



Date: \_\_\_\_\_

**NEW PATIENT REGISTRATION FORM**

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ (m/day/yr)

Address \_\_\_\_\_ City \_\_\_\_\_

Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone (home) (\_\_\_\_) \_\_\_\_\_ (work) (\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

Occupation \_\_\_\_\_ Circle one: Full Time / Part Time / Retired / Student

Marital Status: Married / Separated / Divorced / Widowed / Single

If patient is a child, please indicate the following where applicable:

Mother's name \_\_\_\_\_ Age \_\_\_\_\_ Marital status \_\_\_\_\_

Father's name \_\_\_\_\_ Age \_\_\_\_\_ Marital status \_\_\_\_\_

If child's parents do not live together, which parent does child live with? \_\_\_\_\_

Name and Address of Relatives/Friends in case of Emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about the office? \_\_\_\_\_  
\_\_\_\_\_

Name and phone number of family doctor: \_\_\_\_\_  
\_\_\_\_\_

Main reason for visit:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list in order of importance any other health problems that are of concern to you:

- 1) \_\_\_\_\_ how long? \_\_\_\_\_
- 2) \_\_\_\_\_ how long? \_\_\_\_\_
- 3) \_\_\_\_\_ how long? \_\_\_\_\_
- 4) \_\_\_\_\_ how long? \_\_\_\_\_

Have you seen health practitioners for these concerns? Please state what type of health practitioner(s) and the treatment(s) prescribed:

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### **FAMILY HISTORY and PERSONAL HEALTH HISTORY**

Please indicate if you or anyone in your immediate family presently have or have previously had any of the following conditions. Please indicate whether it was you or a family member who was affected, as well as the outcome.

- Severe Allergies (anaphylaxis) requiring the use of an EpiPen**
- Heart Disease (heart attacks, strokes, arrhythmia, cardiomyopathy)**
- High Blood Pressure**
- Tuberculosis**
- SARS**
- Emphysema**
- Asthma**
- Hemophilia**
- Cancer** – please specify type of cancer: \_\_\_\_\_
- HIV/AIDS**
- Hepatitis**
- Epilepsy**
- Suicidal Tendencies**
- Glaucoma**
- Thyroid Disease**
- Schizophrenia**
- Diabetes**
- Alcoholism/Drug Addiction**
- Genetic Disease (please specify)** \_\_\_\_\_
- Other** \_\_\_\_\_

Are you **allergic** to any medicines or other substances? If so, please indicate:

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Have you ever had any kind of **surgery** or been **hospitalized**? If so, please indicate when and for what reason:

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Please indicate which medicines you are presently taking, including supplements, herbs, vitamins and other nonprescription items – include brand and dosage where applicable

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Do you now, or have you ever smoked cigarettes? If yes, what quantity? \_\_\_\_\_

If you consume alcohol, how much alcohol do you consume per week? \_\_\_\_\_

Do you use recreational drugs? If so, which ones, and how often?

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**EMOTIONAL HEALTH** (please circle appropriate response)

Have you ever received professional counselling? Yes No

Please rate your emotional health via the following scale: (1=unstable, difficulty coping; 10=happy, stable)

1 2 3 4 5 6 7 8 9 10 (please circle)

How stressful is your day to day life (1=stress-free; 10=extremely stressful)

1 2 3 4 5 6 7 8 9 10 (please circle)

Are you able to find joy in some/all aspects of your life? Yes No

Do you often feel anxious or depressed? Yes No If yes, how long has this been going on?

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Please provide a brief explanation of your home life, and your general emotional state

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Is there any information, not included on this form, which you would like to discuss? Please explain.

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Kristin Heins, N.D  
Doctor of Naturopathic Medicine

**REVIEW OF SYSTEMS QUESTIONNAIRE**

**General/Constitutional Information**

General state of health	Excellent	Good	Average	Poor
Sense of well-being	Excellent	Good	Average	Poor
Strength	Excellent	Good	Average	Poor
Ability to conduct usual activities	Excellent	Good	Average	Poor
Exercise tolerance	Excellent	Good	Average	Poor
Emotional well-being	Excellent	Good	Average	Poor

Average weight \_\_\_\_\_  
Recent/Past Weight loss or gain \_\_\_\_\_

Put a checkmark beside any condition you are presently experiencing or that you have experienced in the past. If the symptom was in the past, please indicate by placing a "P" beside the checkmark.

**Eyes/Ears/Nose/Mouth/Throat**

- Headaches
- Double vision
- Nose bleeding
- Dental problems
- Vertigo
- Tearing
- Frequent colds
- Bleeding gums
- Lightheadedness
- Blind spots
- Nasal Obstruction
- Dentures
- Neck stiffness
- Eye pain
- Nasal discharge
- Multiple fillings (3 +)
- Neck Pain/Tenderness
- Cataracts
- Lumps/masses found in neck

Other (please specify): \_\_\_\_\_

**Cardiovascular System**

- Chest pain
- High blood pressure
- Palpitations
- Heart murmurs
- Fainting
- Varicose veins
- Shortness of breath on exertion
- Phlebitis
- Shortness of breath while lying down
- Leg pain worse with exercise and relieved by rest
- Shortness of breath at night
- Cyanosis (bluish tone to skin)
- Swelling of ankles or hands
- Other cardiovascular problems
- Family history of heart disease

Last ECG \_\_\_\_\_  
Other cardiovascular concerns (please specify): \_\_\_\_\_

**Respiratory System**

- Chest pain when breathing
- Environmental allergies
- Coughing up blood
- Shortness of breath
- Sinus infections
- Persistent cough
- Wheezing
- Chronic nasal discharge
- Recurrent respiratory infections
- SARS
- Fever or night sweats
- Asthma
- Tuberculosis (or exposure to TB)

Last chest X-Ray or TB test \_\_\_\_\_  
Other respiratory/chest/breathing concerns (please specify): \_\_\_\_\_

**Gastrointestinal System**

- Change in appetite
- Difficulty swallowing
- Frequent indigestion
- Frequent abdominal pain
- Recent change in bowel habits
- Frequent constipation
- Frequent diarrhea
- Frequent flatulence (passing gas)
- Frequent heartburn
- Jaundice (yellowing of the skin or eyes)
- Frequent vomiting
- Hemorrhoids
- Frequent nausea
- Blood in stool
- Vomiting blood
- Abdominal pain after eating

Other gastrointestinal concerns (please specify): \_\_\_\_\_

**Genitourinary System**

- Urinary urgency
- Frequent urination
- Pain on urination
- Frequent urination at night
- Blood in the urine
- Urinary Incontinence
- Unusual (or change in) color of urine
- Kidney stones
- Frequent bladder/kidney infections
- Nephritis
- Dribbling of urine
- Change in libido
- Impotency
- Infertility
- Genital discharge
- Sexually Transmitted Dis.

Females Only: Age of onset of menses \_\_\_\_\_

Length of cycle and duration of bleeding \_\_\_\_\_

Last menstrual period \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_

Do you experience (please check): \_\_menstrual cramping and pain \_\_ bleeding between cycles  
\_\_heavy menstrual bleeding \_\_missed periods \_\_ vaginal discharge \_\_post-menopausal bleeding  
\_\_ pain during intercourse \_\_breast lumps \_\_breast tenderness \_\_nipple discharge

Are you presently or have you ever been on the birth control pill? \_\_\_\_\_  
Which one and for how long? \_\_\_\_\_

Date of onset of menopause/menopausal symptoms: \_\_\_\_\_

Other urinary or genital concerns (please specify): \_\_\_\_\_

**Skin**

- Frequent/chronic rashes
- Change in texture of skin
- Skin itching
- Skin discoloration
- Excessive moisture or dryness of skin
- Changes in hair growth
- Hair loss
- Nail changes (breaking, chipping, lines, pitting)
- Changes in moles, freckles, birth marks

Other skin concerns (please specify): \_\_\_\_\_

**Musculoskeletal System**

- Muscular pain or swelling
- Redness or heat of muscles and/or joints
- Restricted movement
- Decreased flexibility
- Joint pains
- Muscular weakness
- Muscle wasting
- Muscle cramps
- Bone pains

Other muscular or bone concerns (please specify): \_\_\_\_\_

**Neurological/Psychological**

- Convulsions
- Paralysis
- Tremor
- Loss of coordination
- Memory changes
- Speech Difficulties
- Unusual sensation (pins & needles, numbness, heightened sensation)
- Nervousness
- Emotional problems
- Anxiety
- Panic attacks
- Depression
- Previous psychiatric care
- Unusual perceptions
- Hallucinations

Other neurological/psychological concerns (please specify): \_\_\_\_\_

**Hematological/Immune/Lymphatic/Endocrine Systems**

Life threatening allergies: \_\_\_\_\_

Reactions to drugs, food, insects \_\_\_\_\_

Blood Type: \_\_\_\_\_

- Local or general lymph node enlargement or tenderness
- Increased thirst
- Hormone therapy (thyroid medication, hormonal replacement, birth control pill, diabetic medication, other
- Intolerance to heat or cold
- Previous transfusions
- Bleeding tendency
- Anemia

Other blood-related, immune, lymphatic or hormonal concerns (please specify): \_\_\_\_\_

Is there anything else you feel the doctor should be aware of?

**Kristin Heins, N.D.**  
**Doctor of Naturopathic Medicine**

**FEE SCHEDULE**

**Naturopathic Services**

Initial 1.25 hour Consultation, Assessment and Treatment: \$160.00  
One Hour Follow-up: \$115.00  
45 minute Follow-up: \$85.00  
30 minute Follow-up: \$70.00  
20 minute Follow-up: \$40.00

**Student and Senior Rates:**

Initial 1.25 hour Consultation, Assessment and Treatment: \$130.00  
One Hour Follow-up: \$90.00  
45 minute Follow-up: \$70.00  
30 minute Follow-up: \$60.00  
20 minute "check-in": \$35.00

Fees for naturopathic services are due when services are rendered. Payment may be made by **cash, cheque, visa or debit**. Please ensure that you have the appropriate method of payment available when you visit the clinic.

There will be a \$20 fee for NSF cheques.

Please give **a minimum of 24 hours notice for cancellation of appointments**, or you may be charged for 50% of the missed appointment fee. The amount of time scheduled for each naturopathic visit is significant, and abrupt cancellations make it difficult to run an efficient clinic. Certainly there are unforeseen events which may arise and these will be respectfully understood.

It is of utmost importance to remain on time for all scheduled appointments, out of respect and convenience for all patients of the clinic. Please note that if you arrive late for your appointment, there will be an attempt to accommodate you as much as possible, however only the balance of time that was booked may be available to you.

I have read and understand the naturopathic fee schedule and agree to its conditions.

**Signature of Patient or Guardian:** \_\_\_\_\_  
Name (Please Print): \_\_\_\_\_

**Kristin Heins, N.D.**  
**Doctor of Naturopathic Medicine**

### **INFORMED CONSENT TO NATUROPATHIC TREATMENT**

Naturopathic medicine is a form of primary health care which focuses on the diagnosis, treatment and prevention of disease. Naturopathic therapies are based on the following principles:

1. **First, do no harm.** This means offering health care with the least risk for all patients.
2. **Co-operate with the healing powers of nature.** The human body has an amazing capacity for self-healing. Naturopathic doctors have a deep respect for this ability, with the goal being to augment this ability using gentle therapies.
3. **Treat the cause.** Many conventional therapies focus on treating the symptoms of certain diseases. Naturopathic medicine focuses on the cause, such that if the cause is successfully treated, the symptoms may be permanently removed.
4. **Doctor as teacher.** The goal is to educate patients, such that they have a solid understanding of the disease process, and are empowered to take control of their health and get well.
5. **Treat the whole person.** This means that naturopathic doctors take the whole person into account when developing a treatment protocol. Each person is unique and the factors contributing to their health concerns are therefore unique as well. This includes emotional, spiritual and physical aspects of each individual.
6. **Preventative medicine.** Naturopathic medicine incorporates prevention into all aspect of treatment. Teaching patients about a healthy lifestyle and self-responsibility in preventing disease is a cornerstone of this form of health care.

The following therapies utilized within the scope of naturopathic medicine include:

- Clinical Nutrition and Supplementation
- Botanical (Herbal) Medicine
- Homeopathy
- Acupuncture and Traditional Chinese Medicine
- Spinal and Soft Tissue Manipulation\*
- Hydrotherapy
- Lifestyle Counselling

\*Please note that Kristin Heins, Doctor of Naturopathic Medicine, does not perform Spinal Manipulations within her practice but will assess the health of the spine and provide patients reference to Chiropractic Doctors where she feels applicable.

As a patient of this naturopathic clinic, I recognize that even the gentlest forms of treatment potentially have their complications. Although rare, these complications may arise in certain physiological conditions, as well as in very young children, the elderly, pregnant women, or individuals on multiple medications. These complications may include, but are not limited to: exacerbation of present symptoms, allergic reactions to naturopathic prescriptions, interactions with prescription medications, pain, fainting, bruising, muscle strains and sprains.

I am willing to provide Kristin Heins, Naturopathic Doctor, with all information relevant to my health. I understand that this information will be used only for the purposes of my naturopathic treatment, in order for Kristin Heins to fully understand my symptoms, my health history, and my health goals. I will provide this information voluntarily with the purpose of obtaining naturopathic care. I also understand that this information will remain completely confidential, unless I have given my explicit written consent for disclosure. I acknowledge that my name, address, phone number and email address will also be used for billing purposes and to book and confirm appointments.

I do hereby acknowledge that I have been informed of and understand the recommended naturopathic procedures, and I am aware that I have the choice to accept or reject this naturopathic care of my own free will, at any time during treatment. I further acknowledge and confirm that I have been informed of and understand the naturopathic procedures with respect to the financial costs, expected benefits, potential risks and side effects. I have also been informed of the likely consequences of not following the recommended naturopathic procedures, as well as alternative course(s) of action available to me. I further understand that naturopathic medicine, like other forms of medicine, does have limitations as a healing agent.

I confirm that I have been informed of and understand the naturopathic procedures with respect to financial costs, expected benefits, potential risks, and side effects.

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Kristin Heins, N.D.: \_\_\_\_\_