Dr. Erica Thomson, ND

Vital Links Integrated Health Professionals

745 Bridge St W, Waterloo, ON (519) 725-1300

Personal Information

Name_____ Sex_____Age _____ Birth date _____
dd/mth/yy

Address _____ City _____ Postal_____

Phone (home) _____ (work) _____ ext____(cell)_____

Okay to leave a message? Yes / No

Email _____

Occupation _____ Employer _____

Marital Status: Sgl Mar Div Sep CL Widowed Number of children _____

Emergency contact _____ Relation _____

Phone _____ Alternate Phone _____

How did you find out about my office? _____

_____

Family Doctor/Last physician or health practitioner seen? _____

Address _____ Date of last visit _____

Phone _____ Fax _____

Findings of concern? _____

_____

When was your last physical exam?_____

Blood tests done? Yes / No Blood Type_____

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Confidential Health History

What is your **main** reason for coming in today?

Date of Onset:_____

List in order of importance other health problems that are troubling you:
1)_____ & date of onset:_____
2)_____ & date of onset:_____
3)_____ & date of onset:_____
4)_____ & date of onset:_____
5)_____ & date of onset:_____

What kind of medical treatment have you received?
_____

Previous medical diagnosis: _____
_____

Have you had any major injuries? If so, what happened and when?
_____ _____
_____ _____

Previous surgeries and hospitalizations (include dates)
_____ _____
_____ _____
_____ _____
_____ _____

	Age if Living	Age at Death	Cause of Death	Health Concerns
Mother				
Father				
Sister(s)				
Brother(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Any other blood relatives with notable health conditions (i.e. Cancer, heart disease, stroke etc.)				

Screening Tests and Health Exams: Please inform us of any screening tests or exams you have received

Test	Y/N	Results
CBC – Complete Blood Count		
Blood glucose		
Cholesterol		
PSA test (men)		
Digital rectal exam (men)		
Bone Mineral Density		
Mammogram		
Breast exam		
PAP test (women)		
Colonoscopy		
Spinal exam		
Hormone levels		
Vitamin D		
Physical exam		
Eye exam		
Dental check up		
Other		

Medications / Supplements

Please check any of the following medications that you are taking or have taken in the last 2 years:

□ antacids
□ appetite suppressants
□ aspirin/Tylenol
□ birth control pills
□ chemotherapy
□ diuretics
□ laxatives
□ pain relievers
□ radiation
□ recreational drugs
□ sleeping pills
□ tranquilizers

Any known drug allergies, drug sensitivities, food sensitivities/allergies, environmental allergies (pets/pollens/dust)?_____
Number of times on antibiotics in the last 10 years?_____

Number of times on corticosteroids in the last 10 years Oral?_____Topical? _____

Drugs

Please list any pharmaceutical drugs you have taken within the last year

Name of Drug	Dosage / Amount	Reason for Taking	Duration of Use

Vitamins, Supplements, Herbal or Homeopathic

Please list all natural supplements you have taken within the last year – please bring these with you to your appointment.

Name	Dosage / Amount	Reason for Taking	Duration of use

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Review of Systems

Please circle if Y, P or N relate to you

Y = Yes, currently I am experience this

P = I have experienced this in the past

N = I have never experienced this

Skin, Hair and Nails

Rashes - specify	Y	P	N	
Skin conditions - specify (eczema, psoriasis, etc)	Y	P	N	
Dry skin	Y	P	N	
Itching	Y	P	N	
Changes in skin color	Y	P	N	
Sunburn (how often?)	Y	P	N	
Warts	Y	P	N	
Lumps or abscesses	Y	P	N	
Change in Mole	Y	P	N	
Skin cancer	Y	P	N	
Excessive perspiration	Y	P	N	
Night sweats	Y	P	N	
Strong body odour	Y	P	N	
Hair loss	Y	P	N	
Brittle nails	Y	P	N	

Musculoskeletal

Joint pain/stiffness	Y	P	N	
Joint swelling	Y	P	N	
Arthritis	Y	P	N	
Muscle spasm/cramps	Y	P	N	
Muscle weakness	Y	P	N	
Bone fractures	Y	P	N	
Osteoporosis	Y	P	N	
Low back pain	Y	P	N	
Weak/sore knees	Y	P	N	

Head and Mouth and Throat

Headaches	Y	P	N	
Migraine headaches	Y	P	N	
Head injury	Y	P	N	
Dizziness	Y	P	N	
Jaw pain or clicking	Y	P	N	
Teeth grinding	Y	P	N	
Gum problems	Y	P	N	

Teeth problems (root canals, etc)	Y	P	N	
Bad breath	Y	P	N	
Dry mouth	Y	P	N	
Cold sores	Y	P	N	
Lumps	Y	P	N	
Post nasal drip	Y	P	N	
Poor sense of smell	Y	P	N	
Loss of smell	Y	P	N	
Runny nose	Y	P	N	
Nose bleeds	Y	P	N	

Ears

Impaired hearing	Y	P	N	
Ringing in ears	Y	P	N	
Earaches/infections	Y	P	N	
Itchy ear canal	Y	P	N	
Discharge from ear	Y	P	N	

Eyes

Far sighted	Y	P	N	
Nearsighted	Y	P	N	
Color blindness	Y	P	N	
Poor night vision	Y	P	N	
Visual disturbances	Y	P	N	
Cataracts	Y	P	N	
Glaucoma	Y	P	N	
Blind spots/blindness	Y	P	N	
Double vision	Y	P	N	
Blurring	Y	P	N	
Sensitivity to sun	Y	P	N	
Itchy eyes	Y	P	N	
Dry eyes	Y	P	N	
Red eyes	Y	P	N	
Excessive tearing	Y	P	N	

Immune

Chronic infections (ex. Mono)	Y	P	N	
Cold sores	Y	P	N	
Frequent antibiotics	Y	P	N	
Frequent cold/flu	Y	P	N	
Frequent sore throat	Y	P	N	
Shingles	Y	P	N	

Slow wound healing	Y	P	N	
Swollen glands/lymph nodes	Y	P	N	

Respiratory System

Chronic cough	*Y*	*P*	*N*	
Chronic phlegm	Y	P	N	
Coughing up blood	Y	P	N	
Pain while breathing	Y	P	N	
Shortness of breath (when?)	Y	P	N	
Wheezing	Y	P	N	
Asthma	Y	P	N	
Chronic lung condition - specify	Y	P	N	

Cardiovascular System

High blood pressure	Y	P	N	
High cholesterol	Y	P	N	
Angina	Y	P	N	
Chest pain	Y	P	N	
Heart murmurs	Y	P	N	
Heart palpitations	Y	P	N	
Heart attack	Y	P	N	
Anemia	Y	P	N	
Fainting	Y	P	N	
Dizziness upon standing	Y	P	N	
Easily bruised/bleed	Y	P	N	
Cold hands and/or feet	Y	P	N	
Numbness in hands/feet	Y	P	N	
Heaviness or pain in legs	Y	P	N	
Leg ulcers	Y	P	N	
Varicose veins	Y	P	N	
Your socks leave imprints on your ankles/leg swelling	Y	P	N	
Hemorrhoids	Y	P	N	

Gastrointestinal System

Change in thirst	Y	P	N	
Change in appetite	Y	P	N	
Trouble swallowing	Y	P	N	
Heartburn	Y	P	N	
Burping	Y	P	N	
Bloating	Y	P	N	
Gas	Y	P	N	
Nausea	Y	P	N	

Vomiting (vomiting blood)	Y	P	N	
Stomach cramps or pain	Y	P	N	
Ulcer	Y	P	N	
Constipation	Y	P	N	
Diarrhea or loose stool	Y	P	N	
Undigested food in stool	Y	P	N	
Mucous in stool	Y	P	N	
Black tarry stool	Y	P	N	
Blood in stool	Y	P	N	
Stool floats in toilet	Y	P	N	
Itching around anus	Y	P	N	
Liver disease	Y	P	N	
Gallbladder disease	Y	P	N	

How often do you have a bowel movement? _____

_____

Have you ever travelled to another country? □ Y □ N

Have you ever had parasites that you are aware of? □ Y □ N

Any food sensitivities, intolerances, or allergies?

_____

_____

Urinary System

Pain on urination	Y	P	N	
Blood in urine	Y	P	N	
Increased urinary frequency	Y	P	N	
Frequent bladder infections	Y	P	N	
Kidney infections	Y	P	N	
Kidney stones	Y	P	N	
Change in urine color/odor	Y	P	N	
Must strain to urinate	Y	P	N	
Inability to hold urine	Y	P	N	
Wake at night to urinate	Y	P	N	

Men's Health

Hernia	Y	P	N	
Testicular mass	Y	P	N	
Testicular pain	Y	P	N	
Prostate condition	Y	P	N	
Discharge or sores	Y	P	N	
Low sex drive	Y	P	N	
Sexual difficulties	Y	P	N	

Impotence	Y	P	N	
Sexually active? Sexual preference?	Y	P	N	
Venereal disease	Y	P	N	
Fertility issues	Y	P	N	

Women's Health

Vaginal discharge	Y	P	N	
Vaginal itching	Y	P	N	
Vaginal odor	Y	P	N	
Sores, growths or lumps	Y	P	N	
Abdominal pain mid cycle	Y	P	N	
Abnormal pap tests	Y	P	N	
Menopausal symptoms	Y	P	N	
Low sex drive	Y	P	N	
Sexual difficulties	Y	P	N	
Pain during intercourse	Y	P	N	
Vaginal dryness	Y	P	N	
Venereal disease	Y	P	N	

Breast Health

Fibrocystic breasts	Y	P	N	
Puckering of the skin	Y	P	N	
Nipple discharge	Y	P	N	
Tenderness	Y	P	N	
Flaky dry skin on nipple	Y	P	N	
Breast lump	Y	P	N	
Monthly self-breast exam	Y	P	N	
Last breast exam	Y	P	N	
Regular mammograms	Y	P	N	

Female Menstruation/Reproductive

Age of first menses: _____ Age of last menses (if applicable): _____

Average length of cycle (in days): _____ How many days is your menses? _____

Are you sexually active? □ Y □ N Sexual preference? _____

What birth control do you use? (if any): _____ Number of pregnancies: _____

Number of miscarriages: _____

Are you currently pregnant or trying to conceive? □ N □ Y How many weeks? _____

Pain or cramping	Y	P	N	
Clotting	Y	P	N	
Diarrhea	Y	P	N	
Water retention	Y	P	N	

Bloating	Y	P	N	
Breast tenderness	Y	P	N	
Cravings	Y	P	N	
Mood swings	Y	P	N	
Headache	Y	P	N	
Light flow	Y	P	N	
Heavy flow	Y	P	N	
Bleeding between periods	Y	P	N	
Irregular cycles	Y	P	N	
Difficulty conceiving	Y	P	N	
Fertility treatments	Y	P	N	

Endocrine

Diabetes	Y	P	N	
Excessive hunger	Y	P	N	
Excessive sweating	Y	P	N	
Excessive thirst	Y	P	N	
Excessive urination	Y	P	N	
Generally feeling cold	Y	P	N	
Generally feeling hot	Y	P	N	
Hormone therapy	Y	P	N	
Low blood sugar	Y	P	N	
Mental dullness	Y	P	N	
Poor concentration	Y	P	N	
Sluggish after coffee	Y	P	N	
Sluggish after eating	Y	P	N	
Thyroid trouble	Y	P	N	

Rate your energy level (1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

At what time of day is your energy .best _____ worst _____

Rate your stress level (1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Have you recently lost weight? □ Y □ N How much? _____

Sleep

Fall asleep easily	Y	P	N	
Wake up during the night (specific time?)	Y	P	N	
Difficulty falling asleep	Y	P	N	
Do not sleep/Insomnia	Y	P	N	
Night shift	Y	P	N	
Disturbing dreams	Y	P	N	
Eat before I sleep	Y	P	N	

Sleep 7-8 hours	Y	P	N	
Sleep with electronic device by my head	Y	P	N	
Have a good mattress?				

Mental/Emotional

Abuse	Y	P	N	
Alcohol/drug abuse	Y	P	N	
Anxiety/nervousness	Y	P	N	
Depression	Y	P	N	
Easily angered	Y	P	N	
Indecision	Y	P	N	
Irritability	Y	P	N	
Memory problems	Y	P	N	
Mental illness	Y	P	N	
Mood swings	Y	P	N	
Panic attacks	Y	P	N	
Phobias	Y	P	N	
Prolonged grief/sadness				

What are the three major contributors to stress in your life:

_____ _____ _____

Has there been an illness or event in your life that you feel you have never fully recovered from? Please specify if yes. _____

_____

Lifestyle

Please indicate Y=Yes N=No and explain further where applicable

Have you ever been a smoker?	Y	N	
Are you exposed to second hand smoke?	Y	N	
Do you drink alcohol?	Y	N	
Do you use recreational drugs?	Y	N	
Do you spend time in nature? How much?	Y	N	
Do you exercise? How often and kind? (cardio, walking, weight bearing)	Y	N	
Do you drink water? How much?	Y	N	
Do you have dietary restrictions? (Religious, vegetarian..)	Y	N	
Do you drink pop? How much?	Y	N	

Toxic Exposure

Please indicate Y=Yes N=No and explain further where applicable

Have you been exposed to mold, solvents, fumes, heavy metals, lead paint?	Y	N	
Are you sensitive to perfume, gasoline or other vapors?	Y	N	
Do you have mercury dental fillings?	Y	N	
Have you had root canal procedures?	Y	N	
Do you have any surgical implants?	Y	N	
Do you live near power lines?	Y	N	
Do you dye your hair?	Y	N	
Have you experienced health problems putting down new carpet, painting your home, using pesticides?	Y	N	

Thank you for taking the time to fill in this lengthy questionnaire. It will be a valuable resource in understanding your health

Privacy Form for Dr. Erica Thomson, ND at Vital Links Integrated Health Professionals

PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collection, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

Dr. Erica Thomson, ND acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the College of Naturopathic Doctors of Ontario (CONO).

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our clinic is using and disclosing your information.

This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you any pertinent information and mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the *Drugless Practitioners Act*
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts

- To assist this clinic to comply with all regulatory requirements
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing this consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient Consent
I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information.

I agree that Dr. Erica Thomson via Vital Links Integrated Health Professionals can collect, use and disclose personal information about _____ as set out in the information about the clinic's privacy policies. (**patient name)**

_____ _____
Signature Print Name

_____ _____
Date Signature of Witness

Informed Consent
Welcome to my office. By coming in today you have made a commitment to your health. I hope you enjoy your experience with naturopathic medicine as we work together to help you attain your full health potential.

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, and spiritual aspects of the individual.

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease, and promote health.

Botanical Medicine is the use of plant-based medicine that involves herbal teas, tinctures, capsules and other forms of herbal preparations to assist the body as it moves towards health and healing.

Homeopathy is a form of medicine based on the Law of Similars – that is, the use of tiny doses of the very substance that causes symptoms in a healthy person will eliminate those symptoms in a sick person. These tiny doses are used to stimulate the body's ability to heal itself.

Asian Medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at any of the hundreds of specific points on the body.

Physical Therapies refer to the use of hands-on techniques such as soft tissue manipulation, cranial sacral therapy, and hydrotherapy, which is the use of hot and cold water to stimulate the immune system and improve circulation.

Lifestyle counseling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visit, your Naturopathic Doctor will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take blood or urine samples.

Even the gentlest therapies have the potential to cause adverse reactions under certain physiological conditions. This depends greatly on the individual and the extent of the illness. To help reduce this possibility, it is very important that you inform your Naturopathic Doctor of any and all disease processes that you are suffering from; any medications (prescription or over-the-counter) that you are taking; if you are pregnant, suspect you are pregnant or are actively attempting to become pregnant, or are breastfeeding.

Potential health risks associated with Naturopathic Medicine may include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process.
- Allergic reactions to supplements or herbs.
- Pain, bruising or injury from venipuncture or acupuncture/cupping/bodywork.

_____
Initials

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law.

_____ Initials

I understand that Dr. Thomson will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

_____ Initials

I understand that any treatment or advice provided to me by Dr. Erica Thomson is not mutually exclusive of any treatment or advice that I may now be receiving or may receive in the future from another licensed health care provider.

_____ Initials

I understand that I am at liberty to seek or continue to seek medical care from a physician or surgeon or other health care provider qualified to practice in Ontario. Dr. Erica Thomson has not suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

_____ Initials

I understand that I may purchase recommended medicines or supplements from the dispensary of Dr. Thomson OR any pharmacy/retail store of my choice.

_____ Initials

I understand that email use is strictly limited to answering simple questions about a given treatment plan and is not allowed as a means of diagnosing or addressing new concerns or for communicating lab results. Email is not guaranteed to be secure or confidential and I knowingly accept this risk.

_____ Initials

I understand the fee schedule as stated below and I agree to pay my account in full at the time of each visit or treatment, including fees for services, lab testing, supplements/remedies, administrative fees.

If I am unable to keep my appointment, I must give advance notice of 2 business days in which case no charge will be applied.

_____ Initials

- **Appointments missed without notification will be subject to the full visit cost.**
- **Charge for cancellation of an initial appointment with less than 48 hours notice is $85 and $50 for a follow up appointment.**

Cost of consultation only:

Adults: Initial Visit (60 - 90min) $190; 60 min follow up: $140

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Children (under 13): Initial visit (60mins): $140; 60 mins follow up: $140;
45 mins follow up: $110
Emergency 15 min visit/Acute 15 min Phone consult: $40

I have read and understand the above-stated policies and information. I voluntarily intend this consent form to cover the entire course of treatment for my present conditions. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print): _____Date:_____

Signature of Patient (or Guardian): _____

Signature of Naturopathic Doctor:_____