

Context of Care Overview

What expectations do you have from working with Dr. Kulwinder Sraw or Dr. Lisa Lau (circle one)?

Short Term: _____

Long Term: _____

What do you know about Dr. Kulwinder Sraw or Dr. Lisa Lau (circle one)'s approach?

What is your current level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? *Rate from 0-10 (10 = 100% commitment)*

What behaviors & lifestyle habits do you currently engage in regularly that you believe support your health?

What potential obstacles do you foresee in addressing lifestyle factors that are determining your health and in adhering to the therapeutic protocols which will be shared with you?

Who do you know that will sincerely support you consistently with the beneficial therapeutic and lifestyle changes you will be making?

What do you love to do?

Confidential Patient Health Record

Personal Information

Name: _____ Gender: F M
Age: _____ Birthdate: yyyy _____ mm _____ dd
Address: _____ Postal Code: _____
Email: _____
Phone #: home _____ work _____ cell _____
Occupation: _____ Height: _____ Weight: _____
No. of Children: _____ Miscarriages: _____ Dependents: _____
Marital Status: single common-law married divorced separated widowed

Other health care providers (family physician, specialists, complementary & alternative therapists):

Name: _____ Name: _____ Name: _____
Ph: _____ Ph: _____ Ph: _____

Emergency Contact: _____ Phone #: _____

How were you referred to this office (Dr. Kulwinder Sraw, ND or Dr. Lau - circle one)?

friend. Whom? _____ newspaper referral other _____

Would you like to subscribe to our quarterly Newsletter, via email? Sure No, Thank you.

What are the main health concerns you would like to have addressed?

1. _____
2. _____
3. _____
4. _____
5. _____

Medical History

How would you describe the general state of your health? Excellent Good Fair Poor

Major complaint: _____

Other doctor's seen for this condition: _____

When did this condition begin? _____

Does anyone in your family have the same or similar condition? Whom? yes no If yes, whom? _____

If disabled from work, please give dates: _____

Date of accident / injury: _____ job related auto related

Previous care (Doctor's name and date of last visit): _____

	Type / Reason / Cause	Year
Injuries / Accidents:	_____	_____
Major Illnesses:	_____	_____
Hospitalizations:	_____	_____
Surgeries:	_____	_____

Have you been treated for any health condition in the last year? yes no

Please explain: _____

Does anyone in your family have the same or similar condition? yes no Whom? _____

Please indicate if you use the following:

Aspirin / Tylenol Laxatives Chemotherapy / Radiation Antacid Other: _____
Appetite Suppressant Cholesterol Lowering Diuretic (blood pressure) Pain Killer
Tranquillizer Birth Control Pill Sleeping Pill Recreational Drugs

Please indicate any known allergies or drug sensitivities: _____

Number of times on antibiotics in last 7 years: _____

Family History:

Please indicate if any of your immediate family relatives has ever encountered the following (F - father, M - mother, B1, B2, S1, S2, etc)

____ Alcoholism _____ Allergies _____ Alzheimer's Ds _____ Arthritis _____ Asthma
____ Cancer of _____ Diabetes _____ Drug addiction _____ Eating disorder _____ Genetic disorder
____ Glaucoma _____ Heart disease _____ Hypertension _____ Infertility _____ Intestinal disease
____ Learning disability _____ Mental illness _____ Migraine _____ Neurological ds _____ Obesity

Please indicate if you have had the following:

- | | | | | | | |
|---|------------------------------------|--|---------------------------------------|--|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer of | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Thyroid (hypo / hyper) | | <input type="checkbox"/> Eczema | <input type="checkbox"/> Other: _____ | | | |

Please indicate if you have had any of the following in the past 6 months:

General

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches
- Moodiness
- Excess / Loss of Appetite

Musculoskeletal

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain / Stiffness
- Walking Problems
- Difficulty Chewing / Clicking Jaw
- General Stiffness

Gastro-Intestinal

- Excess Thirst
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Gas / Bloating
- Abdominal Cramps
- Heartburn
- Black / Bloody Stool
- Weight Problems
- Liver Problems
- Gall bladder Problems
- Colitis

C-V-R

- Chest Pain
- Shortness of Breath
- Blood Pressure Problems
- Irregular heartbeat
- Heart Problems
- Lung Problems / Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Earaches
- Hearing Difficulty
- Stuffed Nose

Nervous System

- Nervousness
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confused / Depressed
- Fainting
- Convulsions
- Cold Tingling Extremities
- Stress

Genito-Urinary

- Bladder Trouble / Incontinence
- Painful / Excess Urination
- Discolored Urine

Male/ Female

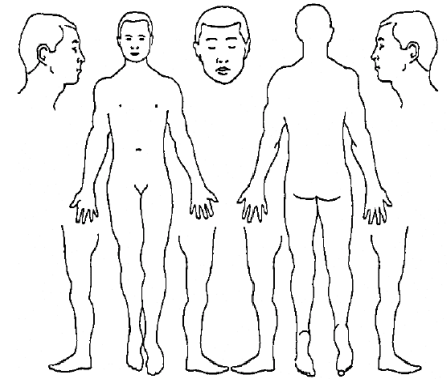
- Prostrate Problems
- Sexual Dysfunction
- Genital Herpes
- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain / Infection(s)
- Breast Pain / Lump(s)

Females:

When was your last period? _____
 Are you pregnant? yes no unsure

Lifestyle

	Heavy	Moderate	Light	None	Type	Per day & Per week
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Coffee / Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
White Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____



Please indicate areas of pain or discomfort.

Do you think you may need to take vitamins, minerals or any other form of supplements? Y or N

Please list all MEDICATIONS you are taking, including dosages, duration and why you are taking them:			
Medication	Dosage	Duration	Condition Treating

Please list all NATURAL HEALTH PRODUCTS (vitamins, minerals, herbs) you are taking, including dosages, duration and why you are taking them:			
Natural Health Product	Dosage	Duration	Condition Treating

New Patient Policy and Fee Explanation

Dear Patient,

The services of Naturopathic Physicians are covered by many extended health care providers, but are currently not covered under the Medical Services Plan (MSP). Please take note of the following clinic policies:

1. The cost of initial consultation is \$160.00, 10% off for children, seniors & students.
2. Subsequent visits are \$80.00 and are booked in 30 minute increments; any time over this will be billed accordingly, 10% off for children, seniors & students.
3. If you receive Assisted Premiums with the Medical Services Plan, please let us know before drawing up the bill (and provide us with your MSP card number).
4. Payment is due when services rendered. Credit cannot be extended without prior approval.
5. **Appointments not cancelled with sufficient notice (greater than 24 hours) are charged a fee of \$65.00 for single appointment, and \$80.00 on a extended appointments.**
6. There is a \$30.00 charge on NSF cheques.
7. Additional services (such as prolotherapy injections, chelation therapy, other injection therapies, supplements, assisted treatments, blood tests, acupuncture, etc) will incur separate or additional fees.

Yours In Sincerest of Health,

Dr. Kulwinder Sraw, N.D.

Signature: _____

Witness: _____

Date: _____

Informed Consent for Treatment

I, _____, hereby authorize the naturopathic physicians and practitioners of the Victoria Centre for Natural Health, Ltd. to perform the following procedures to facilitate my diagnosis and treatment:

Common Diagnostic Procedures: venipuncture, laboratory, physical exam

Medicinal Use of Nutrition: therapeutic nutrition, nutritional supplements, intra-muscular, subcutaneous, intracutaneous and intravenous vitamin/mineral injections.

Physical Medicine: microcurrent / electrical frequency, manipulative therapy, soft tissue therapy, injection therapies (prolotherapy, neural prolotherapy, neural therapy, chelation therapy, platelet rich plasma therapy), trigger point therapy.

Acupuncture: insertion of acupuncture needles into the dermis and subcutaneous layers of the skin.

Botanical Medicine: herbs prescribed as teas, alcoholic tinctures, capsules, tablets, creams, or plasters.

Homeopathic Medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to stimulate the body's healing capabilities.

Lifestyle Counseling and Hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risks – allergic reaction and adverse effect to prescribed herbs, supplements and medications, inconvenience of lifestyle changes, injury from injections or venipuncture, acupuncture, manipulation or other procedures.

Potential Benefits – restoration of health and the body's maximum functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease and its progression.

Notice to Women: all female patients must inform the doctor if they know or suspect pregnancy, as some of the therapies used could present a risk to the pregnancy – mother and fetus.

With this knowledge and understanding, I voluntarily consent to the above procedures. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that the Victoria Centre for Natural Health, Ltd. will keep a record of the health services provided to me. This record will be kept in confidential and will not be released to others unless directed by myself or my representative in writing or unless is required by law. I understand that I may look at my medical record and can request a copy. I understand that my medical records will not be kept for more than seven (7) years after the day of my last appointment. I understand that any questions concerning this form may be asked of the naturopathic physician.

Signature of Patient

Date

Signature of Patient's Representative or Guardian

Date

Witness

Date