

# Welcome !

## The Natural Path Alternative Health Care Center

Thank you for choosing the Natural Path. You have taken the first step towards optimizing your overall health. Please read the following information package and return it to our office on your initial visit. If you have any questions, please feel free to call our clinic at (905) 206-0732.

### INSTRUCTIONS

**All forms must be completed prior to your initial appointment. Please arrive 15 minutes in advance to your appointment.**

1. Please complete the personal history form thoroughly. (Note: Please list all prescription medication you are currently taking.)

2. Carefully read the treatment schedule and fee sheet.

3. Please complete your diet diary 5 days prior to your initial appointment.  
**DO NOT CHANGE YOUR DIET.**

4. Please read and sign "Consent for Treatment, Payment" and "Cancellation Policy" forms.

**Please Note: If you are taking any vitamins or supplements, please stop taking them 24 hours prior to your initial appointment. Do not stop taking any prescribed medication!**

### On the day of your appointment:

1. Please bring your first morning urine sample. Your urine sample should be taken as soon as you awake.

2. **Please bring your first morning saliva sample (5ml=1 teaspoon). This is to be done before brushing your teeth or eating.**

3. Return all forms and samples to our office on your initial appointment.

4. **Please bring all test results that relate to your health concerns to our clinic on the day of your appointment so that the receptionist can make copies, if required.**

Margaret Balajewicz B.Sc., ND



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

Other health care providers:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
\_\_\_\_\_

What are your health concerns, in order of importance to you:

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_

If you are female, are you currently pregnant?      YES      NO

### Medical History

Assess your general state of health?      Excellent    Good    Fair    Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies (medicines, environmental, etc.)?

\_\_\_\_\_  
\_\_\_\_\_

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list past prescription medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

How many times have you been treated with antibiotics? \_\_\_\_\_

Do you use any of the following? (circle)

Aspirin   Laxatives   Antacids   Diet pills   Birth control pills/implants/injections

Alcohol-how much per day or week \_\_\_\_\_

Tobacco- form and amount per day \_\_\_\_\_

Caffeine- form and amount per day \_\_\_\_\_

Recreational drugs- what and how often \_\_\_\_\_

Please indicate what immunizations have you had:

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

Other:

Please indicate if any caused adverse reactions:

\_\_\_\_\_

Do you get regular screening test done by another doctor (Pap, blood tests, etc.)?      YES    NO

Please list the latest blood work taken: (provide a copy if possible)

**Diet**

Do you have any food allergies or intolerances? Please list.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

\_\_\_\_\_  
\_\_\_\_\_

**Margaret Balajewicz B.Sc., ND**

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

Describe a typical day's diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages (and total quantity): \_\_\_\_\_

### Family History

Indicate if a close relative (parent, child, sibling) has had any of the following

Condition	Who?	Condition	Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer (what kind)		Other	
Diabetes			

I do not know my family medical history

Occupation: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Do you exercise regularly? Yes No What do you do for exercise, how much, how often?

\_\_\_\_\_  
\_\_\_\_\_

Margaret Balajewicz B.Sc., ND

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

## Review of Systems

**Y** a condition you have now

**N** a condition you have NEVER had

**P** a condition you have had in the past

Responses and Comments:

1. General				
Weight				
Weight 1 year ago				
Maximum weight				
When				
Height				
Fatigue/Weakness	Y	P	N	
Fever/Chills	Y	P	N	

2. Skin				
Rashes	Y	P	N	
Eczema, hives, acne, boils (circle)	Y	P	N	
Itching	Y	P	N	
Color change	Y	P	N	
Lumps	Y	P	N	
Night sweats	Y	P	N	
Dryness/Moistness (circle)	Y	P	N	
Nail changes	Y	P	N	
Changes in mole	Y	P	N	
Skin cancer	Y	P	N	

3. Head				
Headache	Y	P	N	
Head injury (when)	Y	P	N	
Dizziness	Y	P	N	
Hair loss	Y	P	N	

4. Eyes				
Impaired vision	Y	P	N	
Glasses/Contacts	Y	P	N	
Eye pain	Y	P	N	
Tearing or dryness (circle)	Y	P	N	
Double vision	Y	P	N	
Glaucoma	Y	P	N	
Cataracts	Y	P	N	
Blurring	Y	P	N	
Itching	Y	P	N	
Redness	Y	P	N	
Discharge	Y	P	N	
Blind spot	Y	P	N	

**Margaret Balajewicz B.Sc., ND**

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

5. Ears				
Impaired hearing	Y	P	N	
Earache	Y	P	N	
Discharge	Y	P	N	
Infections	Y	P	N	

6. Nose and Sinuses				
Frequent colds	Y	P	N	
Nose bleeds	Y	P	N	
Stiffness/Post nasal drip (circle)	Y	P	N	
Hay fever	Y	P	N	
Sinus problems	Y	P	N	

7. Mouth and Throat				
Frequent sore throat (how many times a year)	Y	P	N	
Sore tongue/mouth	Y	P	N	
Gum problems	Y	P	N	
Hoarseness of voice (since when)	Y	P	N	
Dental cavities	Y	P	N	
Loss of taste	Y	P	N	

8. Neck				
Pain	Y	P	N	
Lumps/Swollen glands (circle)	Y	P	N	
Goiter	Y	P	N	

9. Respiratory				
Cough	Y	P	N	
Sputum (indicate color)	Y	P	N	
Wheezing	Y	P	N	
Asthma	Y	P	N	
Bronchitis	Y	P	N	
Pneumonia	Y	P	N	
Pleurisy	Y	P	N	
Emphysema	Y	P	N	
Difficulty breathing	Y	P	N	
Pain on breathing	Y	P	N	
Shortness of breath	Y	P	N	
Shortness of breath at night	Y	P	N	
Shortness of breath lying down	Y	P	N	
Tuberculosis	Y	P	N	
Tuberculin test	Y	P	N	
Last chest X-ray				

Margaret Balajewicz B.Sc., ND

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

10. Breasts				
Do you do self-exams?	Y	P	N	
Lumps	Y	P	N	
Pain or tenderness	Y	P	N	
Nipple discharge	Y	P	N	

11. Cardiovascular				
Heart disease	Y	P	N	
Angina	Y	P	N	
High blood pressure	Y	P	N	
Murmurs	Y	P	N	
Rheumatic fever	Y	P	N	
Chest pain	Y	P	N	
Swelling in ankles	Y	P	N	
Palpitations, fluttering	Y	P	N	
Cyanosis	Y	P	N	
Past ECG	Y	P	N	
Other heart tests				

12. Gastrointestinal				
Trouble swallowing	Y	P	N	
Heartburn	Y	P	N	
Change in appetite or thirst (circle)	Y	P	N	
Nausea	Y	P	N	
Vomiting	Y	P	N	
Vomiting blood	Y	P	N	
Bowel movements – how often?				
Is this a change?	Y		N	
Blood in stool	Y	P	N	
Belching or passing gas	Y	P	N	
Jaundice (yellow skin)	Y	P	N	
Liver disease	Y	P	N	
Gall bladder disease	Y	P	N	
Ulcer	Y	P	N	
Indigestion	Y	P	N	
Diarrhea	Y	P	N	
Rectal bleeding	Y	P	N	
Hemorrhoids	Y	P	N	
Black, tarry stool	Y	P	N	
Abdominal pain	Y	P	N	
Food allergy	Y	P	N	
Hernias	Y	P	N	

Margaret Balajewicz B.Sc., ND

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

13. Urinary				
Pain on urination	Y	P	N	
Increased frequency	Y	P	N	
Frequency at night	Y	P	N	
Inability to hold urine	Y	P	N	
Frequent infections	Y	P	N	
Kidney stones	Y	P	N	
Blood in urine	Y	P	N	
Urgency	Y	P	N	
Hesitancy	Y	P	N	

14. Male Reproductive				
Hernias	Y	P	N	
Testicular pain	Y	P	N	
Testicular masses	Y	P	N	
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal diseases	Y	P	N	
Discharge or sores	Y	P	N	
Sexual preference: Heterosexual	Y	P	N	
Bisexual	Y	P	N	
Homosexual	Y	P	N	

15. Female Reproductive				
Age menses began				
Average number of days				
Length of cycle				
Bleeding between periods	Y	P	N	
Are cycles regular	Y	P	N	
Pain during intercourse	Y	P	N	
Painful menses	Y	P	N	
Excessive flow	Y	P	N	
PMS	Y	P	N	
Birth control?	Y	P	N	
What type?				
Number of pregnancies				
Number of live births				
Number of miscarriages				
Number of abortions				
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal disease	Y	P	N	
Last menstrual period				
Vaginal discharge	Y	P	N	
Vaginal itching	Y	P	N	
Difficulty conceiving	Y	P	N	
Last PAP smear (date)				

Margaret Balajewicz B.Sc., ND

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

16. Musculoskeletal				
Joint pain or stiffness	Y	P	N	
Arthritis	Y	P	N	
Broken bones	Y	P	N	
Muscle spasms or cramps	Y	P	N	
Weakness	Y	P	N	
Joint swelling	Y	P	N	
Backache	Y	P	N	

17. Peripheral Vascular				
Deep leg pain	Y	P	N	
Cold hands/feet	Y	P	N	
Varicose veins	Y	P	N	
Thrombophlebitis	Y	P	N	
Leg cramps	Y	P	N	
Extremity numbness	Y	P	N	
Extremity coldness	Y	P	N	
Extremity swelling	Y	P	N	
Extremity ulcers	Y	P	N	

18. Neurologic				
Fainting	Y	P	N	
Seizures/Convulsions	Y	P	N	
Paralysis	Y	P	N	
Muscle weakness	Y	P	N	
Numbness or tingling	Y	P	N	
Loss of memory	Y	P	N	
Involuntary movement	Y	P	N	
Loss of balance	Y	P	N	
Speech problems	Y	P	N	

19. Endocrine				
Heat or cold intolerance (circle)	Y	P	N	
Thyroid trouble	Y	P	N	
Excessive thirst	Y	P	N	
Excessive hunger	Y	P	N	
Excessive urination	Y	P	N	
Excessive sweating	Y	P	N	
Diabetes	Y	P	N	
Hypoglycemia	Y	P	N	
Hormone therapy	Y	P	N	

20. Blood/Lymphatic				
Anemia	Y	P	N	
Easy bleeding or bruising	Y	P	N	
Past transfusions	Y	P	N	
Lymph node swelling	Y	P	N	

Margaret Balajewicz B.Sc., ND

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

21. Allergic history				
Drug sensitivity	Y	P	N	
Reaction to vaccine	Y	P	N	
Please list any allergies:				

22. Emotional				
Depression	Y	P	N	
Mood swings	Y	P	N	
Anxiety/nervousness/tension (circle)	Y	P	N	
Phobias	Y	P	N	
Alcohol/drug abuse	Y	P	N	
Insomnia	Y	P	N	

**Margaret Balajewicz B.Sc., ND**

Name: \_\_\_\_\_

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

## DIET DIARY

**Please complete this diet report five days prior to your first appointment.** Be sure to list all food and beverages consumed each day, indicating type of grains and breads and whether foods are raw or cooked, and how they were cooked. (For example, cod-poached, zucchini-steamed, raw salad-romaine lettuce, cabbage, peppers and cauliflower.)

### DAY 1

Breakfast
Lunch
Dinner

### DAY 2

Breakfast
Lunch
Dinner

Margaret Balajewicz B.Sc., ND

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

**DAY 3**

Breakfast
Lunch
Dinner

**DAY 4**

Breakfast
Lunch
Dinner

**DAY 5**

Breakfast
Lunch
Dinner

Margaret Balajewicz B.Sc., ND

## TREATMENT SCHEDULE AND FEES

VISIT	DESCRIPTION	FEES	
		Adult	Senior/Student 65+/12+
<b>Initial Visit</b>  This appointment is 2 hours in length.	<ul style="list-style-type: none"> <li>• Discussion of chief complaint.</li> <li>• Discussion of diet, lifestyle, and overall health.</li> <li>• Biological Terrain Assessment.</li> <li>• Physical examination.</li> <li>• Recommendation of Naturopathic medicines.</li> <li>• Treatment schedule.</li> </ul> <p style="text-align: center;">REPORT OF ALL HEALTH FINDINGS WILL BE EXPLAINED AND GIVEN IN FULL DETAIL</p>	\$275.00	\$220.00
<b>Subsequent Visits</b>  This appointment is 30 minutes in length.	<ul style="list-style-type: none"> <li>• Progress Assessment</li> <li>• Diet modifications.</li> <li>• Addressing any new symptoms or concerns.</li> </ul>	\$60.00	\$38.00
<b>Re-Assessment</b>  This assessment is 1 hour in length.	<ul style="list-style-type: none"> <li>• Re-testing with BTA</li> <li>• Physical examination.</li> <li>• Progress Assessment.</li> <li>• Address any new symptoms or concerns.</li> </ul>	\$125.00	\$120.00

### TREATMENT SCHEDULE FOR CHILDREN UNDER THE AGE OF 12

VISIT	DESCRIPTION	FEE
<b>Initial Visit</b>  This appointment is 1 hour in length.	<ul style="list-style-type: none"> <li>• Discussion of chief complaint</li> <li>• Discussion of diet, lifestyle, and overall health.</li> </ul>	\$70.00
<b>Subsequent Visits</b>  This appointment is 30 minutes in length	<ul style="list-style-type: none"> <li>• Progress Assessment.</li> <li>• Diet modifications.</li> <li>• Addressing any new symptoms or concerns.</li> </ul>	\$38.00

- Please call our office if you have any questions or concerns in regards to your appointments.

## CANCELLATION POLICY

	<b>Days of Notice</b>	<b>Fee without Notice</b>
<b>NEW PATIENTS</b>	5 working days	Charge of initial appointment
<b>SUBSEQUENT VISITS AND TREATMENTS</b>	2 working days	Charge of that visit and/or treatment

It is in my best interest to attend all appointments. I understand that failure to attend appointments without sufficient notice will result in missed appointment charges.

The Natural Path Alternative Health Care Center has implemented such a policy out of respect for emergency patients, patients who are waiting for appointments and the doctors who are treating you.

I fully understand the cancellation policy enforced by The Natural Path Alternative Health Care Center.

Patient's Signature	Witness
---------------------	---------

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

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

## **INFORMED CONSENT**

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Naturopathic medicine uses a variety of approaches. The main modalities used by Naturopaths are: diet and nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy, physical medicine, lifestyle counseling and intravenous therapy.

**Individual diets and nutritional supplements** are recommended to address deficiencies, treat diseases and promote health. The benefits include increased energy, increased gastrointestinal function, improved immunity and general well being.

**Botanical medicine** is a plant based medicine using herbals teas, tinctures, capsules and other forms of herbal preparations to assist in the recovery from injury and disease. Herbal preparations are used in the treatment as well as prevention of diseases.

**Homeopathy** is a form of medicine based on the Laws of Similars – that is the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal or mineral origins are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool and effects healing on a physical and emotional level.

**Chinese medicine** includes acupuncture, as well as the use of botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Sometimes moxa (a compressed herb in the form of a stick) is burned over an acupuncture point to help relieve symptoms. Botanical formulas may be given in the form of pills, tinctures or decoctions (strong teas) to be taken internally or used externally as a wash. Herbal formulas may include shell, mineral and animal materials as well as plants. Dietary advice is based on traditional Chinese medical theory.

**Physical medicine** refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.

**Intravenous therapy** refers to injection of vitamins, minerals, specific amino acids and botanical extracts into the vein. This therapy ensures 100% absorption rate and allows high dosage administration without intestinal irritation.

The Naturopathic Doctor will take a thorough case history, do a screening physical examination, including a breast exam and urine sample analysis. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

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

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your ND immediately.

There is some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions (anaphylaxis) to supplements, injectables or herbs
- Inflammation of the vein used for injection, phlebitis
- Pain, bruising or injury from injections or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa
- Muscle strains and sprains, disc injures from spinal manipulation

With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list exceptions below):

---

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic and diagnostic procedures and have discussed to my satisfaction this and any requests for related information with the Naturopathic Doctor, and/or with the office or clinical assistant(s). I further acknowledge and confirm that I have been informed of and understand the therapeutic and diagnostic procedures with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having/following the therapeutic and diagnostic procedure(s), and what alternative course(s) of action are available to me.

As a result, I so hereby voluntarily consent my informed consent for the recommended therapeutic and diagnostic procedure(s) as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

**Patient Name: (Please print):** \_\_\_\_\_

**Signature of Patient or Guardian:** \_\_\_\_\_

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

Signature of ND: \_\_\_\_\_  
Margaret Balajewicz B.Sc., ND