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NEW PATIENT QUESTIONNAIRE

Our ability to draw effective conclusion about your present state of health and the best way to improve it depends, to certain extents, on your ability to complete this questionnaire honestly and accurately. The doctor is the only person who will review this survey and your confidentiality is strictly maintained. If you have questions or concerns about this questionnaire, please call the office at once and we will help you to decide how to best solve the issue.

Please be sensitive to the fact that some people are not able to tolerate the odor of the cigarettes, perfume cologne or after-shave lotions. Please come to our office smoke and fragrance free. We will appreciate your attention to this. Thank you.

Name: _____

Address: _____

City: _____ **Postal Code:** _____

Home Phone: _____ **Bus. Phone:** _____

Date of Birth: _____ **Present Age:** _____

Height: _____ **Weight:** _____

Occupation: _____

How did you find about our office: _____

e-mail: _____

Emergency Contact: _____

Name: _____ Date: _____

A. What would you like to see changed in your health? (indicate how long each of these conditions have existed).

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

B. How long has it been since you were totally well? _____

C. How many courses of antibiotics have you had in the past 10 years? _____
Have you had any adverse reactions to antibiotics? _____

D. Have you had any vaccinations? (list)

Have you had any reactions to them? _____

E. Have you had any silicone implants?

F. Do you have a pacemaker or nay other implant?

G. Describe your home/work surroundings (any health hazards e.g. molds, power lines close by, computer exposure, chemical exposure).

H. Please list any surgeries you have had?

Please state your primary reason for attending this office. If this involves a specific health condition, please describe it in detail. In your own words. List the very first time that you noticed this condition and describe carefully any factors that you suspect may have played a role in its onset and perpetuation.

Please list every detail and give the Doctor the opportunity to distinguish what may not be relevant to your care. Please attach a sheet if more space is required.
Please list 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

<p>BREASTS: Lumps Y P Tenderness Y P Self examine Y P Other _____</p> <p>PARATHYROID: Osteoporosis Y P Joint pain Y P Gum/ tooth disease Y P Kidney stones Y P Ridged Fingernails Y P</p>	<p>CARDIOVASCULAR: Heart disease Y P Angina Y P High blood pressure Y P Murmurs Y P Chest pain Y P Palpitation Y P Ankle swelling Y P Rheumatic fever Y P Last ECO test Y P Other _____</p>	<p>MUCULOSKELETAL: Joint pain Y P Arthritis Y P Broken bones Y P Numbness Y P Tingling Y P Muscles spasms Y P Weakness Y P Backache Y P Other _____</p>
<p>URINARY: Pain urinating Y P More frequent Y P Reduced flow Y P Kidney stones Y P Blood in urine Y P Infections Y P Incontinence Y P Other _____</p>	<p>BLOOD/ LYPHATHICS: Anemia Y P Swollen hymphs Y P Easy bleeding Y P Bruising Y P Transfusion Y P Clotting Y P Other _____</p>	<p>PANCREAS: Food allergies Y P Blood sugar abnormalities Y P Maldigestion Y P Undigested food in stool Y P Bowel gas Y P Stool floats Y P</p>
<p>FEMALES: Age of first menses _____ Menopause Symptoms Y P Age _____ Type of birth controls _____ How long _____ Last pap _____ Vaginal discharge Y P Vaginal Itching Y P Other _____</p>	<p>NEUROLOGICAL: Fainting Y P Seizures Y P Convulsion Y P Paralysis Y P Muscle weakness Y P Memory loss Y P Involuntary movements Y P Loss of balance Y P Speech problems Y P Other _____</p>	<p>MALE: Prostate Symptoms Y P Impotence Y P Testicular Masses Y P Hernia Y P Urgency of Urination Y P Incomplete Urination/dribbling Y P Decreased sexual Desire Y P</p>
<p>MENSES: Cycle regular YES NO Length of cycle _____ Bleeding between Periods Y P Painful Menses Y P Excessive flow Y P No. of pregnancies _____ Age _____ No. of miscarriages _____ No. of abortions _____</p>	<p>PSYCHO/SOCIAL: Depression Y P Tension Y P Mood swings Y P Phobias Y P Sleep problems Y P Anxiety Y P Nervousness Y P Alcohol or drug abuse Y P Other _____</p>	<p>LIVER: Anemia Y P Hypertension Y P Elevated blood cholesterol Y P Low energy before eating Y P Decreased drug or alcohol tolerance Y P Premenstrual tension Y P Endometriosis Y P Headaches Y P Skin problems Y P Constipation Y P Gall bladder problems Y P Chronic muscle Tension Y P Eye problems Y P Difficulty digesting fatty foods Y P</p>
<p>PMS SYMPTOMS: Depression Y P Increased Appetite Y P Weight gain Y P Breast tenderness Y P Other _____</p>	<p>ENDOCRINE: Thyroid problems Y P Diabetes Y P Hypoglycemia Y P Hormone therapy Y P Other _____</p>	

LIFESTYLE

Circle if you eat, drink or use:

Alcohol	distilled water	saccharine (sweet low
Candy	fried foods	chew tobacco
Luncheon meats	carbonated beverages	fast foods
Cigarettes	margarine	vitamins
Coffee	minerals	refined sugars
Spring water	aluminum pans	microwaves

How many cups/bottles/glasses do you drink, on average per day?

Coffee _____ Tea _____ Water _____ Milk (2%) _____
Milk (skim) _____ Fruit juice _____ Softdrinks (diet) _____
Soft drinks (reg.) _____ Vegetables Juice _____ Herbal Tea _____
Beer _____ Wine _____ Liquor _____

How often would you have alcoholic beverages? _____

Have you ever been treated for alcoholism? No _____ Yes _____

Do you smoke? No _____ Yes _____ (How many cigarettes? _____
Cigars? _____)

Have you ever smoked? No _____ Yes _____ (For how long? _____)

Does anyone else smoke in your household? No _____ Yes _____

Does anyone smoke in your work place? No _____ Yes _____

Do you use any recreational drugs? Yes _____ No _____

(If yes, indicate type and frequency of usage)

Have you ever used recreational drugs? Yes _____ No _____

Have you ever treated for drug dependence? Yes _____ No _____

How many hours of sleep do you get on average? _____

Do you awaken rested? Yes _____ No _____

How many hours do you work each day? _____

Do you enjoy your work? Yes _____ No _____

What do you do for exercise? (Indicate type, how often you participate and for how long)

How many hours a day do you watch television? _____

How many hours a day do you read? _____

How many hours a day do you spend in front of a computer? _____

What are your main interests and habits?

Do you take vacations regularly? Yes_____No_____

When was your last vacation? _____

What level of personal stress are you experiencing right now?

Minimal_____Average_____Considerable_____Unbearable_____

Is the main stressor: financial _____job- related _____interpersonal

Marriage_____health_____unfulfilled_____expectations_____

Family members_____spiritual_____

Do you participate in any spiritual discipline or belong to a church or religious group?

Are you an active participant?

Thank you for taking the time to fill out the requested information. It will help greatly in our study of your present health and will assist us in choosing an appropriate direction to take in working toward your desired restoration of health.

PATIENT HEALTH HISTORY RECORD

Circle each condition you have had:

Abscesses Abortion Alcoholism Allergies Anemia Arthritis Asthma Cancer Chicken pox Cold Sores
 Depression Diabetes Emphysema Epilepsy Frequent Colds Gallstones Genital Herpes
 Gonorrhea Gout
 Hay Fever Heart disease Hepatitis HIV Influenza Kidney disease Leukemia Low/High Blood Pressure
 Lime disease Malaria Measles Miscarriage Mononucleosis Multiple Sclerosis Mumps
 Parasites Peritonitis
 Pelvic Inflammatory Disease Pleurisy Pneumonia Premenstrual Syndrome Prostatitis
 Rheumatic fever Rubella Scarlet fever Sexual abuse Skin Disease Sinusitis Stroke
 Strep Throat Syphilis Tonsillitis Tuberculosis
 Typhoid fever Venereal wart Warts whooping cough Worms Yellow fever
 Any other conditions?

Are there any other conditions from which you have not fully recovered? Which? _____

FAMILY HEALTH HISTORY

INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER AILMENTS, HAVE AFFECTED YOUR RELATIVES:

Alcoholism Allergies Alzheimer's Arthritis	Asthma Cancer Depression Diabetes	Epilepsy Gonorrhea Gout Hay Fever	Heart disease Hypertension Kidney Dis. Mental Illness	Paralysis Pneumonia Skin Dis. Digestive Disorders	Syphilis Thyroid Disorder Tuberculosis
---	--	--	--	--	--

RELATIVE	AGE if Alive	AGE at death	AILMENTS
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

ACKNOWLEDGEMENT AND INFORMED CONSENT

I _____
(Patient's name

hereby acknowledge and confirm that prior to signing this document and prior to undergoing any treatment:

- I) I have been informed by you and understand that any treatment or advice provided to me as a Patient of this naturopathic office is not being provided in the place of or to the exclusion of any Other treatment or advice that I may now be receiving or may in the future receive from a physician, surgeon or any other licensed health care provider (such other treatment collectively referred to as "Conventional Medical Treatment")
- II) I have been informed by you and understand that I am at liberty to seek or continue to seek Conventional Medical Treatment and to consult with a physician, surgeon or any other licensed Health care provider in order that I can make an informed decision as to whether at any given Time or times it would be in my best interest to obtain Conventional medical Treatment;
- II) No naturopathic practitioner(s), employee(s), agent(s) or any other person(s) directly or indirectly Employed by or associated with this office have suggested or recommended to me that I refrain from and/or discontinue seeking Conventional Medical Treatment;
- III) I have been informed by you and understand that the treatment and products that are rendered, Recommended and supply by this office ("Naturopathic Treatment and Products") may be different from the treatment and products that are rendered, recommended or supplied in Conventional Medical Treatment;
- IV) I have been informed by you and understand that the treatment and products that are rendered, recommended or supplied in Conventional Medical Treatment;
- V) I have been informed by you and understand that the Naturopathic Treatment and provided by This office are not covered under the Ontario Health Insurance Plan (OHIP) and accordingly, I Hereby agree to pay my account to the office at the conclusion of each and every visit. I further Acknowledge and agree that I will be charged the full fee for all and any missed appointments, Unless I have advised the office of my cancellation no less than forty-eight hours in advance of the Scheduled appointments;
- VI) You have explained to me and I understand the nature of the Naturopathic Treatment and Products that you will be providing to me. You have advised me of and I understand the potential Side effects that may associated with certain Naturopathic Treatment and Products. You have also urged and encouraged me to ask such questions as I may have at any time and to advise you immediately if I either wish to discontinue or should decide not to undergo any specified type(s) Of treatment(s).

I am at least sixteen years old and I have read and am in agreement with the foregoing statements and have Had the opportunity to discuss the same with a naturopathic practitioner at the office. I hereby authorize And consent to such treatment by the office as the naturopathic practitioner considers necessary or Desirable, subject to any additional instruction or modifications that I may provide/authorize from time to Time.

OR

I am the _____ of the patient who is under the age of sixteen years. I
(Relationship)

confirm that I am legally authorized to grant consent to have the patient treated by the office. I have read and am in agreement with the foregoing statements and have had the opportunity to discuss the same with a naturopathic practitioner at the office. I hereby authorize and consent to such treatment of the patient by the office as the naturopathic practitioner considers necessary or desirable, subject to any additional instructions or modifications that I may provide/authorized from time to time.

Dated this _____ day of _____, 200__.

Witness

Signature of Patient or Legal Guardian

NATUROPATHIC HEALTH CARE – WHAT TO EXPECT

PATIENT INFORMATION

Dr. Anca Martalog, B.Sc., N.D.

Congratulations on choosing a health care system that addresses your health needs as a complete person, physical, emotional and spiritual.

This flyer is designed to inform you about the protocol used in my practice. Your first appointment will be one hour and 15 minutes in length. During this time, a detailed history of your present and previous health concerns is taken, as well as a family history. Please try to find out as much as possible about your family health history, as this can be crucial to the understanding of your present and future health.

An investigation into your natural health and habits, as well as into your personality and life stresses, follows. Please do not feel uncomfortable about this, you do not have to release any information you do not have to, but remember that I am not here to judge you, but to assist you and that will be much easier the I know about you as a whole being, not just a body. I am more than willing to listen to you and I take your interpretations of your present concerns very seriously. Additionally, all information is strictly confidential, By law.

Treatment is usually commenced on the first visit, and continued in the second visit, as more information is often necessary.

Depending on your particular problem, I may ask you to fill out a diet intake or other questionnaires or complete an assignment over the next week and/ or you may be sent for specific laboratory tests.

The second visit is usually 30 minutes in length, about two weeks after the first one. During this time, a relevant physical examination is performed tailored to your concerns, test or questionnaires are discussed and additional information gathered by interview if necessary. Treatment is then continued.

Treatment plans are based on my expertise with your particular preferences and lifestyle in mind; in other words, you will have a major input into your treatment plan and will not have to do or take things you don't want to.

The follow-up visits are usually 30/45 minutes in length and may take place 3-4 weeks after the previous one. Your complaints are reviewed and treatment and progress are evaluated. If necessary, you will be referred to other health care providers.

Acute subsequent visits will be 20 to 30 minutes in length and will continue to monitor your progress. Visits tend to require less time as we proceed, however feel free to book an appointment anytime if you need to.

Thank you for taking the time to fill out the requested information. It will help greatly in our study of present health and will assist us in choosing an appropriate direction to take in working toward your desired restoration of health

DIET SURVEY

MEALS	DAY- 1	DAY-2	DAY-3	DAY-4	DAY-5	DAY-6	DAY-7
Breakfast							
Lunch							
Dinner							
Snacks							
Water/cups							
Fats/oils Used							
Condiments							
Exercise (time&type)							

