Dr. Megan Kimberley, Naturopath.

www.drmegan.net

Email: drmegankimberley@protonmail.com

Name: _____________________________Age: ___ Date of Birth: ___(d)___(m)___(y)

Address: ____

Postal Code: ___________ Email: ____

Phone: (home): ___________________________ (office): _________________________

Occupation: ___________________________MSP#: __________________________

Emergency Contact: ___________________________Phone: ___________________

Health Concerns in Order of Importance for You:

1. ____________________________3. _________________________________

2. ____________________________4. _________________________________

List Medications and Supplements You Are Currently Taking (Include Dosage):

____

____

____

Other Health Care Providers (Medical Doctor, Chiropractor...):

____

____

Please List Any Major Illnesses, Injuries, or Surgery's with Dates:

____

____

____

Any Allergies or Sensitivities?

____

____

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Consent Form

I ___________________________ (Patients name), acknowledge that I am aware naturopathic treatment and conventional medical treatments are not mutually exclusive and I am free to seek or continue medical care from the health practitioners of my choice. I hereby authorize and consent to naturopathic examination and treatment by Dr. Megan Kimberley, BSc, N.D.

Payment is due the day service is rendered. Extended Benefits may reimburse your fees, when you submit them to your provider. Receipts will be emailed to expediate the process. Do let us know if you need the Underemployed Fee Schedule.

You will be charged for missed appointments.

By signing you are acknowledging that you have read and understood the above.

Signature: ______________________________________ Date: _____________

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Review Of Systems

Y = **Yes** you have this symptom now.
N = **No** you have never had it.
P = In the **Past** you have had it.

Name: ______________________

Date: ______________________

Weight:	**Fever**	Y N P
Height:	**Chills**	Y N P

Skin

Rashes	Y N P	**Acne**	Y N P	**Moles**	Y N P
Eczema	Y N P	**Itching**	Y N P	**Skin Cancer**	Y N P
Hives	Y N P	**Psoriasis**	Y N P	**Dryness**	Y N P
Lumps	Y N P	**Color Changes**	Y N P	**Boils**	Y N P
Night Sweats	Y N P	**Nail Changes**	Y N P		

Comments: ____

Head

Headaches	Y N P	***Head Injury***	Y N P	**Dandruff**	Y N P
Migraines	Y N P	**Hair Loss**	Y N P	**Dizziness**	Y N P

Comments: ____

Eyes

Redness	Y N P	**Glaucoma**	Y N P	**Itching**	Y N P

Pain	Y N P	Cataracts	Y N P	Floaters	Y N P
Spots	Y N P	Discharge	Y N P	Double Vision	Y N P
Blurring	Y N P	Tearing	Y N P	Dryness	Y N P
Glasses	Y N P	Contacts	Y N P		

Comments: ____

Ears

Infections	Y N P	Hearing Loss	Y N P	Discharge	Y N P
Earaches	Y N P	Hearing Aid	Y N P	Ringing In Ears	Y N P

Comments: ____

Nose And Sinuses

Stuffiness	Y N P	Nose Bleeds	Y N P	Frequent Colds	Y N P
Discharge	Y N P	Sinus infections	Y N P	Itching	Y N P

Comments: ____

Mouth And Throat

Dryness	Y N P	Loss of Taste	Y N P	Tooth Pain	Y N P
Bleeding	Y N P	Sore Throats	Y N P	Root Canals	Y N P
Tonsillitis	Y N P	Canker Sores	Y N P	Tooth Fillings	#: ____

Comments: ____

Respiration

Sputum	Y N P	Chest Pain	Y N P	Emphysema	Y N P
Cough	Y N P	Bronchitis	Y N P	Asthma	Y N P

Wheezing	Y N P	**Pneumonia**	Y N P	**Tuberculosis**	Y N P
Shortness of Breath	Y N P	**Smoker**	Y N P	**Loss of Voice**	Y N P

Comments: ____

Cardiovascular

Chest Pain	Y N P	**Rapid Heart Beat**	Y N P	**Heart Disease**	Y N P
Murmurs	Y N P	**Varicose Veins**	Y N P	**Ankle Swelling**	Y N P
Fluttering	Y N P	**Deep Leg Pain**	Y N P	**Leg Cramps**	Y N P
ECG Test	Y N P	**Cold Hands**	Y N P	**Cold Feet**	Y N P
Numbness	Y N P	**Easy Bruising**	Y N P	**Anemia**	Y N P

Comments: ____

Gastrointestinal

Heart Burn	Y N P	**Indigestion**	Y N P	**Hemorrhoids**	Y N P
Hernia	Y N P	**Ulcers**	Y N P	**Constipation**	Y N P
Nausea	Y N P	**Bloating**	Y N P	**Diarrhea**	Y N P
Vomiting	Y N P	**Flatulence/Gas**	Y N P	**Stomach Pain**	Y N P
Belching	Y N P	**Black Stools**	Y N P	**Anal Bleeding**	Y N P
Change in Thirst	Y N P	**Change in Appetite**	Y N P	**Trouble Swallowing**	Y N P
Gall Stones	Y N P	**Number Of Bowel Movements A Day:**			#:____

Comments: ____

Musculoskeletal

Backache	Y N P	**Joint Pain**	Y N P	**Joint Stiffness**	Y N P
Twitching	Y N P	**Joint Swelling**	Y N P	**Broken Bones**	Y N P
Cramps	Y N P	**Muscle Weakness**	Y N P	**Sprains**	Y N P

Comments: ____________________

Genito-Urinary

Urgency	Y N P	**Infections**	Y N P	**Incontinence**	Y N P
Dribbling	Y N P	**Blood In Urine**	Y N P	**Smelly Urine**	Y N P
Hesitancy	Y N P	**Kidney Stones**	Y N P	**Cloudy Urine**	Y N P
Increased Frequency	Y N P	**Frequency At Night**	Y N P	**Pain On Urination**	Y N P

Comments: ____________________

Neurological

Fainting	Y N P	**Numbness**	Y N P	**Convulsions**	Y N P
Weakness	Y N P	**Loss Of Memory**	Y N P	**Tremors**	Y N P
Paralysis	Y N P	**Loss Of Balance**	Y N P	**Tingling**	Y N P

Comments: ____________________

Mental/Emotional

Anxiety	Y N P	**Depression**	Y N P	**Insomnia**	Y N P
Tension	Y N P	**Mood Swings**	Y N P	**Alcoholism**	Y N P
Phobias	Y N P	**Addictions**	Y N P	**Hyperactivity**	Y N P
Recreational Drug Use (Pot, Hallucinogens)			Y N P	**Irritability**	Y N P

Comments: ____________________

Male Genitalia And Reproduction

Hernias	Y N P	**Impotence**	Y N P	**Testicle Pain**	Y N P
Discharges	Y N P	**Sexual Problems**	Y N P	**Sexually Active**	Y N P
Sores	Y N P	**Warts**	Y N P	**Itching**	Y N P

Comments: ____________________

Female Genitalia And Reproduction

PMS	Y N P	**Discharges**	Y N P	**Prolapse**	Y N P
Spotting	Y N P	**Yeast Infection**	Y N P	**Heavy Bleeding**	Y N P
Cramping	Y N P	**Itching**	Y N P	**Pain With Sex**	Y N P

Fibroids	Y N P	Ovarian Cysts	Y N P	Painful Periods	Y N P
Warts	Y N P	Sexually Active	Y N P	Hot Flashes	Y N P
Nipple Discharge	Y N P	Breast Tenderness	Y N P	Breast Lumps/ Fibrosities	Y N P
Number Of Term Pregnancies:			Number of Miscarriages:		
Number Of Abortions:			Birth Control Used:		
Age Of First Menses:			Last Menses (Menopause):		

Comments: ____

Family History (Please indicate if any family members have had the following)

Allergies		Heart Disease		Osteoporosis	
Arthritis		High Blood Pressure		Rheumatic Fever	
Cancer		Kidney Disease		Skin Rashes	
Chronic Bronchitis		Mental Illness		Strep Throat	
Diabetes		Mononucleosis		Strokes	
Emphysema		Multiple Sclerosis		Tuberculosis	
Nationality:					

Comments: ____

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What Are Your Hobbies? ____________________________________

____

How Do You Manage Stress? __________________________________

____

What Forms of Exercise Do You Get? ___________________________

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