

WELCOME TO THE OFFICE OF DR. PAULETTE ROSCOE.
WE ARE COMMITTED TO OFFERING YOU EXCELLENT HEALTH CARE.

<u>Office Visits</u>		<u>GST</u>
First Office Visit	\$95.00	\$4.75
Return Office Visit	\$55.00	\$2.75
Phone Consultation	\$55.00	\$2.75
Counselling (60 minutes)	\$95.00	\$4.75
Food and Environmental	\$125.00	\$6.25
Sensitivity testing (includes retest)		
Additional Sensitivity Testing	\$55.00	\$2.75
IonWave Foot Detox Therapy	\$60.00	\$3.00

Package Prices available for IonWave Foot Detox Therapy:
3 Sessions Save 5% : 6 Sessions Save 10% : 10 Sessions Save 15%

If you have extended coverage check with your plan to see how much of the visit fee will be reimbursed to you. MSP no longer covers any portion of the fees unless you are on low income MSP.

Seniors (over 65) receive 10% off services and supplements.

FOR YOUR CONVENIENCE WE ACCEPT CASH, CHEQUE, VISA, MASTERCARD AND INTERAC.

A missed appointment fee of \$40.00 will be charged for short cancellations (Less than 24 hours).

Please sign to indicate you have read the above.

Signed _____

Patient Profile

Section I

Date _____

Month Day Year

Name _____ Date of Birth ____/____/____

Age _____ Sex _____

Address _____ City _____ Postal Code _____

Ph(home) _____ Ph(work) _____ Occupation _____

Email address _____

Employer (name and address) _____

Name in case of emergency _____ Ph _____

Care Card Number _____

What other health care are you presently receiving? _____

Medical Doctor _____

How did you hear about our clinic? _____

Have you seen a Naturopathic Physician before? ___Y___N When? _____

Naturopathic physician's name _____

A note to patients: Naturopathic health care is only possible when the physician has a complete picture of the patient physically, mentally, & emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

Present Health Concerns: In your opinion, what are your most important health concerns in their order of significance? Please indicate the problem that motivated you to come in today.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Section II

Your Health History:

Health as a child? ___Good___Fair___Poor

Childhood illnesses: ___Scarlet fever___German measles___Measles___Pertussis

___Rheumatic fever___Chicken pox___Diphtheria___Mumps

Hospitalisations (year & reason): _____

Surgeries (year & type): _____

Serious illnesses or injury (year & cause): _____

Vaccinations (year, type, adverse reaction?): _____

Medications: All vitamins, prescriptions, & non-prescription drugs. Please include everything (pills, tablets, liquids, ointments, suppositories, etc.) and indicate dosage:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____
- 9) _____
- 10) _____

Habits: Substance use: Alcohol ___Y___N Tobacco ___Y___N
Caffeine ___Y___N Recreational Drugs ___Y___N

Diet: Any diet restrictions or regimen?

Describe: _____

Are you satisfied with your diet as it is now? ___Y___N Do you eat 3 meals/day? ___Y___N

Do you crave starches? ___Y___N Sweets? ___Y___N Salt? ___Y___N Fats ___Y___N

Do you: Sleep well? ___Y___N Wake rested ___Y___N Average hrs of sleep? _____

Enjoy your work? ___Y___N Spend time outside? ___Y___N How much? _____

Exercise regularly? ___Y___N What type? _____

How long? _____ How often? _____

Relaxation technique? _____ Daily? _____

Family History: check those applicable

	Father	Mother	Brothers	Sisters	Spouse/ Partner	Child	Other
Age (if living)	_____	_____	_____	_____	_____	_____	_____
Age(at death)	_____	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____	_____
Health G=good P=poor	_____	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____	_____

Stroke	_____	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____	_____
Asthma,hayfever,hives	_____	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____	_____
Syphilis	_____	_____	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____	_____

Allergies: List any allergies you have to:

Drugs _____

Foods _____

Other _____

What happens when you have an allergy attack? _____

Review of systems: Y= a condition you have now N= never had P= had in the past

Please circle.

General

Weight	_____
Weight 1 yr ago	_____
Maximum weight	_____
When	_____
Height	_____
Night sweats	Y P N
Fatigue	Y P N
Date of last physical	_____

Respiratory

Cough	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N
Shortness of breath	Y	P	N
“ lying down	Y	P	N
“ at night	Y	P	N
Positive TB test ever	Y	P	N

Skin

Rashes	Y	P	N
Inflammation	Y	P	N
Infection	Y	P	N
Growths	Y	P	N
Changes in hair/nails	Y	P	N

Heart

Heart disease	Y	P	N
High blood pressure	Y	P	N
Rheumatic fever	Y	P	N
Chest pain	Y	P	N
Swelling in ankles	Y	P	N
Palpitations, fluttering	Y	P	N

Head

Headache	Y	P	N
Head injury	Y	P	N

Digestion

Trouble swallowing	Y	P	N
Heartburn	Y	P	N
Stomach pain	Y	P	N

Eyes				Change in thirst	Y	P	N
Impaired vision	Y	P	N	Change in appetite	Y	P	N
Eye pain	Y	P	N	Nausea	Y	P	N
Tearing or dryness	Y	P	N	Vomiting	Y	P	N
Double vision	Y	P	N	Bowels move	daily	more	less
				Loose stools	Y	P	N
Ears				Is this a change?	Y	P	N
Impaired hearing	Y	P	N	Blood in stool?	Y	P	N
Ringing	Y	P	N	Belching or gas	Y	P	N
Earache/itch	Y	P	N	Liver/gallbladder disease	Y	P	N
Dizziness	Y	P	N	Hemorrhoids	Y	P	N
Nose & Sinuses				Urinary			
Frequent colds	Y	P	N	Pain on urination	Y	P	N
Nose bleeds	Y	P	N	Increase in frequency	Y	P	N
Stuffiness	Y	P	N	Frequency at night	Y	P	N
Sinus problems	Y	P	N	Inability to hold urine	Y	P	N
Post nasal drip	Y	P	N	Bladder infection	Y	P	N
Mouth & Throat				Circulation			
Frequent sore throat	Y	P	N	Deep leg pain	Y	P	N
Sore tongue	Y	P	N	Cold hands/feet	Y	P	N
Sore in mouth/on lips	Y	P	N	Varicose veins	Y	P	N
Gum problems	Y	P	N				
Hoarseness	Y	P	N	Neurologic			
Dental problems	Y	P	N	Fainting	Y	P	N
				Seizures	Y	P	N
Neck				Paralysis	Y	P	N
Swollen glands	Y	P	N	Muscle weakness	Y	P	N
Pain or stiffness	Y	P	N	Numbness or tingling	Y	P	N
				Loss of memory	Y	P	N
Blood				Male reproduction			
Anemia	Y	P	N	Hernia	Y	P	N
Easy bleeding or bruising	Y	P	N	Testicular masses	Y	P	N
				Testicular pain	Y	P	N
Female reproduction				Are you sexually active	Y	P	N
Age of menses _____				Sexual difficulties	Y	P	N
# of days menstrual flow _____				Any prostate problems	Y	P	N
Length of complete cycle _____				Venereal disease	Y	P	N
Bleeding between periods	Y	P	N	Discharge or sores	Y	P	N
Are cycles regular?	Y	P	N	Difficulty starting or			
Pain during intercourse	Y	P	N	stopping urination	Y	P	N

Cramps Y P N
 Abnormal vaginal discharge Y P N
 Excessive flow Y P N
 PMS Y P N
 Date of last PAP smear _____
 Normal results? Y P N
 Date of last period Y P N
 No. of pregnancies _____
 No. of live births _____
 No. of miscarriages _____
 Birth control? Y P N
 What type? _____
 Difficulty conceiving Y P N
 Menopausal symptoms Y P N
 Are you sexually active? Y P N
 Sexual difficulties Y P N
 Venereal disease Y P N

(The following 2 questions are optional)

Sexual preference: Heterosexual____
 Bisexual____Lesbian____
 No. of abortions _____

Breasts

Do you self exam regularly Y P N
 Lumps Y P N
 Pain or tenderness Y P N
 Nipple discharge Y P N

Emotional

Depression Y P N
 Mood swings Y P N
 Anxiety or nervousness Y P N
 Tension Y P N

Musculoskeletal

Joint pain or stiffness Y P N
 Broken bones Y P N
 Muscle spasms or cramps Y P N
 Weakness Y P N

Birth control? Y P N
 What type? _____

(The following question is optional)

Sexual preference: Heterosexual____
 Bisexual____Homosexual____

Endocrine

Thyroid problem Y P N
 Heat or cold intolerance Y P N
 Hypoglycemia Y P N
 Excessive thirst Y P N
 Excessive hunger Y P N
 Easy weight gain Y P N

Indicate on diagram any problem areas:

