Statement of Acknowledgement

In order to clarify that Dr. Bablad's position as a health care practitioner, and the mutual responsibilities in your health care, please sign this statement of acknowledgement.

1. That you understand that Dr. Bablad is a Naturopathic Doctor and not a Medical doctor; that non-invasive, natural methods of assessment and treatment of body dysfunctions and body optimization are used.

2. That you understand that the methods utilized by Dr. Bablad have a proven clinical foundation, yet may not be accepted practice by standardized (allopathic) medicine.

3. That you understand that the treatment and/or referral to other health practitioners is based upon assessment of your health revealed through personal history, physical examination, laboratory tests and other appropriate methods of evaluation.

4. That you understand that Dr. Bablad has the right to determine which cases fall outside of his scope of practice as a Naturopathic Doctor and/or Bowen Therapist. In which event an appropriate referral will be recommended.

5. That you are not an agent or any private or government agency attempting to gather information without so stating your intentions.

6. That you are accepting or rejecting this care of your own free will.

7. That you understand that the ultimate responsibility for your health care is your own, and that Dr. Bablad supports you in this. He reserves the right to discontinue services where it is apparent that your expectations and what he provides are not in agreement.

8. That you understand that your written permission is necessary to release your file to anyone else and that information is treated confidentially.

9. That you understand that fees are payable at the time of the appointment by the patient or their guardian. There is a fee for completion of any other insurance forms. Twenty four hours notice is required for appointment cancellation, otherwise you will be responsible for the full fee of the appointment.

10. That you are aware that several Extended Health Care Insurance Plans provide additional coverage for Naturopathic Care. Please check your policy.

I _____ have read, understood and acknowledged the above statements.

Signature: _____ Date: _____

During the course of your examination and treatments, please feel free to comment, ask questions and provide us with feedback. I feel that the more you know about yourself, the more active role you can play in restoring and maintaining your own health. Together, we can form a team on the side of a healthy future.

Head to Heal Naturopathic Family Wellness
2706 13th Avenue
Regina, Saskatchewan

t: (306) 551.3384
w: reginanaturopathicdoctor.com
e: naturopath@headtoheal.net

Lifestyle Index

Name _____ Date _____

Please indicate on each of these scales where you think and feel you are currently functioning in these areas of your life. There are obviously no right or wrong answers here so just be honest with yourself, listen to your intuition and mark your response by circling the mark on the appropriate level. You can also choose to indicate whether the level is rising or falling with an arrow up and down.

Scale: 0 = Non-existant **10 = Ideal**

Mental

0	1	2	3	4	**5**	6	7	8	9	**10**

Emotional

0	1	2	3	4	**5**	6	7	8	9	**10**

Physical

0	1	2	3	4	**5**	6	7	8	9	**10**

Social

0	1	2	3	4	**5**	6	7	8	9	**10**

Spiritual

0	1	2	3	4	**5**	6	7	8	9	**10**

Family

0	1	2	3	4	**5**	6	7	8	9	**10**

Creativity

0	1	2	3	4	**5**	6	7	8	9	**10**

Fun

0	1	2	3	4	**5**	6	7	8	9	**10**

Financial

0	1	2	3	4	**5**	6	7	8	9	**10**

Career

0	1	2	3	4	**5**	6	7	8	9	**10**

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New Patient Information:

Please provide us with your information and sign and date the **Statement of Acknowledgement**. These forms are helpful for creating a complete health picture. Thank you.

Name _____ Phone Home _____ Business _____

Address _____
(Street) (City) (Province) (Postal Code)

Age _____ Birthdate _____/_____/_____ Sex _____ Place of birth _____
day month year

Referred to Dr. Bablad by _____ email: _____

Occupation _____

Circle the best description of your living situation
Married Significant other Single Other Adults Dependent Adults

Number of Dependent Children _____ Ages _____

Have you received naturopathic care previously?
No _____ If yes, when? _____ Name of N.D. _____

Are you currently under the care of a medical doctor or other health care practitioner?
No _____ If yes, please name the practitioner(s) and reasons:

_____
_____

SECTION 1 - Health Concerns

1. Please describe your primary reason(s) for seeking health care with Dr. DiCicco/Dr. Bablad. If this involves a specific health condition, please describe the first time you noticed the condition and what symptoms have increased or decreased since then. Please attach another sheet if more space is required.

_____
_____
_____
_____

2. Please list all of your secondary health concerns/conditions, which you are aware of.

_____
_____
_____

3. Please list all prescribed drug medications, which you are presently using or have used in the past and list the reason for taking them. Note any negative reactions you have had.

4. Please list all vitamins, minerals, herbs, homeopathic remedies which you are presently using – please indicate the content and potencies. Note any negative reactions you have has in the past to these types of supplements.

5. Is your primary health concern (Question 1) currently better, worse or staying the same? How do you know?

6. What are the most significant measures you have taken to improve your health?

7. Have you consulted an allopathic medical doctor for these conditions? What are the test results, diagnosis, therapy and outcome?

8. Have you consulted a naturopathic doctor for these conditions? What were the test results, diagnosis, therapy and outcome?

9. Have you consulted any other health care professionals now or in the past? For what reason? (Chiropracter, Dentist, Optometrist, Massage therapist, Counselor, Psychologist, Medical specialist)

10. Please list the **5 most significant stressful** events in your life, from the most recent to the least recent. Please indicate if any of these situations are still impacting your life.

11. **Circle** any recent changes in your ability to:
    SEE HEAR TASTE SMELL FEEL HOT/COLD SENSATIONS MOVE BODY PARTS

12. Do you consider your body weight:
    JUST RIGHT OVERWEIGHT UNDERWEIGHT CHANGING

13. Using above words how would you have described your weight 2 years ago?
    _____

14. Please **circle** the following flavours that you:
    LIKE:
    SOUR BITTER SWEET RICH/FATTY SPICY/PUNGENT SALTY

    DISLIKE:
    SOUR BITTER SWEET RICH/FATTY SPICY/PUNGENT SALTY

15. Please circle the temperatures you prefer (ex. food, drink, weather etc.):
    WARM COLD NO PREFERENCE

16. Please circle the time of day when you feel the most energy or the least symptoms:

7 am to 9 am	3 pm to 5 pm	11 pm to 1 am
9 am to 11 am	5 pm to 7 pm	1 am to 3 am
11 am to 1 pm	7 pm to 9 pm	3 am to 5 am
1 pm to 3 pm	9 pm to 11 pm	5 am to 7 am

17. Circle the time of day when you feel the least energy or the worst symptoms:

7 am to 9 am	3 pm to 5 pm	11 pm to 1 am
9 am to 11 am	5 pm to 7 pm	1 am to 3 am
11 am to 1 pm	7 pm to 9 pm	3 am to 5 am
1 pm to 3 pm	9 pm to 11 pm	5 am to 7 am

SECTION 2 – HEALTH HISTORY

1. Please indicate whether there is any history of the following conditions in your family and list the type of relation i.e. parent, sibling, aunt, cousin etc. **Circle** the conditions that apply to you.

Alcoholism	Depression	Multiple Sclerosis
Allergies	Diabetes Type 1 or 2	Non-physical Abuse
Anxiety	Drug Abuse	Osteoarthritis
Asthma	Eczema	Psoriasis
Auto-immune disorder	Heart disease	Rheumatoid Arthritis
Cancer	Mental illness	Thyroid Disease

Other _____

2. Was you mother's health normal during her pregnancy with you? Yes No, if no please explain the complications_____

3. Was your birth process natural, without medical intervention such as forceps, C-section, epidural, anesthesia etc.? Yes No, if not please explain _____

4. Were you separated from your mother for any medical or other reason for the first six months after your birth? No Yes, If yes for approximately how long and why? _____

5. Were you breastfed within the first 10 hours after birth? No Yes

6. Were you breastfed at all? No Yes, if yes for how long? _____

7. Were you a colicky baby? No Yes If so, for how long? _____

8. Did you require medical attention, hospitalization or medication before the age of 10 years old? No Yes, if yes please explain in detail _____

9. Have you ever been hospitalized? No Yes, if so when and for how long _____

10. Have you ever had surgery? No Yes If yes, please list all surgeries (including tonsils and wisdom teeth), dates, why they were done and the outcomes.
_____
_____

11. Have you had any illness or prolonged health problem other than ordinary self-limiting childhood diseases? No Yes Please indicate any of the following and list the treatment used for those conditions.

Arthritis	Chronic fatigue Syndrome	Diabetes	Hepatitis	Mononucleosis	Rheumatic fever
Asthma	Chronic pain	Diverticulitis	HIV/AIDS	Multiple Sclerosis	Scarlet fever
Cancer	Debilitating fatigue	Fibromyalgia	Insomnia	Nausea	TB
Cataracts	Depression	Glaucoma	Irritable Bowel Syndrome	Parasites	Thyroid Dysfunction

12. Have you ever had any disease or condition involving your bones, joints, muscles, ligaments or tendons? No Yes if yes please explain _____

13. Have you ever been x-rayed? No Yes If yes, which area, for what reason and what was found? _____

14. Have you ever had any recurring infections of inflammation? No Yes , if so what area of your body _____

15. What do you feel are your 3 weakest organ systems and why?
_____
_____
_____
___

16. Have you ever had a respiratory condition? No Yes if yes what was the treatment and the outcome?
_____

17. How many times each year do you have a cold, sinusitis, flu, bronchitis? _____
How long do they last and how what treatment do you use?
_____
_____
__

18. Have you ever had a sexually transmitted disease? No Yes, if yes please list which ones and the treatments for each. _____
_____

19. Have you ever fainted, blacked out or had a convulsion? No Yes if yes please describe the circumstances. _____

20. Do you wear a medical alert bracelet or tag? No Yes if yes, for what condition?
_____
_

21. Are you aware of any allergies to foods, drugs, inhalants or other substances? No Yes If so please list the terms and your reactions.
_____

SECTION 3 - DIGESTION

1. Do you have stomach gas, heart burn or use anti-acid medications? No Yes If so, explain what happens.
_____
_

2. Indicate how often, on average, you have a bowel movement?
_____ **x**/day **or** _____ **x**/week **or** _____ **x** /month

3. Do you ever use laxatives? If so how often do you use them?
_____ **x**/day _____ **x**/week _____ **x** /month

4. Do you pay attention when 'nature calls' to have a bowel movement? Yes No
If not what do you do? _____

5. Do you have trouble initiating your bowel movements? If so how do you start them?
   No Yes, _____

6. **Circle** all that describes your stool:

Large, soft & well formed	Yellow or clay coloured	Loose but not watery
Thin, long & narrow	Greasy or shiny	Diarrhea, watery
Small & hard	Visible mucous	Very dark to black
Alternates between hard and loose/watery	Medium, soft & well formed	Greenish in colour
Offensive odour	Floating on bowl	Visible red blood
Difficult to pass	Large and hard	Gas with stool

7. Does abdominal discomfort or cramping ever accompany bowel movements? If so, how often?
   No Yes, _____

8. Have you ever had disorders of the stomach, liver, gallbladder, pancreas, small or large intestines, hemorrhoids or varicose veins? If so please describe and list treatments.
   No Yes, _____
   _____

9. Do you make a conscious effort to eat a high fibre diet? If so what do you eat, please elaborate _____

SECTION 4 – KIDNEY and BLADDER

1. How much water do you drink per day? _____ cups/day

2. Please circle the type of water you drink
   TAP BOTTLED FILTERED WELL SPRING REVERSE OSMOSIS DISTILLED

3. Please list the amount and kinds of any other liquids you drink on the average day?
   _____

4. Do you feel your bladder empties completely? If not how long has this been happening? _____
   _____

5. Do you feel any burning or irritation during or after urination? If so what aggravated this symptom? _____

6. Do you have difficulty starting or stopping when urinating? If so how long?

7. Do you get up in the middle of the night to urinate? If so, how many times per night ___, times per week _____.

8. Does your urine have a strong odour? No, Yes, if yes what does it smell like?

9. Please indicate all that describe your urine:
   CLEAR CLOUDY ORANGE RED BRIGHT YELLOW DARK YELLOW

   GREENISH BROWN

SECTION 5 – RESPIRATION and CIRCULATION

1. Do you exercise regularly? No, Yes If yes, how often and what type of exercise?

2. If you monitor your pulse while exercising, what is your heart rate with which activities?

3. Do you get short of breath with even slight exertion? If so describe the movements.

4. Do you have difficulty perspiring? No Yes If yes please elaborate _____

5. Do you perspire easily with no provocation? No Yes
6. Do you perspire when you sleep? No Yes If so which areas of your body are involved? Does the perspiring awaken you? _____

7. Do you perspire with exercise and after what duration of exercise? No Yes, after _____

8. Does your perspiration have a strong odour? No Yes

9. Does you take regular saunas, steam baths or do skin friction rubs? If so which and how often? No Yes
_____
_____

10. Have you ever had areas of skin removed i.e. moles? If so, which areas and what was the diagnosis? No Yes _____
_____

SECTION 6 – ENVIRONMENTAL EXPOSURES

1. Please describe your work/occupation. _____
_____

2. Is your work done in an office building and do windows open? If you work in other circumstances please describe. _____
_____

3. Do you have air filters and humidifiers at work and home? No Yes If yes, describe.
_____

4. Do you now or have you ever worked with toxic fumes or chemicals? No Yes, if yes please list kind and duration of exposure.
_____
_____

5. Do you live in a city? No Yes
6. How much time do you spend outside per day _____ or per week _____

7. Indicate if you wear: sunglasses _____ Perscription glasses _____ contact lenses ____

8. Do you now or have you ever smoked? No Yes. If yes, in what form, amount per day and for how long? _____
_____

9. Are you now or have you ever been exposed to second hand smoke? No Yes. If yes, for how long?
_____
_____

10. Check if you use: ____ dentures ____ hearing aid ____ medical implants _____ orthotics

11. Do you have pets? No Yes, If so please list the types._____
_____

12. How many hours per day _____ or per week _____ do you spend in a car?

13. How many hours per day _____ or per week _____ do you spend at a computer?

14. How many hours per day _____ or per week _____ do you spend watching T.V.?

15. Do you have hobbies? Please list them and also list any toxic material that may be involved (ex. stain glass – lead) _____

_____

_____

SECTION 7 – SLEEP

1. On average what time do you go to bed ____ get up ____ number of hours slept _____
2. Do you feel well rested on awakening in the morning? Yes No
3. Do you nap during the day? No Yes, If so, for how long? _____
4. Is your sleep disturbed by awakening each night? _____ If so, is there a regular time when you awaken and what is that time?_____
5. Do you have trouble getting to sleep? No Yes If so, do you do or use anything to sleep. _____

SECTION 8 – WOMEN'S REPRODUCTIVE SYSTEM

1. What was your age when you first had your menstruation? _____
2. If you are in your menstruating years of life what is the range of days between each cycle? _____
3. Please circle if you have ever had any of these tests:

   Mammogram Ultrasound Thermograph Pap Test
4. Please circle if any of these tests had abnormal results:

   Mammogram Ultrasound Thermograph Pap Test
5. What form of safe sex method and/or birth control do you use? _____
6. Are you currently sexually active? No Yes
7. How many times have you been pregnant? ___ How many resulted in live births? ___
8. Have you ever had fertility concerns? No Yes, _____
9. If you have gone through menopause, at what age did you have your last menstruation? _____
10. Do you have any perimenopausal symptoms currently? No Yes, if so please describe what is happening.

    _____

SECTION 9 – MEN'S REPRODUCTIVE SYSTEM

1. Have you ever had an abnormal prostate exam ___ or PSA blood test ____. If yes how long ago and when did this begin _____

2. Have you ever had trouble urinating or abnormal discharge? _____

3. What form of safe sex method and/or birth control do you use?
   _____

4. Are you currently sexually active? No Yes

5. Have you ever had fertility or impotence converns? No Yes

SECTION – DETOXIFICATION

1. Have you ever done a fast or detoxification program? No Yes, if yes please explain what type and when you did _____

2. Are you on a special diet or do you avoid any food in particular? No Yes, if yes please explain which foods _____
_____

Thank you for taking the time to complete these forms.

_____ _____

Patient's Signature **Date**

Name _____ **(Please Print)**

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