Context of Care
Overview

What expectations do you have from working with Dr. Kulwinder Sraw?

Short Term:_____

Long Term:_____

What do you know about Dr. Sraw's approach?

What is your current level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? *Rate from 0-10 (10 = 100% commitment)*

What behaviors & lifestyle habits do you currently engage in regularly that you believe support your health?

What potential obstacles do you foresee in addressing lifestyle factors that are determining your health and in adhering to the therapeutic protocols which will be shared with you?

Who do you know that will sincerely support you consistently with the beneficial therapeutic and lifestyle changes you will be making?

What do you love to do?

Confidential Patient Health Record

Personal Information

Name:_____ Gender: □F □M
Age:_____ Birthdate:yyyy mm dd
Address:_____ Postal Code:_____
Email: _____
Phone #: home _____ work _____ cell _____
Occupation:_____ Height:_____ Weight:_____
No. of Children:_____ Miscarriages:_____ Dependents:_____
Marital Status: □single □common-law □married □divorced □separated □widowed

Other health care providers (family physician, specialists, complementary & alternative therapists):
Name: _____ Name: _____ Name: _____
Ph: _____ Ph: _____ Ph: _____

Emergency Contact:_____ Phone #:_____

How were you referred to this office?
□friend. Whom? _____ □newspaper □referral □other _____
Would you like to subscribe to our quarterly Newsletter, via email? □ Sure □ No, Thank you.

What are the main health concerns you would like to have addressed?
1. _____
2. _____
3. _____
4. _____
5. _____

Medical History

How would you describe the general state of your health? Excellent Good Fair Poor
Major complaint:_____
Other doctor's seen for this condition:_____
When did this condition begin?_____
Does anyone in your family have the same or similar condition? Whom?□yes □no If yes, whom?_____
If disabled from work, please give dates:_____
Date of accident / injury:_____ □job related □auto related
Previous care (Doctor's name and date of last visit): _____

	Type / Reason / Cause	*Year*
Injuries / Accidents:	_____	_____
Major Illnesses:	_____	_____
Hospitalizations:	_____	_____
Surgeries:	_____	_____

Have you been treated for any health condition in the last year? □yes □no
Please explain: _____
Does anyone in your family have the same or similar condition? □yes □no Whom? _____

Please indicate if you use the following:

□Aspirin / Tylenol	□Laxatives	□Chemotherapy / Radiation	□Antacid	□Other: _____
□Appetite Suppressant	□Cholesterol Lowering	□Diuretic (blood pressure)	□Pain Killer	
□Mood Medication(s) _____	□Birth Control Pill	□Sleeping Pill	□Recreational Drugs	

Please indicate any known allergies or drug sensitivities:_____
Number of times on antibiotics in last 7 years:_____

Family History:

Please indicate if any of your immediate family relatives has ever encountered the following (F - father, M - mother, B1, B2, S1, S2, etc)

____ Alcoholism	____ Allergies	____ Alzheimer's Ds	____ Arthritis	____ Asthma
____ Cancer of _____	____ Diabetes	____ Drug addiction	____ Eating disorder	____ Genetic disorder
____ Glaucoma	____ Heart disease	____ Hypertension	____ Infertility	____ Intestinal disease
____ Learning disability	____ Mental illness	____ Migraine	____ Neurological ds	____ Obesity
____ Osteoporosis	____ Stroke	____ Suicide	Other: _____	

Please indicate if you have had the following:

☐Pneumonia ☐Mumps ☐Influenza ☐Hepatitis ☐Rheumatic Fever ☐Small Pox ☐Pleurisy
☐HIV / AIDS ☐Polio ☐Chicken Pox ☐Arthritis ☐Epilepsy ☐Tuberculosis ☐Diabetes
☐Whooping Cough ☐Cancer of ☐Mental Disorder ☐Anemia ☐Heart Disease ☐Lumbago ☐Measles
☐Thyroid (hypo / hyper) ☐Eczema ☐Other: _____

Please indicate if you have had any of the following in the past 6 months:

General
☐Fatigue
☐Allergies
☐Loss of Sleep
☐Fever
☐Headaches
☐Moodiness
☐Excess / Loss of Appetite

Musculoskeletal
☐Low Back Pain
☐Pain Between Shoulders
☐Neck Pain
☐Arm Pain
☐Joint Pain / Stiffness
☐Walking Problems
☐Difficulty Chewing / Clicking Jaw
☐General Stiffness

Gastro-Intestinal
☐Excess Thirst
☐Nausea
☐Vomiting
☐Diarrhea
☐Constipation
☐Gas / Bloating
☐Abdominal Cramps
☐Heartburn
☐Black / Bloody Stool
☐Weight Problems
☐Liver Problems
☐Gall bladder Problems
☐Colitis

C-V-R
☐Chest Pain
☐Shortness of Breath
☐Blood Pressure Problems
☐Irregular heartbeat
☐Heart Problems
☐Lung Problems / Congestion
☐Varicose Veins
☐Ankle Swelling
☐Stroke

EENT
☐Vision Problems
☐Dental Problems
☐Sore Throat
☐Earaches
☐Hearing Difficulty
☐Stuffed Nose

Nervous System
☐Nervousness
☐Numbness
☐Paralysis
☐Dizziness
☐Forgetfulness
☐Confused / Depressed
☐Fainting
☐Convulsions
☐Cold Tingling Extremities
☐Stress

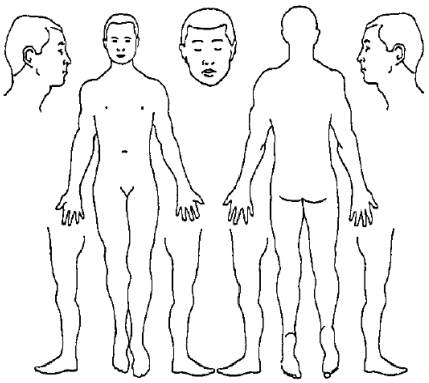
Genito-Urinary
☐Bladder Trouble / Incontinence
☐Painful / Excess Urination
☐Discolored Urine

Male/ Female
☐Prostrate Problems
☐Sexual Dysfunction
☐Genital Herpes
☐Menstrual Irregularity
☐Menstrual Cramping
☐Vaginal Pain / Infection(s)
☐Breast Pain / Lump(s)

Females:
When was your last period? _____
Are you pregnant? ☐yes ☐no ☐unsure

Lifestyle

	Heavy	*Moderate*	*Light*	*None*	*Type*	*Per day & Per week*
Alcohol	☐	☐	☐	☐	_____	_____
Coffee / Tea	☐	☐	☐	☐	_____	_____
Tobacco	☐	☐	☐	☐	_____	_____
Drugs	☐	☐	☐	☐	_____	_____
White Sugar	☐	☐	☐	☐	_____	_____
Exercise	☐	☐	☐	☐	_____	_____
Sleep	☐	☐	☐	☐		_____
Appetite	☐	☐	☐	☐		



Please indicate areas of pain or discomfort.

Do you think you may need to take vitamins, minerals or any other form of supplements? Y or N

Please list all MEDICATIONS you are taking, including dosages, duration and why you are taking them:

Medication	**Dosage**	**Duration**	**Condition Treating**

Please list all NATURAL HEALTH PRODUCTS (vitamins, minerals, herbs) you are taking, including dosages, duration and why you are taking them:

Natural Health Product	**Dosage**	**Duration**	**Condition Treating**

New Patient Policy and Fee Explanation

Dear Patient,

The services of Naturopathic Physicians are covered by many extended health care providers, but are currently not covered under the Medical Services Plan (MSP). Please take note of the following clinic policies:

1. The cost of initial consultation is $165.00, 10% off for children, seniors & students.
2. Subsequent visits are $85.00 and are booked in 30 minute increments; any time over this will be billed accordingly, 10% off for children, seniors & students.
3. If you receive Assisted Premiums with the Medical Services Plan, please let us know before drawing up the bill (and provide us with your MSP card number).
4. Payment is due when services rendered. Credit cannot be extended without prior approval.
5. **Appointments not cancelled with sufficient notice (greater than 24 hours) are charged a fee of $65.00 for single appointment, and $80.00 on extended appointments.**
6. There is a $30.00 charge on NSF cheques.
7. Additional services (such as prolotherapy injections, chelation therapy, other injection therapies, supplements, assisted treatments, blood tests, acupuncture, etc) will incur separate or additional fees.

Yours - In Sincerest of Health,

Dr. Kulwinder Sraw, N.D.

Signature:_____ Witness:_____

Date: _____

Informed Consent for Treatment

I,_____, hereby authorize Dr. Kulwinder Sraw, ND to perform the following procedures to facilitate my diagnosis and treatment:

Common Diagnostic Procedures: venipuncture, laboratory, physical exam
Medicinal Use of Nutrition: therapeutic nutrition, nutritional supplements, intra-muscular, subcutaneous, intracutaneous and intravenous vitamin/mineral injections.
Physical Medicine: microcurrent / electrical frequency, manipulative therapy, soft tissue therapy, injection therapies (prolotherapy, neural prolotherapy, neural therapy, chelation therapy, platelet rich plasma therapy), trigger point therapy.
Acupuncture: insertion of acupuncture needles into the dermis and subcutaneous layers of the skin.
Botanical Medicine: herbs prescribed as teas, alcoholic tinctures, capsules, tablets, creams, or plasters.
Homeopathic Medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to stimulate the body's healing capabilities.
Lifestyle Counseling and Hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

I recognize the potential risks and benefits of these procedures as described below:
Potential Risks – allergic reaction and adverse effect to prescribed herbs, supplements and medications, inconvenience of lifestyle changes, injury from injections or venipuncture, acupuncture, manipulation or other procedures.
Potential Benefits – restoration of health and the body's maximum functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease and its progression.

Notice to Women: all female patients must inform the doctor if they know or suspect pregnancy, as some of the therapies used could present a risk to the pregnancy – mother and fetus.

With this knowledge and understanding, I voluntarily consent to the above procedures. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
I understand that Dr. Kulwinder Sraw, ND will keep a record of the health services provided to me. This record will be kept in confidential and will not be released to others unless directed by myself or my representative in writing or unless is required by law. I understand that I may look at my medical record and can request a copy. I understand that my medical records will not be kept for more than seven (7) years after the day of my last appointment. I understand that any questions concerning this form may be asked of the naturopathic physician.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative or Guardian Date

_____ _____
Witness Date