Mary-Ellen Kelly, B.P.E., N.D.
DOCTOR OF NATUROPATHIC MEDICINE

2490 Bloor Street West ☞ Toronto, Ontario ☞ M6S 1R4 ☞ 416-766-7227

NEW CLIENT INFORMATION FORM

Dear Client:
My ability to draw effective conclusions about your present state of health and how to improve it, depends to a significant extent on your ability to respond thoughtfully and accurately to both these written questionnaires and those posed during your consultations. I am the only person who will review these forms and your confidentiality will be strictly maintained. Your careful consideration of each of the following questions will allow for more effective use of your scheduled consultation time. A list of fees is included for your convenience. Thank you for your time in advance and I look forward to working together to achieve your health goals.
Mary-Ellen Kelly, N.D.

Name: ____

Address: ____

Phone: Residence: {____}_______________ Business: {____} ________________

Date of Birth: _______________________ **Age:** ___________________________

Height: ____________________________ **Weight:** __________________________

Do you have insurance coverage for Naturopathy? YES/NO

What is your occupation? ____

Who referred you to this clinic? ____

What are your main health concerns at this time? Date symptoms started

1) ____ / ___________________

2) ____ / ___________________

3) ____ / ___________________

Please list any medications you are taking:

____

____

Please list any supplements (vitamins, etc.) you are taking:

____

____

NEW CLIENT INFORMATION FORM

Have you had Naturopathic care in the past? **YES/NO**

If yes, please explain how your needs were *not* met in the past:

____

Please list any medical conditions or abnormal lab results that you have had in the past:

____

____

Any hospitalizations or surgeries?:

____

____

Any known allergies or food sensitivity?:

____

____

How many hours do you sleep? ______ **Is it interrupted?** **YES/NO**

If interrupted, for what reason(s) ____

How often do you move your bowels? {please circle one answer}

every day; 2 x's daily; 3 x's daily, ____x's a week; every 2 days.

		Amount per: /day	or /week
Do you smoke?	**YES/NO**	____/day	_____ /week
Do you drink alcohol?	**YES/NO**	____/day	_____ /week
Do you drink coffee	**YES/NO**	____/day	_____ /week
/or caffeinated tea?	**YES/NO**	____/day	_____/week
Do you drink soda pop?	**YES/NO**	____/day	_____ /week
Do you drink water?	**YES/NO**	____/day	_____ /week
Do you exercise?	**YES/NO**	How often? _____	Type? ______
Do you meditate or pray?	**YES/NO**	How often? __________________	

What do you feel is the cause of your current health concerns?

____

____

____

Health Appraisal Questionnaire

0= Never **1= Mild or Occasional** **2= Moderate** **3= Severe or Frequent**

Burping	0	1	2	3
Fullness for extended time after meals	0	1	2	3
Bloating	0	1	2	3
Poor Appetite	0	1	2	3
Stomach upsets easily	0	1	2	3
History of constipation	0	1	2	3
Abdominal cramps	0	1	2	3
Indigestion after eating	0	1	2	3
Fatigue after eating	0	1	2	3
Lower bowel gas	0	1	2	3
Heartburn	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Roughage and fiber causes constipation	0	1	2	3
Mucous in stools	0	1	2	3
Stool poorly formed	0	1	2	3
Three or more large bowel movements daily	0	1	2	3
Foul smelling stool	0	1	2	3
Dry, flaky skin and/or dry brittle hair	0	1	2	3
Pain on the left side under rib cage	0	1	2	3
Pain on the right side under rib cage	0	1	2	3
Acne	0	1	2	3
Intolerance to greasy foods	0	1	2	3
Antacid use	0	1	2	3
Sudden, acute indigestion	0	1	2	3
Relief of symptoms by carbonated beverages	0	1	2	3
Black stool when not taking iron supplements	0	1	2	3
Bladder and kidney infections	0	1	2	3

Vaginal yeast infections	0	1	2	3
Bad breath	0	1	2	3
Body odour	0	1	2	3
Big toe painful	0	1	2	3
Trouble waking up in the morning	0	1	2	3
Depressed, apathetic	0	1	2	3
Low sex drive	0	1	2	3
Sugar causes irritability and mood swings	0	1	2	3
History of antibiotic use	Yes		No	
Thinning or loss of outside portion of eyebrow	Yes		No	
Smoker	Present		Past	
High cholesterol	Present		Past	
Sensitive to exhaust fumes, smog, petrochemicals, perfume	0	1	2	3
Dizziness when standing suddenly	0	1	2	3
Crave sweets	0	1	2	3
Headaches relieved by eating sweets or alcohol	0	1	2	3
Feel shaky or jittery	0	1	2	3
Irritable if a meal is missed	0	1	2	3
Wake up in middle of night craving sweets	0	1	2	3
Need to drink coffee to get started	0	1	2	3
Poor memory, forgetfulness	0	1	2	3
Poor concentration	0	1	2	3
Night sweats	0	1	2	3
Increased thirst	0	1	2	3
Lowered resistance to infection	0	1	2	3
Family history of diabetes	0	1	2	3
Frequent urination	0	1	2	3

MALES ONLY

Pain or burning while urinating	0	1	2	3
Wake up to urinate at night	0	1	2	3
Dripping after urination	0	1	2	3
Difficulty attaining and/or maintaining an erection	0	1	2	3

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DECLARATION AND CONSENT TO TREATMENT

This is to acknowledge that I understand that:

1) Any treatment or advice provided to me as a client of Mary-Ellen Kelly,N.D., Doctor of Naturopathic Medicine is not mutually exclusive from any treatment or advice that I may now be receiving or may receive in the future from another licensed health care provider.

2) I am at liberty to seek or continue medical care from a medical doctor or other health care provider licensed to practice in Ontario.

3) The practitioners in this health care centre are Naturopathic or Chiropractic Doctors and are not medical doctors.

4) Treatments are non-invasive, natural methods, which have a proven clinical foundation, yet may not be accepted practice by standard allopathic medicine.

5) I declare that I have received an explanation of the treatment and/or services that I will receive at this office and hereby authorize and consent to treatment by Mary-Ellen Kelly, N.D.

6) The ultimate responsibility for my health is my own and the clinic is here to support me in this. The clinic reserves the right to discontinue services should my expectations and what is provided be found to be incongruous.

7) I agree to pay my full account at the time of each visit or treatment, including fee for services, cost of supplements, cost of laboratory tests and other fees.

8) 24 - hour notice is required for appointment cancellation, otherwise a $ 30.00 fee applies.

Dated this _______ day of _____________________, 20 ______.

____
Client's Signature

Print Client's Name: ____