

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?

Personal Information

Full Name: _____ Age: _____ Sex: _____ Birthdate: _____
mm / dd / yyyy

Name preferred to be called: _____ Parent's Names: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Parent's Work Phone: _____ (Mother, Father, Other)

Parent's Cell Phone: _____ (Mother, Father, Other) Email: _____

Emergency Contact: _____ Phone: _____

Other Health Care Providers (Family Physician, Specialists, Complementary and Alternative Therapy):

Name: _____ Name: _____ Name: _____
Phone: _____ Phone: _____ Phone: _____

How were you referred to this office (Dr. Kulwinder Sraw, ND or Dr. Lau - *circle one*)? friend newspaper referral other _____
Would you like to subscribe to the quarterly Newsletter, via email? Sure No, Thank you.

What are the main health concerns you would like addressed?

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

Medical History

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

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

Do you have allergies (medications, environmental, etc)?

Please indicate which immunizations you have had:

- | | | |
|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Tetanus booster, when? _____ | <input type="checkbox"/> Hepatitis B | |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Polio | Other: _____ |
| <input type="checkbox"/> Haemophilus Influenza B | <input type="checkbox"/> "Flu" | |

Please indicate if any of the above caused adverse reactions? _____

Childhood Illnesses

- | | | | | | |
|---------------------------------------|------------------------------------|--|---|--|--|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Other: _____ |

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

How frequently have you been treated with antibiotics? _____

Please indicate if you use the following:

- Aspirin Tylenol Antacids Laxatives Antibiotics Decongestants
 Diet Pills Birth Control Pills Fluoride Other: _____

Caffeine — form and amount per day or week? _____

Alcohol — how much per day or week? _____

Tobacco — form and amount per day or week? _____

Recreational Drugs — type and how often? _____

Please indicate if you have had the following:

	<i>currently</i>	<i>past</i>		<i>currently</i>	<i>past</i>
Acne	_____	_____	Epilepsy / Seizures	_____	_____
Allergies	_____	_____	Fatigue	_____	_____
Anemia	_____	_____	Frequent infections	_____	_____
Asthma	_____	_____	Headaches	_____	_____
Bed wetting	_____	_____	Heart murmur	_____	_____
Birth defects	_____	_____	High fever	_____	_____
Colic	_____	_____	Hyperactivity	_____	_____
Constipation	_____	_____	Insomnia	_____	_____
Cough / Wheeze	_____	_____	Jaundice	_____	_____
Cradle cap	_____	_____	Learning disorder	_____	_____
Depression	_____	_____	Moodiness	_____	_____
Diarrhea	_____	_____	Stuffy nose	_____	_____
Dizzy spells	_____	_____	Thrush	_____	_____
Earaches	_____	_____	Vomiting spells	_____	_____
Eczema	_____	_____	Other: _____	_____	_____

How would you describe your own disposition? _____

Prenatal, Antenatal, Postnatal and Feeding History

Mother's health during pregnancy with this patient:

_____ Age	_____ Trauma / Injury	_____ Alcohol Consumption	_____ Diabetes
_____ Bleeding	_____ Stress	_____ Drugs	Other: _____
_____ Nausea	_____ High Blood Pressure	_____ Smoking	Medications: _____
_____ Illness	_____ X-Rays	_____ Toxemia	_____

Pregnancy Term

_____ Premature. If yes, how many weeks / days early? _____
_____ Full Term

Birth Weight: _____

How would the pregnancy be described?

_____ Easy _____ Difficult _____ C-Section

Feeding of Infant

_____ Breast Fed. How long? _____ Milk? What type? How long? _____
_____ Formula Fed How long? _____ Type of formula? _____

_____ Age solid foods were begun

What foods? _____

Were any food allergies or intolerances noted? _____ Which foods? _____

Do you have any food restrictions (religious, vegetarian, vegan, etc?) _____

Daily Diet Sample (choose a typical day including food and liquid):

Breakfast:

Dinner:

Lunch:

Snacks:

Please comment on previous pregnancies by natural mother, including complications:

Family History

Father (age): _____ Mother (age): _____ Brothers (ages): _____ Sisters (ages): _____

**If deceased, please list age at death and circle.*

Please identify all family members who have had any of the following (F - father, M - mother, B1, B2, S1, S2, etc)

_____ Alcoholism	_____ Bleeding Disorder	_____ Heart Disease	_____ Obesity
_____ Allergies	_____ Cancer of _____	_____ Hearing Loss	_____ Stomach Ulcers
_____ Anemia	_____ Colitis	_____ High Blood Pressure	_____ Stroke
_____ Arthritis	_____ Diabetes	_____ Hypoglycemia	_____ Thyroid Disorder
_____ Asthma	_____ Eczema	_____ Kidney Disease	_____ Tuberculosis
_____ Birth Defects	_____ Epilepsy	_____ Mental Illness	Other: _____

Do you have any of the above? _____ If yes, which one(s)? _____

Social History

Child's Parents: _____ Married _____ Separated _____ Divorced

Mother's Occupation: _____ Full time _____ Part time

Father's Occupation: _____ Full time _____ Part time

Other Guardian: _____ Relationship: _____

Other's residing at home: _____ Relationship: _____

Interaction with relatives: Whom? _____ How often? _____

Do you attend daycare, preschool or school? If yes, how many hours per day? _____ # days per week? _____

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