

# Simmonds McMurrer Naturopathic Medicine

Dr.Kali Simmonds,N.D.      Dr.Lana McMurrer,N.D.      Dr.Nara Simmonds,N.D.  
34 Queen Street, 2<sup>nd</sup> Floor Charlottetown, PE C1A 4A3  
Tel.902.894.3868 Fax.902.894.4054  
[www.simmondsmcmurrer.com](http://www.simmondsmcmurrer.com)

## Naturopathic Adult Intake (16yrs+)

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C) \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Male/Female: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_

Contact person in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you had Naturopathic Services? Yes/No: \_\_\_\_\_ If so when? \_\_\_\_\_

Have you had Chiropractic Services? Yes/No: \_\_\_\_\_ If so when? \_\_\_\_\_

Date of last medical visit: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about the clinic? \_\_\_\_\_

### Past injuries:

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

### Past surgeries:

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

### Past vaccinations/Any reactions? :

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Currently used medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Supplements:

\_\_\_\_\_

\_\_\_\_\_

### Allergies:

\_\_\_\_\_

### Physical activities:

\_\_\_\_\_ How often? \_\_\_\_\_

\_\_\_\_\_ How often? \_\_\_\_\_

Reason for seeking Naturopathic Services: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List in order of priority which areas you would like to improve:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

### FAMILY HEALTH HISTORY

Indicate below which of the following ailments, or any other ailments, have affected your relatives:

Alcoholism	*Cancer	Gout	Mental Illness	Syphilis
Allergies	Depression	Hay Fever	Paralysis	Thyroid
Alzheimer's	Diabetes	Heart Disease	Pneumonia	Tuberculosis
Arthritis	Epilepsy	Hypertension	Skin Disease	
Asthma	Gonorrhea	Kidney Disease	Digestive Disorders	

RELATIVE	Age if alive	Age at death	AILMENTS
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

\*Please specify type of cancer:

\_\_\_\_\_

\_\_\_\_\_

Indicate which, if any, of the following conditions you have had:

Abscesses	_____	Gonorrhea	_____	Pleurisy	_____
ADD/ADHD	_____	Gout	_____	Pneumonia	_____
Alcoholism	_____	Hay Fever	_____	Premenstrual Syndrome	_____
Allergies	_____	Heart Disease	_____	Prostatitis	_____
Anemia	_____	Hepatitis	_____	Rheumatic Fever	_____
Arthritis	_____	HIV	_____	Scarlet Fever	_____
Asthma	_____	Infertility	_____	Sinusitis	_____
Cancer	_____	Influenza	_____	Sexual Abuse	_____
Cankers	_____	IBS	_____	Stroke	_____
Chicken Pox	_____	Kidney Disease	_____	Strep Throat	_____
Chlamydia	_____	Leukemia	_____	Syphilis	_____
Cold Sores	_____	Low/High Blood BP	_____	Thyroid Disease	_____
Crohn's/Colitis	_____	Lyme's Disease	_____	Tonsillitis	_____
Depression	_____	Malaria	_____	Tuberculosis	_____
Diabetes	_____	Measles	_____	Typhoid Fever	_____
Emphysema	_____	Miscarriage	_____	Uterine Fibroids	_____
Endometriosis	_____	Mononucleosis	_____	Venereal Warts	_____
Epilepsy	_____	MS	_____	Warts	_____
Fibrocystic Breasts	_____	Mumps	_____	Whooping Cough	_____
Frequent Colds	_____	Parasites	_____	Worms	_____
Fungal Infections	_____	Peritonitis	_____	Yeast Infections	_____
Gallstones	_____	Pelvis Inflammatory	_____		

Any other conditions not mentioned:

\_\_\_\_\_

Are there any conditions from which you have NOT fully recovered? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## REVIEW OF SYMPTOMS

Please circle "Y" if you have the condition now and "P" if you have had it in the past (persistently)

EYES			RESPIRATORY			GASTROINTESTINAL		
Impaired vision	Y	P	Wheezing	Y	P	Heartburn	Y	P
Pain	Y	P	Cough	Y	P	Difficult swallow	Y	P
Redness	Y	P	Breath short	Y	P	Thirst changes	Y	P
Double vision	Y	P	Difficult breath	Y	P	Appetite changes	Y	P
Cataracts	Y	P	Chest pain	Y	P	Nausea	Y	P
Light sensitive	Y	P	Bloody sputum	Y	P	Indigestion	Y	P
Discharge	Y	P	Emphysema	Y	P	Gas/belching	Y	P
Tearing	Y	P	Asthma	Y	P	Constipation	Y	P
Dryness	Y	P	Breath painful	Y	P	Rectal bleeding	Y	P
Itching	Y	P	Bronchitis	Y	P	Hemorrhoids	Y	P
Blurring	Y	P	Pneumonia	Y	P	Jaundice	Y	P
Glaucoma	Y	P	Pleurisy	Y	P	Hernias	Y	P
Blind spot(s)	Y	P	Last chest x-ray			Diarrhea	Y	P
Contact lenses	Y	P	Last TB test			No. BM/day		
Other:			Other:			Other:		
URINARY			CARDIOVASCULAR			NOSE & SINUSES		
Pain urinating	Y	P	Heart Disease	Y	P	Bleeding	Y	P
More frequent	Y	P	Angina	Y	P	Stuffiness	Y	P
Reduced flow	Y	P	High blood pres.	Y	P	Hay fever	Y	P
Kidney stones	Y	P	Murmurs	Y	P	Injury	Y	P
Blood in urine	Y	P	Chest pain	Y	P	Colds	Y	P
Infections	Y	P	Palpitations	Y	P	Allergies	Y	P
Inconsistent	Y	P	Ankle swelling	Y	P	Obstructions	Y	P
Other:			Rheumatic fever	Y	P	Sinus problems	Y	P
			Last ECG test			Other:		
			Other:					
MOUTH & THROAT			EARS			MUSCULOSKELETAL		
Hoarseness	Y	P	Discharge	Y	P	Joint pain	Y	P
Gum problems	Y	P	Itching	Y	P	Arthritis	Y	P
Dental fillings	Y	P	Excess wax	Y	P	Broken bones	Y	P
Sores	Y	P	Infections	Y	P	Numbness	Y	P
Mouth dryness	Y	P	Ringing	Y	P	Tingling	Y	P
Sore throat	Y	P	Earache	Y	P	Muscle spasms	Y	P
Lost taste	Y	P	Hearing loss	Y	P	Weakness	Y	P
Other:			Other:			Backache	Y	P

SKIN			FEMALES			BLOOD/LYMPHATICS		
Rashes	Y	P	Age of first menses			Anemia	Y	P
Hives	Y	P	Age of menopause			Swollen lymph nodes	Y	P
Acne	Y	P	Birth control type			Easy Bleeding	Y	P
Boils	Y	P	How long			Bruising	Y	P
Eczema	Y	P	Vaginal discharge	Y	P	Transfusions	Y	P
Psoriasis	Y	P	Vaginal itching	Y	P	Other:		
Dry skin	Y	P	Decrease sex drive	Y	P			
Itching	Y	P	Other:			ENDOCRINE		
Lumps	Y	P				Thyroid problems	Y	P
Night sweats	Y	P	MENSES			Diabetes	Y	P
How often			Cycle regular	YES	NO	Hypoglycemia	Y	P
Other:			Length of cycle			Hormone therapy	Y	P
			Spotting	Y	P	Other:		
HEAD			Painful menses	Y	P			
Headache	Y	P	Excessive flow	Y	P	NEUROLOGICAL		
Migraine	Y	P	# of pregnancies			Fainting	Y	P
Dizziness	Y	P	Age			Seizures	Y	P
Injuries	Y	P	# of miscarriages			Convulsions	Y	P
Other:			# of abortions			Paralysis	Y	P
			PMS SYMPTOMS			Muscle weakness	Y	P
NECK			Depression	Y	P	Memory loss	Y	P
Pain	Y	P	Irritability	Y	P	Numbness/tingling	Y	P
Swollen glands	Y	P	Bloating	Y	P	Loss of balance	Y	P
Lumps	Y	P	Increased appetite	Y	P	Speech problems	Y	P
Goiter	Y	P	Weight gain	Y	P	Other:		
Stiffness	Y	P	Breast tenderness	Y	P			
Other:			Other:			THYROID		
						Loss of hair	Y	P
						Weight gain	Y	P
BREASTS			REPRODUCTION			Dry skin	Y	P
Lumps	Y	P	Sexual difficulty	Y	P	Thinning eyebrows	Y	P
Tenderness	Y	P	Venereal disease	Y	P	Chronic constipation	Y	P
Self examine	Y	P	Other:			Goiter	Y	P
Other:			MALES			High cholesterol	Y	P
PERIPHERAL VASCULAR			Prostate disease	Y	P	Feeling very cold	Y	P
Cold hands/feet	Y	P	Impotence	Y	P	Menstrual disorders	Y	P
Deep leg pain	Y	P	Testicular masses	Y	P	Other:		
Varicose veins	Y	P	Hernia	Y	P			
Thrombophlebitis	Y	P	Urgency to urinate	Y	P			
Other:			Low libido	Y	P			

PSYCHO/SOCIAL			LIVER			ADRENAL		
Depression	Y	P	Anemia	Y	P	Fatigue/apathy	Y	P
Tension	Y	P	Hypertension	Y	P	Allergies	Y	P
Mood swings	Y	P	High cholesterol	Y	P	Delayed healing	Y	P
Phobias	Y	P	Hypoglycemia	Y	P	Low BP	Y	P
Sleep problems	Y	P	Drug sensitive	Y	P	Dizzy when standing	Y	P
Anxiety	Y	P	PMS	Y	P	Frequent urination	Y	P
Nervousness	Y	P	Endometriosis	Y	P	Muscle weakness	Y	P
Drug abuse	Y	P	Heavy menses	Y	P	Nervousness	Y	P
Other:			Chronic headaches	Y	P	Lower back pain	Y	P
			Skin problems	Y	P	Ringing in ears	Y	P
PARATHYROID			Constipation	Y	P	Other:		
Osteoporosis	Y	P	Gallstones	Y	P	PANCREAS		
Joint pain	Y	P	Muscle tension	Y	P	Food allergies	Y	P
Gum/tooth disease	Y	P	Eye problems	Y	P	Blood sugar abnor.	Y	P
Kidney stones	Y	P	Difficulty digesting	Y	P	Maldigestion	Y	P
Ridged nails	Y	P	Other:			Food in stool	Y	P
Other:						Bowel gas	Y	P

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_

Are you currently working with a professional counselor, psychologist, social worker, or other therapist?

Please give details: \_\_\_\_\_  
\_\_\_\_\_

Have you had naturopathic treatment before? Please give details: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Indicate which, if any, of the following medications you are currently taking:

anti-inflammatory/cortisone	_____	heart medications	_____
antacids	_____	laxatives	_____
antibiotic	_____	lithium	_____
antidiabetic/insulin	_____	oral contraceptives	_____
antidepressants	_____	radiation	_____
antifungal	_____	relaxants/sleeping pills	_____
aspirin/tylenol	_____	thyroid	_____
chemotherapy	_____	recreational drugs	_____
hormones	_____	ulcer medications	_____
high blood pressure	_____	other (specify) _____	_____

---

Indicate which, if any, of the following items you eat, drink or use:

alcohol	_____	herbal teas	_____
aluminum pans	_____	luncheon meats	_____
candy	_____	margarine	_____
carbonated beverages	_____	microwave	_____
chew tobacco	_____	minerals	_____
cigarettes	_____	refined sugars	_____
coffee	_____	saccharin (sweet & low)	_____
distilled water	_____	spring water	_____
fast foods	_____	tea	_____
fried foods	_____	vitamins	_____

Indicate which, if any, of the following apply to you:

Diet often	_____	Under excessive stress	_____
Do not exercise regularly	_____	Exposed to chemicals at work	_____
Salt food without tasting	_____	Exposed to cigarette smoke	_____

How much do you drink of the following items on a daily basis:

Beer	_____	Milk (2%)	_____
Coffee	_____	Soft Drinks (diet)	_____
Fruit juice	_____	Soft Drinks (reg.)	_____
Herbal tea	_____	Tea	_____
Liquor	_____	Water	_____
Milk (skim)	_____	Wine	_____

How often would you have an alcoholic beverage? \_\_\_\_\_



## **AGREEMENT TO TREATMENT**

It is my pleasure to provide you with effective, economical and quality health care. In order to do this, please understand the following policies and procedures:

If you cannot make a scheduled appointment, please call 24 hours in advance to reschedule. Patients will be charged the full fee for a missed appointment.

Payment for appointments is due in full at the time of service. We will provide you with a receipt for submission to your insurance company when services are rendered.

### **FEE SCHEDULE**

#### **New patient appointments:**

New patient consultation (1 hour and 15 minutes)	\$ 150.00
--	-----------

#### **Follow up visits:**

15 minutes	\$ 40.00
------------	----------

30 minutes	\$ 75.00
------------	----------

45 minutes	\$ 100.00
------------	-----------

1 hour	\$ 120.00
--------	-----------

#### **Acupuncture:**

45 minutes (Existing patient)	\$ 100.00
-------------------------------	-----------

#### **Letters:**

Brief / concise	\$ 25.00
-----------------	----------

Extensive	\$ 35.00
-----------	----------

#### **Sauna (Infrared)**

Session	\$ 25.00
---------	----------

Package (10)	\$ 200.00
--------------	-----------

#### **Telephone Consultation / follow up:**

Follow the same fee schedule as an in office appointment and are based on the length of the consultation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Food Diary

This form gives your naturopathic doctor important information about your health. Please DO NOT change your eating habits, eat exactly as you normally would (e.g. if you don't eat breakfast, then simply record that on the form). It is not necessary to "eat healthy". The purpose is to see what you eat most days, as this will help to determine if your diet may be contributing to specific health concerns.

NAME: \_\_\_\_\_

START DATE: \_\_\_\_\_

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			
Snacks			
Energy 1-10			
Water intake			
Other liquids			
# Bowel Movements			
Comments**			

\*\*Include symptoms experienced that day, such as headaches, stomach upset, sleeplessness, etc.