

# ODETTE BULAONG, BSC(HONS), ND | NATUROPATHIC DOCTOR

Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

## ADULT FEMALE NEW PATIENT FORM

Name			Age
Date of Birth	Height	Weight	Gender
Marital Status	Occupation	Employer	
Address, City, Postal Code	Phone Numbers [Home:] [Work:] [Cell:] May we leave you messages regarding your clinic visits? Yes No	In case of emergency notify:  Phone number:	
Email: _____ Would you like to join Odette Bulaong, ND's FREE e-newsletter list? Yes No			
<b>Who referred you to or how did you hear about Odette Bulaong, ND?</b>			

### Health Care Providers (e.g. Medical Doctor, Gynecologist, Specialist, Chiropractor)

Name	Name	Name
Occupation: FAMILY DOCTOR OR GP	Occupation	Occupation
Phone	Phone	Phone

## Health Concerns

1. Please describe your main health concern(s). Please list when you first noticed the problem.

\_\_\_\_\_ Year Started: \_\_\_\_\_

\_\_\_\_\_ Year Started: \_\_\_\_\_

\_\_\_\_\_ Year Started: \_\_\_\_\_

2. Please list/describe any past major illnesses, injuries, surgeries, and hospitalizations:

\_\_\_\_\_ When: \_\_\_\_\_

\_\_\_\_\_ When: \_\_\_\_\_

\_\_\_\_\_ When: \_\_\_\_\_

When was your last physical exam with your family doctor? \_\_\_\_\_

When did you last have laboratory blood work done? \_\_\_\_\_

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## Medication History

Please list all **CURRENT** and **PAST** prescription and over-the-counter medications (including aspirin, antacids, laxatives) you are taking or have taken:

	MEDICATION (E.G. ACETAMINOPHEN)	AMOUNT (E.G. TWO 325 MG CAPSULES)	# TIMES TAKEN/DAY (E.G. 2 TIMES/DAY)	LENGTH OF TIME TAKEN
C U R R E N T				
P A S T				

On average, how many times have you been treated with **ANTIBIOTICS**? \_\_\_\_\_ Date of last time: \_\_\_\_\_

## Natural Health Product History

Please list all **CURRENT** and **PAST** natural health products (vitamins, minerals, herbal medicines, homeopathic remedies) you are taking or have taken:

	NATURAL HEALTH PRODUCT *INCLUDING BRANDNAME (E.G. VITAMIN C)	AMOUNT (E.G. ONE 100 MG CAPSULE)	# TIMES TAKEN/DAY (E.G. 2 TIMES/DAY)	LENGTH OF TIME TAKEN
C U R R E N T				
P A S T				

**Medical History**

1. Please check all illnesses or diagnoses you have had in the past along with the year it started.

Illness	Year	Illness	Year
<input type="checkbox"/> AIDS/Positive HIV	_____	<input type="checkbox"/> Liver/Gall Bladder Condition	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Mental Illness	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Migraine Headaches	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Mononucleosis	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Osteoporosis/osteopenia	_____
<input type="checkbox"/> Convulsions/Seizures	_____	<input type="checkbox"/> Pap test, abnormal	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Eating Disorder	_____	<input type="checkbox"/> Sexually Transmitted Illness (STI)	_____
<input type="checkbox"/> Endometriosis	_____	<input type="checkbox"/> Stomach/Duodenal Ulcer	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Thyroid Problems	_____
<input type="checkbox"/> Heart Murmur	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Urinary Tract Infections	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Yeast Infections	_____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Vaginitis	_____
<input type="checkbox"/> Kidney/Bladder Disease	_____	<input type="checkbox"/> Other _____	_____

2. **Family Illnesses:** Please list whether your *mother, father, siblings, children, maternal or paternal grandparents* have had any of the following conditions:

	WHO?		WHO?		WHO?
Allergies		Diabetes		Kidney Disease	
Anemia		Digestive Conditions		Liver Disease	
Asthma		Heart Disease		Mental Illness	
Birth Defect		Heart Attack		Stroke	
Bleeding Disorder		High Cholesterol		Thyroid condition	
Cancer Type:		High Blood Pressure		Other:	

3. Have you had any dental work procedures? Please describe and include the year it was done.

4. Please list any known or suspected allergies to foods, drugs, inhalants, environment or other substances:

5. Please list the 5 most significant stressful events in your life, from the most recent to the least recent. Please indicate if any of these situations are still impacting on your life.

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## Lifestyle

1. Do you participate in regular physical activities? What type and how often?

2. Please describe if you follow a particular diet or avoid any specific foods?

3. Please list what you would usually eat in a day, including approximate amounts:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Beverages \_\_\_\_\_

Approximate number of 250 mL glasses of water you drink per day: \_\_\_\_\_

4. Please indicate usage and circle whether per day/ week/month describes this amount best:

Cigarettes \_\_\_\_\_ per day/wk/month

Alcohol \_\_\_\_\_ per day/wk/month

Recreational Drugs \_\_\_\_\_ per day/wk/month

Chewing tobacco \_\_\_\_\_ per day/wk/month

5. Have you smoked in the past? How much and how long?

6. Are you now or have you been exposed to breathing in second hand smoke?

If yes, for how long?

## Review of Body Systems

Check the box and fill in the blank spaces for each of the symptoms you currently have. For symptoms you have had in the past but not currently, print the letter P beside the symptom box.

### General

- Recurrent infections
- Swollen lymph nodes
- Night sweats
- Sweat easily
- Strong, excessive thirst
- Thirst but no desire to drink
- Excessive appetite
- Recent change in appetite
- Fatigue
- Poor sleep
- Edema (water retention)
- Underweight
- Overweight

- Heat intolerance
- Cold intolerance
- Other \_\_\_\_\_

### Skin

- Bleed easily
- Bruise easily
- Rashes
- Itching
- Eczema
- Psoriasis
- Dry skin/scalp
- Oily skin/scalp
- Loss of hair

- Dandruff
- Ulcerations
- Pimples
- Hives
- Fungal infection
- Recent moles
- Mole changes (colour, size)
- Other \_\_\_\_\_

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## Head, Eyes, Ears, Nose, Throat

- Dizziness
- Concussions
- Headaches
- Ringing in ears
- Hearing aid
- Poor hearing
- Draining/discharge from ear
- Teeth problems
- Bleeding gums
- Dentures
- Sores on lips or tongue
- Dry mouth
- Grinding teeth
- Dry throat/hoarseness
- Jaw clicks
- Spots in eyes
- Wear glasses/contacts
- Color blindness
- Eye pain
- Cataracts
- Night blindness
- Blurry vision
- Nose bleeds
- Snore
- Sinus problems
- Mucus in nose or throat
- Other \_\_\_\_\_

## Cardiovascular

- Blood clots
- Fainting
- Chest pain
- Heart palpitations
- Cold hands/feet
- Difficulty breathing
- Irregular heartbeat
- Swelling in hands/feet
- Other \_\_\_\_\_

## Respiratory

- Coughing blood
- Coughing phlegm/mucus
- Tight chest
- Shortness of breath
- Wheezing
- Difficulty breathing when lying down
- Recurrent/persistent cough
- Other \_\_\_\_\_

## Gastrointestinal

- Nausea
- Vomiting
- Gas
- Bloating
- Bad breath
- Constipation
- Use laxatives
- Diarrhea
- Bowel movement changes
- Abdominal pain or cramps
- Sensitive abdomen
- Indigestion/heartburn
- Belching
- Rectal pain
- Bloody stools
- Mucus in stools
- Hemorrhoids
- Black stools
- Other \_\_\_\_\_

## Genito-Urinary

- Pain on urination
- Unable to hold urine
- Urgency to urinate
- Frequent urination
- Wake up to urinate
- Blood in urine
- Dribbling urination
- Kidney stones
- Other \_\_\_\_\_

## Musculoskeletal

- Neck ache/pain
- Back ache/pain
- Muscle pains
- Muscle spasm
- Muscle cramps
- Joint pain
- Stiffness
- Muscle weakness
- Orthotics
- Other \_\_\_\_\_

## Neurological

- Numbness/tingling
- Twitching
- Tremors
- Loss of balance or coordination
- Nerve damage
- Vertigo
- Other \_\_\_\_\_

## Behavioral

- Nervousness/anxiety
- Depression
- Easily stressed
- Moody
- Aggressive/bad temper
- Panic attacks
- Fear
- Other \_\_\_\_\_

## Female

- Vaginal itching or burning
- Vaginal discharge
- Painful menstrual periods
- Lumps in breast
- Discharge from nipple
- Pain with intercourse
- Bleeding between periods
- No periods in over 3 months
- Fibroids (leiomyomas)
- Ovarian cyst
- Polycystic Ovarian Syndrome
- Premenstrual syndrome (PMS)
- Change in sex drive
- Age of first menstrual period
- \_\_\_\_\_
- Date of last menstrual period
- \_\_\_\_\_
- Date of last pap smear
- \_\_\_\_\_
- Methods of birth control
- \_\_\_\_\_
- History of birth control pill
- Hysterectomy
- Fertility Issues
- Number of pregnancies:
- Number of live births:
- Number of miscarriages:
- Number of stillbirths:
- Number of abortions:
- Insufficient lactation (breastmilk)
- Tubal ligation
- Perimenopausal
- Menopausal (no periods in >1 yr)
- History of hormone replacement
- Other \_\_\_\_\_

Thank you ☺

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## Declaration of Informed Consent to Naturopathic Diagnostic and Therapeutic Procedures

In order for your Odette Bulaong, ND to assess your health, identify risk factors for potential diseases and create a treatment plan for your existing health condition(s), the following **naturopathic diagnostic procedures** may be performed:

- A thorough Health History Intake
- Complaint-Oriented Physical Exam: body systems that may be affected by your health condition may be examined.
- Urinalysis
- Complete Screening Physical Exam: a basic examination of all major body systems.
- Laboratory Blood Work: a requisition to have your blood work drawn privately at LifeLabs will be provided or you may choose to have your blood work done through your family doctor as time permits.
- Additional In-House/Laboratory Work: salivary hormone testing, allergy testing, etc.
- Chinese tongue and pulse diagnosis: examination of the tongue and pulses to provide important information on body organs with respect to Chinese Medicine.
- Breast Exam
- Genital Exam

**\*Please note** that the clinic is not set up for gynecological exams (including Pap smears) or rectal exams at this time. If your health condition requires these, you will be referred back to your family doctor to have these exams completed.

Naturopathic medicine is a form of primary health care that uses natural substances and treatments to support and stimulate the body's ability to heal itself. The **naturopathic therapeutic procedures** that may be used by Odette Bulaong, ND individually or in combination to address your health condition(s) are:

- Nutritional Counseling
- Botanical Medicine
- Acupuncture and Chinese Medicine
- Homeopathic Medicine
- Lifestyle Counseling
- Physical Medicine & Hydrotherapy
- Facial Rejuvenation Acupuncture

Although the above treatments are safe and natural, even the gentlest therapies can have complications. This is especially true in certain conditions such as pregnancy, lactation, or in very young children. Some therapies must be used with caution in certain diseases such as pregnancy, diabetes, heart, liver or kidney disease. It is very important therefore that you inform Odette Bulaong, ND immediately of any health condition you may have.

Some complications that can occur with naturopathic treatment include but are not limited to:

- Aggravation of pre-existing or existing symptoms
- Allergic reactions (for example to supplements or herbs)
- Minor bleeding or bruising from acupuncture needles, B12 shots
- Fainting or puncturing of an organ with acupuncture needles
- Accidental burning of the skin from the use of moxa or cupping
- Muscle strains and sprains, disc injuries from spinal manipulation
- The potential for stroke is a concern in neck manipulation.

I understand that the results are not guaranteed. I do not expect Odette Bulaong, ND to be able to anticipate or explain all risks and complications. I will rely on Odette Bulaong, ND to exercise judgment during the course of treatment which she feels at that time is in my best interests, based on the facts then known. I, the undersigned, do hereby acknowledge that I have been informed of and understand the naturopathic diagnostic and therapeutic procedure(s) and have discussed to my satisfaction this and any requests for related information with Odette Bulaong, ND.

I further acknowledge and confirm that I have been informed of, and understand the diagnostic and therapeutic procedure(s) with respect to the financial costs, expected benefits, potential risks and side effects, the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.



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## Privacy Information

Privacy of your personal information is important to this clinic while I provide you with quality naturopathic care. We understand the importance of protecting your personal information and are committed to collecting, 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. All staff members who come into 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.

## Collection of Personal Health Information

We collect personal health information about you directly from you or from the person acting on your behalf. The personal health information that we collect may include, for example, your name, date of birth, address, health history, records of your visits with Odette Bulaong, ND and the care that you received during those visits. Occasionally, we collect personal health information about you from other sources if we have obtained your consent to do so or if the law permits.

## Uses and Disclosures of Personal Health Information

We use and disclose your personal health information to:

- Assess your health care needs;
- Develop effective treatment plans for you;
- Provide you with treatment, health services, and care of an acute, chronic and/or preventive nature;
- Research and inform you of additional treatment options you may benefit from;
- Inform you of clinic services, events, updates, and health care information;
- Contact you and maintain communication with you;
- Contact you to book and confirm appointments;
- Follow up with treatment, care, health status and billing;
- Communicate with other treating health care providers, including specialists, family practitioners, referring physicians, and any other health provider involved in your care;
- Plan, administer and manage our internal operations;
- Conduct risk management and quality improvement activities;
- Teach, demonstrate or conduct research on an anonymous basis;
- Conduct patient satisfaction surveys;
- Compile statistics on an anonymous basis;
- Invoice, process payments and collect unpaid accounts for goods and services;
- Permit potential purchasers, practice brokers or advisors to evaluate the naturopathic practice and/or conduct an audit in preparation for a practice sale;
- Deliver your charts and records to the naturopathic doctor's insurance carrier to enable the insurance company to assess liability and quantify damages, if any;
- Comply with legal and regulatory requirements, and fulfill other purposes permitted or required by law;
- Comply with legal and regulatory requirements, including the delivery of patient's charts and records to The College of Naturopaths of Ontario (CONO) in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act (RHPA);
- Comply with the agreements/undertakings entered into voluntarily by the member with CONO, including the delivery and/or review of patient's charts and records to the Board in a timely fashion for regulatory and monitoring purposes;
- Prepare materials for CONO complaints committee, if necessary.

Your information may be accessed by regulatory authorities under the terms of the RHPA for the purpose of CONO fulfilling its mandate under the RHPA and/or for the defence of a legal issue.

You may access and correct your personal health records, or withdraw your consent for some of the above uses and disclosures by informing Odette Bulaong, ND in writing (subject to legal exceptions). If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

We take steps to protect your personal health information from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal. We conduct audits and complete investigations to monitor and manage our privacy compliance.

