DR. NICOLE CERF B.SC. ND
NATUROPATHIC PHYSICIAN

newleaf
massage & wellness

Confidential Adult Health Record

Personal Information

Name ______________________ Date of first visit ______________
Address ____
City ______________ Province ___________ Postal Code__________
Phone # (home) __________ (work) __________ (cell) __________
Email address ____________________ Relationship status _________
Date of Birth (M/D/Y) ________________ Age _____ Gender: M F
Occupation ______________________ Hours per week ___________
Emergency contact (name) _________________ (phone) __________
How did you hear about Dr. Cerf? ______________________________

Medical Information

Medical doctor (name) ________________ (phone) ________________
Medical specialist (name) ______________ (phone) ________________
Do you have extended medical Y N
Are you currently seeing a chiropractor? ______ massage therapist? ________

Informed Consent to Treat

I hereby consent to receive treatment by Dr. Nicole Cerf, ND. I understand that Dr. Nicole Cerf is a licensed Naturopathic Physician providing nutritional and lifestyle counseling, acupuncture/traditional oriental medical care, naturopathic spinal manipulations, botanical/herbal medicine, homeopathic medicine, and intravenous/intramuscular injections. I authorize Dr. Nicole Cerf, ND to perform specific procedures as deemed necessary to facilitate my diagnosis and treatment. I understand that I am free to withdraw my consent and discontinue my treatment at anytime.

Cancellation Policy

I understand that I am solely responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

Email correspondence

Yes / No I would like to receive free newsletters from New Leaf Wellness
Yes / No Dr. Nicole Cerf, ND may correspond with me at the above email address

Signature ______________________ Date ______________________
(Parent or Guardian if patient is a minor)

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Current Health Overview

What are your most significant health concerns? List in order of importance.

1. ______
2. ______
3. ______
4. ______
5. ______

List current medications (*include dose*) ______

______

______

______

List current supplements (*include brand and dose*) ______

______

______

______

Height ______ Current Weight ______ Weight 1 yr ago ______

Smoker Y / N Smoked ______ years Amount/d ______ Year Stopped ______

Recreational Drug Use Y / N Type ______ Frequency ______

Coffee ______ cups/d Tea ______ cups/d Water ______ cups/d

Diet: Are there any foods that you avoid? ______

Are there any foods that you crave? ______

On a scale of 1-10 (*10 being highest*):

Rate your current stress level ______ Rate your current energy level ______

How many hours do you sleep/night? ______ Do you wake up rested? ______

Regular exercise Y / N Type ______ Duration ______ Frequency ______

(*women only*) Are you currently pregnant? Y / N / Not sure

Type of birth control used ______ Last pap smear ______

Past Health History

List major surgeries with type and year.

______

______

How many times a year do you get a cold or flu? Do you miss work?

______

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Please check all conditions that pertain to you

- Arthritis
- Allergies
- Bladder/Urinary problems
- Bleeding problems
- Blood pressure problems/stroke
- Cancer
- Childhood illnesses
- Colitis
- Frequent cold/flus
- Diabetes
- Digestive disturbances
- Ear problems
- Eating disorder
- Edema
- Epilepsy
- Eye problems
- Fatigue
- Female gynecological problems
- Mononucleosis
- Gall bladder/liver problems
- Gout
- Hay fever
- Headaches
- Heart problems
- Hepatitis
- High cholesterol
- Hypoglycemia
- Infertility
- Joint problems
- Kidney problems
- Lung problems
- Migraine
- Obesity
- Occupational exposure to toxins
- Osteoporosis
- Parasites
- Psychological difficulties (suicide/depression/anxiety/OCD)
- Sexually transmitted infection
- Skin problems
- Substance abuse
- Tuberculosis
- Thyroid problems
- Other ______________________

Please list all allergies (*food and environmental*)

____

Explain dental health (*any fillings/root canals*)

____

Clarification of goals

What expectations do you have from this visit to our clinic?

____

What expectations do you have of me as your naturopathic physician?

____

Any other information you would like to mention? *(family history/goals/health obstacles)*

____

____

____

Thank you for your time in providing this information.