

Dr. Megan Kimberley, Naturopath.

410C Upper Bench N., Penticton, B.C. V2A 8T4

778-476-6016

Name: _____ Age: ____ Date Of Birth: ___(d)___(m)___(y)

Address: _____

Postal Code: _____ Email: _____

Phone: (Home): _____ (Office): _____

Occupation: _____ MSP#: _____

Emergency Contact: _____ Phone: _____

How Did You Hear About Us?: _____

Health Concerns In Order Of Importance For You:

1. _____ 3. _____

2. _____ 4. _____

List Medications And Supplements You Are Currently Taking (Include Dosage):

Other Health Care Providers (Medical Doctor, Chiropractor...):

Please List Any Major Illnesses, Injuries, or Surgery's With Dates:

Any Allergies or Sensitivities?

Do you or your employer pay premiums on your Care Card? _____

If no, please show Care Card to reception to check coverage.

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YOU WILL BE CHARGED FOR MISSED APPOINTMENTS

Consent

I _____ (Patient Name), acknowledge that I am aware naturopathic treatment and conventional medical treatments are not mutually exclusive and I am free to seek or continue medical care from the health practitioners of my choice. I hereby authorize and consent to naturopathic examination and treatment by Dr. Megan Kimberley.

Signature: _____ Date: _____

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Review Of Systems

Y = Yes you have this symptom now.

Name: _____

N = No you have never had it.

P = In the Past you have had it.

Date: _____

Weight:	Fever	Y N P
Height:	Chills	Y N P

Skin

Rashes	Y N P	Acne	Y N P	Moles	Y N P
Eczema	Y N P	Itching	Y N P	Skin Cancer	Y N P
Hives	Y N P	Psoriasis	Y N P	Dryness	Y N P
Lumps	Y N P	Color Changes	Y N P	Boils	Y N P
Night Sweats	Y N P	Nail Changes	Y N P		

Comments: _____

Head

Headaches	Y N P	Head Injury	Y N P	Dandruff	Y N P
Migraines	Y N P	Hair Loss	Y N P	Dizziness	Y N P

Comments: _____

Eyes

Redness	Y N P	Glaucoma	Y N P	Itching	Y N P
Pain	Y N P	Cataracts	Y N P	Floaters	Y N P
Spots	Y N P	Discharge	Y N P	Double Vision	Y N P
Blurring	Y N P	Tearing	Y N P	Dryness	Y N P
Glasses	Y N P	Contacts	Y N P		

Comments: _____

Ears

Infections	Y N P	Hearing Loss	Y N P	Discharge	Y N P
Earaches	Y N P	Hearing Aid	Y N P	 ringing In Ears	Y N P

Comments: _____

Nose And Sinuses

Stiffness	Y N P	Nose Bleeds	Y N P	Frequent Colds	Y N P
Discharge	Y N P	Sinus infections	Y N P	Itching	Y N P

Comments: _____

Mouth And Throat

Dryness	Y N P	Loss of Taste	Y N P	Tooth Pain	Y N P
Bleeding	Y N P	Sore Throats	Y N P	Root Canals	Y N P
Tonsillitis	Y N P	Canker Sores	Y N P	Tooth Fillings	#: ____

Comments: _____

Respiration

Sputum	Y N P	Chest Pain	Y N P	Emphysema	Y N P
Cough	Y N P	Bronchitis	Y N P	Asthma	Y N P
Wheezing	Y N P	Pneumonia	Y N P	Tuberculosis	Y N P
Shortness of Breath	Y N P	Smoker	Y N P	Loss of Voice	Y N P

Comments: _____

Cardiovascular

Chest Pain	Y N P	Rapid Heart Beat	Y N P	Heart Disease	Y N P
Murmurs	Y N P	Varicose Veins	Y N P	Ankle Swelling	Y N P
Fluttering	Y N P	Deep Leg Pain	Y N P	Leg Cramps	Y N P
ECG Test	Y N P	Cold Hands	Y N P	Cold Feet	Y N P
Numbness	Y N P	Easy Bruising	Y N P	Anemia	Y N P

Comments: _____

Gastrointestinal

Heart Burn	Y N P	Indigestion	Y N P	Hemorrhoids	Y N P
Hernia	Y N P	Ulcers	Y N P	Constipation	Y N P
Nausea	Y N P	Bloating	Y N P	Diarrhea	Y N P
Vomiting	Y N P	Flatulence/Gas	Y N P	Stomach Pain	Y N P
Belching	Y N P	Black Stools	Y N P	Anal Bleeding	Y N P
Change in Thirst	Y N P	Change in Appetite	Y N P	Trouble Swallowing	Y N P
Gall Stones	Y N P	Number Of Bowel Movements A Day:			#:_____

Comments: _____

Musculoskeletal

Backache	Y N P	Joint Pain	Y N P	Joint Stiffness	Y N P
Twitching	Y N P	Joint Swelling	Y N P	Broken Bones	Y N P
Cramps	Y N P		Muscle Weakness	Y N P	Sprains

Comments: _____

Genito-Urinary

Urgency	Y N P	Infections	Y N P	Incontinence	Y N P
Dribbling	Y N P	Blood In Urine	Y N P	Smelly Urine	Y N P
Hesitancy	Y N P	Kidney Stones	Y N P	Cloudy Urine	Y N P
Increased Frequency	Y N P	Frequency At Night	Y N P	Pain On Urination	Y N P

Comments: _____

Neurological

Fainting	Y N P	Numbness	Y N P	Convulsions	Y N P
Weakness	Y N P	Loss Of Memory	Y N P	Tremors	Y N P
Paralysis	Y N P	Loss Of Balance	Y N P	Tingling	Y N P

Comments: _____

Mental/Emotional

Anxiety	Y N P	Depression	Y N P	Insomnia	Y N P
Tension	Y N P	Mood Swings	Y N P	Alcoholism	Y N P
Phobias	Y N P	Addictions	Y N P	Hyperactivity	Y N P
Recreational Drug Use (Pot, Hallucinogens)			Y N P	Irritability	Y N P

Comments: _____

Male Genitalia And Reproduction

Hernias	Y N P	Impotence	Y N P	Testicle Pain	Y N P
Discharges	Y N P	Sexual Problems	Y N P	Sexually Active	Y N P
Sores	Y N P	Warts	Y N P	Itching	Y N P

Comments: _____

Female Genitalia And Reproduction

PMS	Y N P	Discharges	Y N P	Prolapse	Y N P
Spotting	Y N P	Yeast Infection	Y N P	Heavy Bleeding	Y N P
Cramping	Y N P	Itching	Y N P	Pain With Sex	Y N P
Fibroids	Y N P	Ovarian Cysts	Y N P	Painful Periods	Y N P
Warts	Y N P	Sexually Active	Y N P	Hot Flashes	Y N P
Nipple Discharge	Y N P	Breast Tenderness	Y N P	Breast Lumps/ Fibrosities	Y N P
Number Of Term Pregnancies:			Number of Miscarriages:		
Number Of Abortions:			Birth Control Used:		
Age Of First Menses:			Last Menses (Menopause):		

Comments: _____

Family History (Please indicate if any family members have had the following)

Allergies		Heart Disease		Osteoporosis	
Arthritis		High Blood Pressure		Rheumatic Fever	
Cancer		Kidney Disease		Skin Rashes	
Chronic Bronchitis		Mental Illness		Strep Throat	
Diabetes		Mononucleosis		Strokes	
Emphysema		Multiple Sclerosis		Tuberculosis	
Nationality:					

Comments: _____

What Are Your Hobbies? _____

How Do You Manage Stress? _____

What Forms of Exercise Do You Get? _____