Carolyn Mercer, B.Sc., N.D.
Revive Health Solutions –Unit #4 – 737 Silver Seven Rd. Kanata K2V 0H3
ISM Clinic and Lab – Suite 302- 80 Aberdeen St. Ottawa, Ont. K1S 5R5

PERSONAL INFORMATION

Name: _____ Age: ____ Date of Birth: _____

Address: _____

Office Phone: _____ Home Phone: _____

Marital Status: S M D W Sep Name of Spouse: _____

Dependants: _____

How did you find out about the clinic? _____

Emergency Contact:_____ Relation: _____

Phone Number: _____

Health Care Resources:

Medical Doctor: _____
Office:_____ Fax: _____

Other Health Care Practitioner: _____
Office:_____ Fax: _____

Other Health Care Practitioner: _____
Office:_____ Fax: _____

1.Main Health Concern:

What is your chief concern?

_____
_____

Who diagnosed this condition? _____ When? _____
Current Treatments or Regimes

Treatment or Regime	Doctor or Therapist	Last Visit

How long has it been since you were totally well? _____

2. Medical History

Prenatal Influences (eg: alcohol, cigarettes, drugs, stress) _____

Breast fed: ____ mos.

Describe your health as an infant/child?

_____

_____

Have you been vaccinated: Yes No
Have you ever had a severe reaction to a vaccination? If yes, explain:

_____

Did you have any specific health concerns as a teenager (eg: acne, weight, mono, other)?

Adult Illness	Age	Were you hospitalized?
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

Do you have any history of previous surgeries or accidents?

Were there any complications? Was other treatment required?

_____

List all prescribed medications presently being taken:

Drug Name	Dosage	Frequency	How Long

List any over the counter medications you take (Tylenol, Tums, Cold/Flu Remedies) Indicate how often you take them?

_____
_____
_____

How many courses of antibiotics have you been on in the past 10 years? _____
Have you ever had a bad reaction to an antibiotic? _____

Have you ever had a nervous breakdown? _____
If yes, what type of treatment did you receive?

_____
_____

3. Family History

Relative	Age	Ailments
Mother		
Father		
Brothers		
Sister		
Children		
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		

4. Lifestyle

Diet: normal, junk food, vegetarian, other _____
What is an average days food intake. Include beverages?
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Do you eat quickly? _____ Standing up? _____ On the run? _____
At restaurants? _____ If so, which ones? _____

List all food supplements you are currently taking and the total dosage?

_____
_____

Exercise: Type:_____ Quantity?_____
Drugs:
Do you smoke? _____If so, for how long? _____ How many per day? _____
Does anyone else smoke in your household or workplace? _____
How many alcoholics do you have per week? _____
Sleep:
What are your regular sleeping hours? From _____ to _____
Do you wake feeling refreshed? _____
Relaxation:
What do you do to relax? _____

4. Psychosocial History

List any important life experiences in chronological order, especially traumatic events.

Age	Event	Comment

Briefly outline a typical week day. What do you do from waking to sleeping?

Age	Activity	Time	Activity

Who are the most significant others in your life and what are the challenges in each relationship?

_____
_____

What is your view of the present and your outlook for the future?

_____
_____

How do you feel about yourself?

_____

Do you have a preference for the type of treatment used? _____
Do you have supportive home environment for making these changes? _____
Religion/Spiritual Path? _____

General
Height ___ Weight ____
Changes in weight _____
Energy: hi med low
Fatigue

Skin
___ Rash ___ Lumps
___Itching ___ Dryness
___Colour Change
___Change in Hair
___Change in Nails
___Eczema

Blood
___Abnormal blood test
___Bleed/Bruise easily
___Anemia
___Allergies

Head
___Headache
___Head Injury
___Forcep Birth

Eyes
___Poor Vision
___Glasses/Contacts
___Sensitive to Light
___Last Eye Exam
___Pain
___Redness
___Discharge
___Excess tearing
___Double Vision
___Glaucoma
___Cataracts
___Infections

Ears
___Poor hearing
___Ringing in ears
___Dizziness
___Earaches
___Infection
___Discharge
___Excess ear wax

Nose/Sinuses
___Frequent Colds
___Nasal Stuffiness
___Hay Fever
___Nosebleeds
___Sinus Trouble

Immune
___Allergies
___HIV Positive

Mouth/Throat
___Cavities/Root Canals
___Poor gums
___Sore Tongue
___Cold/Canker Sores
___Last Dental Exam
___Coated Tongue
___Hoarseness
___Frequent Sore Throat
___Bitter Taste in Mouth

Lymph Nodes
Neck/Underarms/Groin
___Lumps ___Pain

Breasts
___Lumps ___ Pain
___Nipple Discharge
___Self examination

Lungs
___Cough
___Sputum
___Wheezing
___Shortness of breath
___Last Chest x-ray
___Difficult breathing
___at night

Heart
___Heart Problems
___High Blood Pressure
___Rheumatic Fever
___Swollen Ankles
___Chest Pain
___Palpitations
___Last ECG/Other tests
___Cholesterol hi/low
___Heart Murmurs

Urinary
___Urinations per day
___Urination at night
___Pain
___Blood in Urine
___Urgency
___Kidney Trouble
___Incontinence
___Infections
___Stones
___Dribbling

Endocrine
___Thyroid trouble
___Excessive sweating
___Diabetes
___Excess hunger/thirst, urination

Musculoskeletal
___Joint Pains
___Stiffness
___Arthritis
___Bad Posture
___Gout
___Backache
___Muscle pain/Cramps

Circulation
___Pain in calves after exercise
___Leg cramps
___Varicose Veins
___Cold extremities
___Thrombophlebitis

Digestion
___Trouble swallowing
___Heart burn
___Nausea
___Appetite up and down
___Vomiting ___w/blood
___Indigestion
___Bowel movements/day
___Rectal Bleeding
___Change in bowel movements
___pale ___black stools
___ w/ undigested food
___constipation
___diarrhea
___abdominal pain
___difficulty skipping a meal
___food intolerances
___food cravings
___excess belching
___bloating
___passing gas
___haemorrhoids
___jaundice
___liver or gallbladder trouble
___hepatitis

Nervous System
___Fainting
___Blackouts
___Paralysis
___Local weakness
___Numbness
___Tingling
___Tremors
___Memory Problems
___Stroke

Female
___Age at first period
___Length of cycle
___Duration of Periods
_____Cycle Length
___Regular?
_____Last period
_____Amount of bleeding
_____b/w periods
_____after intercourse
___Painful Periods
___Age of Menopause
___Symptoms
___Post Menopausal Bleeding
___Discharge
___Itching
___Infections
___Treatments
___Last pap smear
___# of pregnancies
___# of deliveries
___# of abortions
___complications of pregnancy
___birth control
___libido
___sexual difficulties

Male
___discharge from penis
___sores on penis
___hernias
___testicular pains
___venereal disease treatment
___masses
___prostate problems
___libido
___sexual difficulties

Mind
___Nervousness
___Tension
___Mood swings
___Depression
___Lack of concentration
___Fuzziness

Emotions
Excess anger/ sadness/
Frustration/ mania/
Difficulty feeling or
Expressing emotions
_____
_____

Carolyn Mercer, B.Sc., N.D.

Statement of Acknowledgement and Release:

Naturopathy uses non-invasive methods for the assessment of bodily dysfunctions, and natural therapeutics for their correction. Each person seeking care from Carolyn Mercer should understand that she is a specialist in Naturopathy and is not a Medical Doctor (MD) and that you are accepting or rejecting services based on your own free will and choice. If standard medical diagnosis or treatment is required it must be obtained from a licensed Medical Doctor.

Each patient or their legal guardian must read and sign this document before any treatment will be rendered. Your signature acknowledges the following:

1. You have read the foregoing information and you understand that responsibility for your own health is your own and you understand that improving lifestyle can be as important as remedies and treatment.
2. You understand that Carolyn Mercer is a Naturopathic Doctor and is not a Medical Doctor and may employ alternative means of achieving a diagnosis.
3. You understand treatment and/or referral to other health care practitioners is based upon the assessment of conditions revealed through your personal history and interview, physical exam and lab testing.
4. The decision to discontinue prescription drugs or any other prescribed treatment is your sole responsibility. If you forego standard medical treatment in favour of natural healing, you assume responsibility for any potential risks that may be entailed.
5. You are not an agent of any private or local, county, provincial or federal agency attempting to gather information without stating your intentions.
6. You understand that you accept all responsibility for fees incurred during care and treatment and the fees for services rendered are to be paid at the end of each visit.
7. You understand that naturopathic visits are not covered by the provincial governments but are covered under many extended health insurance plans and may also be tax deductible.

I, _____ (Print name of patient or legal guardian) have read, understood and acknowledge the above statements and give my consent to be treated by Carolyn Mercer.

I am the legal guardian of _____. (Print name if applicable.)

I also understand that 24 hours notice must be given for cancellation or changing of an appointment time or the full fee will be charged. _____ (Sign Here)

I understand that my health records may be used in research providing my name is not revealed. At all other times, my health records will be held in the strictest confidence. _____ (Initial Here)

Date: _____ Signature:_____ Witness:_____