CONTACT INFORMATION

Patient Privacy: Patient information will not be released to any person except when you have authorized us to do so. Information contained herein is used solely by Dr. Freda Tam, ND for administrative, diagnostic and/or treatment purposes, and will be treated in the strictest confidence.

Name:				Date:
Address:			City:	Postal Code:
Telephone # (home):	Cell / Daytime Telephone #:		Best time to call:	Email:
Birth Date: MM / DD / YYYY	Age:	Sex & Gender:	May we leave phone messages or use your email for reminders / follow-up calls?	
Marital Status: ☐ Single ☐ Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Re-married				
Live with: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone				
Occupation – present:		Hours per week:	Occupation – past:	

EMERGENCY CONTACTS		
1. Name:	Relationship to you:	Phone #:
2. Name:	Relationship to you:	Phone #:

OTHER HEALTH CARE PRACTITIONERS

(ie. Family Doctor, Medical Specialist, Chiropractor, Physiotherapist, Acupuncturist, Homeopathic Doctor, etc.)

Are you currently receiving health care? ☐ Yes ☐ No

If yes, where and from whom: (please include contact below) _____

1. Name of Family Doctor: Phone #: Address: Date of last visit:	2. Name: Phone #: Address: Specialty / focus:	3. Name: Phone #: Address: Specialty / focus:

Have you seen a naturopathic doctor previously? ☐ Yes ☐ No

How did you hear about us? ☐ Referral ☐ Website ☐ Facebook / Twitter ☐ Friend / Family ☐ Advertisement
☐ Other. Please specify: _____

Have you any family members that are patients of Dr. Freda Tam, ND?

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NATUROPATHIC ADULT INTAKE FORM

Please fill out this form as accurately and completely as possible. Successful health care and proactive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Complete answers to all of the questions are to your benefit for the most effective naturopathic treatment. Your time, thoughtfulness and honesty in completing this overview will greatly aid us to assist your individual health needs.

Patient Privacy: This is a confidential record of your medical history. Patient information will not be released to any person except when you have authorized us to do so. Information contained herein is used solely by Dr. Freda Tam, ND for administrative, diagnostic and/or treatment purposes, and will be treated in the strictest confidence.

CONTEXT OF CARE REVIEW

Why did you choose to come to see Dr. Freda Tam, ND?

What do you know of her approach to health and wellness?

What 3 expectations do you have from this visit?

1. _____
2. _____
3. _____

What *long term* expectations do you have of Dr. Freda Tam, ND? _____

What is your present level of commitment to address any underlying cause of your signs / symptoms that relate to your lifestyle? _____ **%** (*Rate from 0 to 10, with 10 being 100% committed*)

0% 1 2 3 4 5 6 7 8 9 10 100%

What behaviours / habits do you currently engage in regularly that you believe support your health? (Please list)

What behaviours / habits do you currently engage in regularly that you believe are self-destructive? (Please list)

What potential lifestyle factors do you foresee as barriers / obstacles that may prevent you from adopting new healthy changes that we will be sharing with you?

Who will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do? Why? _____

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GENERAL

Name: _____ Age: _____ Ethnicity: _____

Height: _____ Current Weight: _____ Max Weight: _____ When? _____

What are your chief health concerns? Please list them in order of importance to you:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Regarding your concerns, have any treatments, diets or therapies brought you real improvement or relief?

_____

_____

Describe your general overall state of health at present in less than 10 words.

_____

Describe your general overall state of health as a child, and as a teenager.

_____

How do you rate your overall energy? (Please check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

When during the day is your energy the best? _____ Worst? _____

Please list any significant illnesses that you have had in the past.

_____

_____

Have you ever been hospitalized? Please indicate reason and year.

_____

Please list any significant traumas, accidents or injuries, grief or stress (ie. emotional, physical, etc.) in the past.

_____

_____

ALLERGIES

Are you hypersensitive or allergic to any drugs? (ie. penicillin) _____

Any foods or environmental influences? _____

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CURRENT MEDICATIONS

Pleas list all medications (prescription & over-the-counter) that you are currently taking. Include dosage and how long you have taken it.

Medication	Dose /per day	How long have you taken it?
1)		
2)		
3)		
4)		
5)		
6)		

Please list all vitamins, minerals, herbal medicines, homeopathic medicines, Asian medicines and other supplements that you are currently taking. Include dosage and how long you have taken it.

Supplement (please include the brand)	Dose /per day	How long have you taken it?
1)		
2)		
3)		
4)		
5)		
6)		

How many courses of antibiotics have you been on in the last 5 years? _____

Do you use any recreational drugs? If yes, indicate type and frequency of usage.

_____

TYPICAL FOOD & DRINK INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Water: (cups /per day) _____

IMMUNIZATIONS

Did you have a flu shot this year? ☐ Yes ☐ No How many times in total? _____

What type of vaccinations have you received?

☐ Tetanus
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Tuberculosis
☐ Smallpox
☐ DPT (Diphtheria, Polio, Tetanus)
☐ Chickenpox
☐ MMR (Measles, Mumps, Rubella)
☐ Other vaccination (Please specify): _____

Have you ever experienced an adverse reaction to the above vaccinations?

_____

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HABITS

What do you do in your spare time? Any interests or hobbies? _____

_____

Do you exercise? ☐ Yes ☐ No

If yes, what type, and how often? _____

Do you smoke? ☐ Yes ☐ No If yes, since when, and how many cigarettes / cigars a day? _____

Do you have a spiritual or religious practice? ☐ Yes ☐ No If yes, what? _____

Please indicate your frequency of use of the following:

TV (hrs)	_____	☐ day	☐ week	☐ month	Alcohol	_____	☐ day	☐ week	☐ month
Computer (hrs)	_____	☐ day	☐ week	☐ month	Coffee	_____	☐ day	☐ week	☐ month
Microwave	_____	☐ day	☐ week	☐ month	Sugar	_____	☐ day	☐ week	☐ month
Antacids	_____	☐ day	☐ week	☐ month	Pop (regular / diet?)	_____	☐ day	☐ week	☐ month
Pain Relievers	_____	☐ day	☐ week	☐ month	Tea (black / green / herbal?)	_____	☐ day	☐ week	☐ month

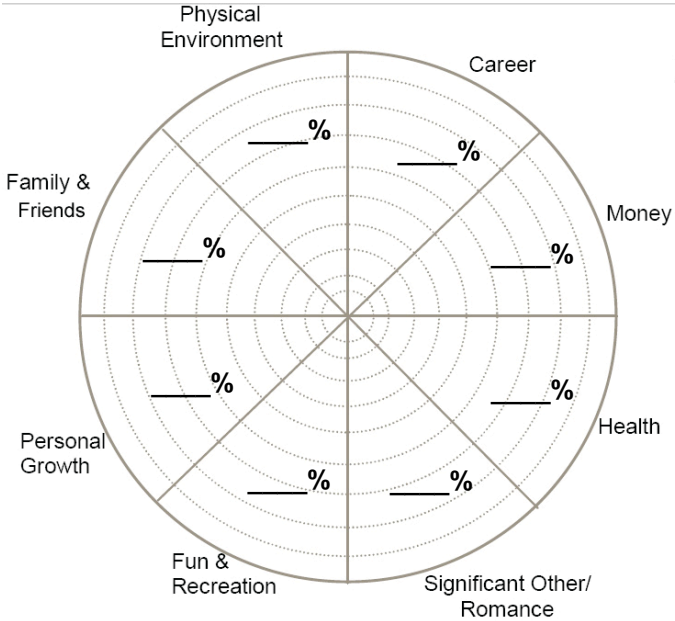
Do you have any pets? (include number and type) _____

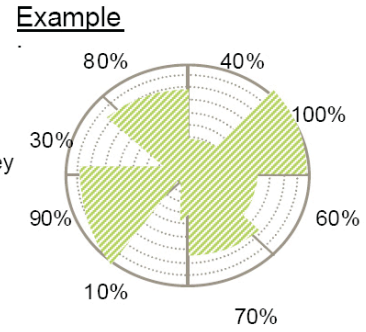
WHEEL OF BALANCE

Health and wellness is a balance of many factors. Using the circle, write down your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, write down 100% for the "career" section.

Do the same for each area!





What level of personal stress are you experiencing at the present moment? (Please check one)

☐ Minimal ☐ Average ☐ Considerable ☐ Unbearable

What are the **main stressors** in your life?

_____

_____

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FAMILY HEALTH HISTORY

Please indicate, where applicable, if anyone in your family currently has or has had any of the following conditions:

	Father	Mother	Brothers	Sisters	Maternal G. Mother	Maternal G. Father	Paternal G.Mother	Paternal G. Father
Age (if living)								
Health (G=good, P=poor)								
Anemia								
Asthma								
Hay Fever / Hives								
Cancer (what type?)								
Arthritis								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Mental Illness								
Alcoholism								
Kidney Disease								
Tuberculosis								

Have any of your family members had any other significant illness or health concerns?
Y

CONFIDENTIAL HEALTH APPRAISAL

For the sections below, please place one of the following in the space provided:

" Y " – If you currently have the symptom / condition

" P " – If the condition has been a problem in the past

VITALITY

____ Low stamina
____ Low ambition
____ Averages 7-8 hours of sleep daily
____ Poor sleep
____ Feel un-refreshed on waking
____ – When? _____
____ Unexplained weight gain / loss

HAIR

____ Thin hair
____ Excessive loss of hair
____ Prematurely gray
____ Grows slowly
____ Thinning eyebrows, underarm, r pubic hair

ENDOCRINE / HORMONES

____ Heat intolerance
____ Cold intolerance
____ Thyroid abnormalities
____ Excessive thirst / hunger / urination
____ Excessive sweating
____ Diabetes
____ Hypoglycemia
____ Hormone therapy

HEAD

____ Headaches / Migraines
____ Head injury
____ Dandruff
____ Dizziness

IMMUNE SYSTEM

____ Frequent cold / flu
____ Chronic infections
____ Slow wound healing
____ Chronically swollen glands

NECK

____ Pain /or stiffness
____ Enlarged thyroid / glands

EARS

____ Impaired hearing
____ Ringing in the ears
____ Wax build-up
____ Earaches
____ Ear infections
____ Discharge

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SKIN & NAILS

____ Dryness / cracking
____ Itching
____ Acne (pimples)
____ Easy bruising
____ Hives (allergy)
____ Eczema
____ Rosacea
____ Boils
____ Rashes
____ Blotchy / white patches
____ Psoriasis
____ Spots on nails
____ Nails brittle / split
____ Bite nails
____ Fungal infection of nails

CARDIOVASCULAR

____ Heart disease
____ Palpitations, fluttering
____ Angina
____ Heart murmurs
____ Chest pain / heaviness

CIRCULATION / BLOOD

____ Dizziness
____ Cold hands / feet
____ Swelling in hands / feet
____ Numbness in hands / feet
____ Deep leg pain
____ Varicose veins
____ High / low blood pressure
____ Anemia
____ Fainting

RESPIRATION

____ Coughing
____ Sputum / phlegm
____ Frequent colds / coughs
____ Asthma
____ Hayfever
____ Bronchitis
____ Difficulty breathing
____ Pain on breathing
____ Shortness of breath

MOUTH & THROAT

____ Frequent sore throats
____ Hoarse voice
____ Dry mouth
____ Sore tongue / mouth
____ Cold sores
____ Lip cracking
____ Canker sores
____ Peculiar taste in mouth
____ Bad breath
____ Impaired taste

TEETH

____ Cavities
____ Loose teeth
____ Bleeding gums
____ Gum disease
____ Dentures / bridges
____ Root canal
____ Sensitivity to hot / cold
____ Grinding teeth

EYES

____ Glasses / contact lenses
____ Failing vision
____ Eye pain / strain
____ Tearing
____ Dryness
____ Discharge
____ Itching
____ Double vision
____ Spots floating in front of eyes
____ Blurring
____ Sensitive to light
____ Cataracts
____ Glaucoma
____ Frequent conjunctivitis / styes
____ Dark circles under eyes
____ Night / colour blindness

EMOTIONAL

____ Depression / low moods
____ Mood swings
____ Anxiety / nervousness / tension
____ Alcohol / drug abuse

NOSE

____ Loss of smell
____ Prone to nose bleeds
____ Stuffiness
____ Sinus problems / infections
____ Polyps
____ Itching
____ Discharge

GASTROINTESTINAL

____ Poor appetite
____ Large appetite
____ Hungry shortly after eating
____ Change in thirst
____ (strong / no thirst)
____ Nausea / vomiting
____ Heartburn
____ Indigestion
____ Fatty foods cause indigestion
____ Belching
____ Excessive passing of gas
____ Bloating after eating
____ Stomach pains, burning, aching after eating
____ Pain under right side of rib cage
____ Ulcer
____ Constipation
____ Diarrhea
____ Liver / gallbladder disease
____ Jaundice (yellow skin)
____ Intestinal worms / parasites
____ Mucous (slimy stuff) in stools
____ Bloody (red) /or black stools
____ Anal itching
____ Hemorrhoids

Bowel movements: how often? _____

URINARY

____ Painful urination
____ Dribbling
____ Increased frequency
____ Blood in urine
____ Inability to hold urine
____ Frequent urinary infections
____ Kidney stones

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MUSCULO-SKELETAL

____ Arthritis
____ Weakness
____ Stiffness or aches
____ Twitching
____ Muscle spasms / cramps
____ Numbness / tingling
____ Prone to sprains
____ Backache
____ Joint pain / stiffness
____ Joint swelling
____ Broken bones
____ Sciatica
____ Bursitis
____ Foot pain

NEUROLOGICAL

____ Dizziness / vertigo
____ Forgetfulness
____ Convulsions / seizures
____ Paralysis
____ Unsteady / lose balance
____ Involuntary movement
____ Speech problems

FOR FEMALES:

Age at first period: _____
Age at last menses: _____ (if menopausal)
Duration of period: _____ days
Length of cycle: _____ days

____ Irregular periods
____ Painful periods
____ Bleeding between periods
____ Menstrual clots
____ Excessive flow
____ Bloating during period

____ **PMS** (breast tenderness, irritability, sadness, cramping, heavy feeling)
Date of last PAP: _____
____ Vaginal discharge
____ Vaginal itching
____ Ovarian cysts
____ Uterine fibroids
____ Yeast infections
____ Venereal disease (ie. Clamydia, Syphilis, Condyloma, Gonorrhea, etc.)
____ Menopausal symptoms
____ Breast lumps / pain / tenderness

Do you do self breast exams? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No
Any sexual difficulties? ☐ Yes ☐ No
Birth control? ☐ Yes ☐ No
– What type? _____
Sexual orientation: _____
Difficulty conceiving? ☐ Yes ☐ No

____ # of pregnancies
____ # of live births
____ # of miscarriages
____ # of abortions

FOR MALES:

____ Frequent / urgent urination
____ Weak / delayed urinary stream
____ Urge to urinate several times per night
____ Dribbling after urination
____ Painful testicles
____ Testicular masses
____ Prostate disease
____ Discharge or sores
____ Genital rash
____ Low sperm count
____ Low sperm motility

____ Venereal disease (ie. Clamydia, Condyloma, Syphilis, Gonorrhea, etc.)

Are you sexually active? ☐ Yes ☐ No
Sexual orientation: _____
____ Lack of sex drive
____ Sexual difficulties

Birth control? ☐ Yes ☐ No
– What type? _____

Is there anything else you would like to add or comment on?

_____

Thank you very much for your time and effort in completing this form.
I look forward to providing you with the best possible care!

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CONSENT TO TREATMENT

I would like to take this opportunity to welcome you. My naturopathic practice utilizes the principles of naturopathic medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

As a naturopathic doctor I will conduct a detailed case history, conduct physical examinations and may utilize specific blood, salivary and/or urinary laboratory reports as part of the treatment work-up. Some treatments or procedures may include:

Nutritional supplements, botanical (herbal) medicine, Traditional Chinese Medicine & acupuncture, individualized dietary and lifestyle modification, hydrotherapy, naturopathic manipulation and homeopathy.

Even the gentlest of therapies may cause aggravation in certain physiological conditions. This depends greatly on the individual and the extent of their illness. Potential health risks associated with Naturopathic Medicine may include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process
- Allergic reaction to prescribed substances
- Pain, bruising, fainting or injury from acupuncture
- Inconvenience or lifestyle changes

If there is a chance that you may be **pregnant**, **actively attempting to become pregnant**, or if you are **breast-feeding**, please alert me as some of the therapies used could present a risk to the pregnancy and your child.

Please initial beside each of the following statements as appropriate:

_____ I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy by paying the appropriate fee.

_____ I understand that Dr. Freda Tam, ND will answer any questions that I have to the best of her ability. I understand that results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. I voluntarily consent to the diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions): _____.

_____ I understand that the risks will be explained to me in a manner than I can understand prior to any treatment. I understand that I may ask questions regarding my treatment at any time, and that I am free to withdraw my consent and discontinue participation in any procedure / treatments at any time.

_____ I understand that any treatment provided for me by Dr. Freda Tam, ND is not mutually exclusive of any treatment or advice that I may be receiving now or in the future from another licensed health care provider, and that I am at liberty to seek or continue medical care from a physician or other health care provider qualified to practice in Ontario.

_____ I understand the fee schedule and agree to pay billings at the time services are rendered and/or at the time products are purchased.

_____ I understand that if I have insurance coverage for Naturopathic Medicine, I am responsible for billing my own insurance company. Most policies do not cover the supplements / remedies that are prescribed.

_____ I understand that I may purchase any recommended supplements or remedies from the clinic dispensary, or from any retail store of my choice.

_____ **Parents / Guardians:** I agree that I am solely responsible for the safety of my child/children while on the premise of Dr. Freda Tam's clinic. Children are to be supervised at all times and never left un-attended by the parent.

_____ ***Cancellation Policy:** I agree that if I am unable to make my appointment, I will provide advanced notification within 24 hours. Failure to give 24 hours notice will result in **a cancellation fee of $30**.

I have read and understand the above stated information and policies. I consent to treatment by Dr. Freda Tam, ND modified as indicated above. I understand that I am free to withdraw my consent at any time.

Patient's Full Name (please print): _____

Signature of Patient (or guardian : if patient is under 18 years old) _____ Date: _____

Signature of Dr. Freda Tam, ND : _____ Date:_____

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PRIVACY POLICY

FOR COLLECTION, USE & DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of my practice, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

In this office, Dr. Freda Tam, ND acts as the Privacy Information Officer.

All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate uses and protection of your information.

Our privacy policy outlines what our clinic is doing to ensure that:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention, and destruction of your personal information complies with existing legislation and privacy protection protocols
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, *The College of Naturopaths of Ontario (CONO).*

HOW OUR OFFICE COLLECTS, USES, AND DISCLOSES PATIENTS' PERSONAL INFORMATION

This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns, to provide safe and comprehensive health care, and to advise you of treatment options
- To book, confirm, and remind you of upcoming appointments
- To communicate with other health-care providers involved in your care as appropriate
- To invoice for goods and services
- To comply with legal and regulatory requirements when required
- For teaching purposes anonymously

Our office will not, under any circumstances, supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes outlined above.

Patient Consent: I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I agree that Dr. Freda Tam, ND can collect, use, and disclose personal information about measures set out above in the information about the office's privacy policies.

Patient's Full Name (please print): _____

Signature of Patient /or Guardian : _____ Date: _____
(if patient is under 18 years old)

Signature of Dr. Freda Tam, ND : _____ Date:_____