KIANI Naturopathic Clinic

Core Link Wellness Centre
2238 Caroline St., Burlington ON L7R 1M5
Tel: 905. 592.0095 Fax. 905.592.0106

Women's Fertility Intake

Date:_____

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care.

Name: _____ Occupation: _____

Date of Birth: _____ Employer: _____

Home Address: _____ Work Tel #:_____

_____ Emergency Contact #: _____

Home Tel #:_____ Contact Relationship: _____

Cell #: _____ Marital Status: _____

E-Mail Address: _____

Please list any other medical providers:

Type of Medical Provider	Name	Phone #	Address

MENSTRUAL HISTORY:

Age at which menses began: _____

Date of last menstrual period: _____

How many days does your menses last for?_____

Are your menstrual cycles spaced irregularly? ❑ Yes ❑ No

How many days are there from one period to the next? _____

Are your periods painful: ❑ Yes ❑ No; If yes how many days does the pain last?_____

How heavy is the bleeding? ❑ Light ❑ Normal ❑ Heavy

What color is the blood? ❑ Light red ❑ Bright Red ❑ Dark Red ❑ Purple ❑ Brown ❑ Black

Is there clotting? ❑ Yes ❑ No

Do you bleed or clot between periods? ❑ Yes ❑ No

Have your cycles changed since they began? ❑ Yes ❑ No

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If yes, describe how?_____

Do you ovulate on your own? ❑ Yes ❑ No

On what day of your cycle do you ovulate? _____

Do your breasts become tender during your menses? ❑ Yes ❑ No

Do your breasts become tender pre-menstrually ❑ Yes ❑ No

Do you get premenstrual low back pain? ❑ Yes ❑ No

Do your bowel movements become loose at the beginning/during your period? ❑ Yes ❑ No

Do you have premenstrual symptoms? ❑ Yes ❑ No; If YES: describe _____

_____

Does your face break out before or during your period? ❑ Yes - before ❑ Yes –during ❑ No

Do you have nipple discharge? ❑ Yes ❑ No

Do you chart your cycles? ❑ Yes ❑ No

Do you chart your Basal Body Temperature? ❑ Yes ❑ No

MEDICAL HISTORY:

How many pregnancies have you had? _____

How many children do you have? _____

Have you had any abortions? ❑ Yes ❑ No

- If YES, when did the abortion take place: _____
- How many abortions have you had: _____

Have you had any miscarriages? ❑ Yes ❑ No

- If YES, when was the last miscarriage: _____
- How many miscarriages have you had: _____

Have you had any D&C performed? ❑ Yes ❑ No

Have you ever had an abnormal pap smear? ❑ Yes ❑ No

Have you ever had a cervical biopsy, operation, cauterization or conization? ❑ Yes ❑ No

- Please specify:_____

Have you ever had an STI (Sexually Transmitted Infections)? ❑ Yes ❑ No

Have you ever been diagnosed with a Chlamydia infection? ❑ Yes ❑ No

Have you ever been diagnosed with a Herpes genitalis? ❑ Yes ❑ No

Do you get yeast infections regularly? ❑ Yes ❑ No

Do you have chronic vaginal discharge? ❑ Yes ❑ No

Have you ever had pelvic inflammatory disease? ❑ Yes ❑ No

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- Were you treated for it? ❑ Yes ❑ No
- How?_____

Have you ever been diagnosed with uterine fibroids? ❑ Yes ❑ No

- If YES: when were they diagnosed:_____

Have you ever been diagnosed with endometriosis? ❑ Yes ❑ No

- If YES: when were they diagnosed:_____

Have you ever been diagnosed with pelvic adhesions? ❑ Yes ❑ No

Have you ever been diagnosed with pelvic abnormalities? ❑ Yes ❑ No

Have you been diagnosed with a thyroid condition? ❑ Yes ❑ No

- If YES: are you on any medications? _____

Do you experience fatigue? ❑ Yes ❑ No

Have you ever taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	When/How Long

Are you taking any medications currently? ❑ Yes ❑ No

If YES: specify: _____

PERSONAL HISTORY:

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? ❑ Yes ❑ No

- What was the diagnosis?_____

Have you had fertility treatments? ❑ Yes ❑ No

- If YES: when and where? _____
- What types?_____

Date of last PAP smear:_____

Have you taken medication to help you ovulate? ❑ Yes ❑ No

- When:_____ How long?_____

Have your fallopian tubes been evaluated medically? ❑ Yes ❑ No

- What were the results?_____

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Have you had any tubal operations? ❑ Yes ❑ No

Have you had any hormone laboratory tests performed? ❑ Yes ❑ No

- What were the results?_____

Please indicate any serious illnesses, conditions, or reasons for hospitalizations

Medical Condition/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

CONTRACEPTIVE USE HISTORY:

Have you taken oral contraceptives? ❑ Yes ❑ No

- When? _____ How long?_____
- Reason for oral contraceptive use:_____

Have you ever used an IUD? ❑ Yes ❑ No

- When? _____ How long?_____
- Reason for IUD use:_____

Have you ever taken Depo-Provera? ❑ Yes ❑ No

- When? _____ How long?_____

PARTNER INFORMTATION:

Has your partner had a complete fertility workup? ❑ Yes ❑ No

Has your partner undergone semen analysis? ❑ Yes ❑ No

Is your partner supportive of your wish to conceive? ❑ Yes ❑ No

OTHER:

Current Weight: _____

Current Height:_____

Is there a family history of any congenital birth defects? ❑ Yes ❑ No

How is your sexual desire? ❑ Low ❑ Normal ❑ High

Do you have a stressful occupation? ❑ Yes ❑ No

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Do you exercise regularly? ❑ Yes ❑ No How often:_____

Have you recently gained or lost weight? ❑ Yes ❑ No; Weight gained/lost _____lbs

Do you have excessive facial hair? ❑ Yes ❑ No

Have you experienced excessive loss of head hair? ❑ Yes ❑ No

Have you noticed discharge from your nipples? ❑ Yes ❑ No

Have you been exposed to any known environmental toxins or hormones? ❑ Yes ❑ No

Are you presently taking any steroids? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No

Do you consume alcohol? ❑ Yes ❑ No

Do you consume caffeine? ❑ Yes ❑ No

Do you use recreational drugs? ❑ Yes ❑ No

Is there anything that you feel is important that has not been covered?

_____

_____

Where did you learn about this clinic?

Friend/Family; name:_____

Internet:
- ❑ Google
- ❑ OAND/CAND
- ❑ Yellow pages (online)
- ❑ Canadian Naturopaths website

❑ Media
❑ Yellow pages book
❑ Seminars
❑ Robert Schad Naturopathic Clinic
❑ Other: _____

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CORELINK WELLNESS CENTRE

INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES

Name_____

Address_____

City and Postal Code_____

Attending N.D._____

RECOMMENDED THERAPEUTIC PROCEDURE(S) / PLAN
(Including those by referral to another practitioner)
(Filled in at visit)

_____
_____
_____

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic procedure(s)/ plan and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of and understand the therapeutic procedure(s)/plan with respect to the financial costs, expected benefits, potential risks and side effects the likely consequences of not having/following the procedure(s)/plan, and what alternative course(s) of action are available to me.

As a result I do hereby voluntarily consent/ withhold/ my informed consent for the recommended therapeutic procedure(s)/plan as specified above. I also understand that I may change the status of my voluntary consent at any time.

Signature_____ Print Name_____

Date _____Witness Signature_____

PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our clinic while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We 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.

In this clinic, Payam Kiani, ND acts as the Privacy Information Officer.

All staff members who come in 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.

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Our privacy policy outlines what our Clinic is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards or our regulatory body, the Board of Directors of Drugless Therapy — Naturopathy.

How our clinic collects, uses and discloses patients' personal information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our clinic is using and disclosing your information.

This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy — Naturopathy acting under the authority of the *Drugless Practitioners Act*
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this clinic to comply with all regulatory requirements
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient Consent ~

I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information.

I agree that the Core Link Wellness Clinic can collect, use and disclose my personal information as set out above in the information about the clinic's privacy policies.

Signature_____ Print Name_____

Date _____ Witness Signature_____

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7 Day Diet Diary

Name: _____
Date:_____

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Breakfast							
Lunch							
Dinner							
Snacks							
Fluids							
Comments							

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Name: _____ Date: _____

Check the conditions that you are currently experiencing, or have experienced often in the past. If more space is required please use the reverse side of this sheet.

	current	previous
General Symptoms		
Loss of consciousness	□	□
Numbness / tingling	□	□
Fever	□	□
Sweats	□	□
Fainting	□	□
Dizziness	□	□
Loss of sleep/insomnia	□	□
Frequent colds / flus	□	□
Loss of weight	□	□
Head / Neck		
Headaches	□	□
Type _____		
Vision problems	□	□
TMJ concerns	□	□
Earaches	□	□
Decreased hearing	□	□
Sinus problems	□	□
Difficulty swallowing	□	□
Skin		
Rashes / Eczema	□	□
Itching	□	□
Bruise easily	□	□
Dryness	□	□
Boils / Hives	□	□
Contagious skin disease	□	
Respiratory		
Chronic cough	□	□
Shortness of breath	□	□
Smoking	□	□
Breathing problems	□	□
Asthma / Bronchitis	□	□

	current	previous
Cardiovascular		
High blood pressure	□	□
Low blood pressure	□	
Bleeding disorders	□	□
Chest pain	□	□
Stroke	□	□
Artery hardening	□	□
Varicose veins	□	□
Swelling of the ankles	□	
Poor circulation	□	□
Angina	□	□
Heart disease	□	□
Genitorurinary		
Trouble urinating	□	□
Blood in the urine	□	□
Kidney infections	□	□
Bed wetting	□	□
Prostate trouble	□	□
Gastrointestional		
Poor digestion	□	□
Indigestion	□	□
Excessive hunger	□	□
Belching or gas	□	□
Nausea / Vomiting	□	□
Abdominal pain	□	□
Constipation	□	□
Diarrhea	□	□
Hemorrhoids	□	□
Liver concerns	□	□
Gall bladder trouble		□
Bladder concerns	□	□
Ulcer	□	□
Diabetes	□	□

	current	previous
Infections / Illnesses		
Herpes	□	□
Hepatitis	□	□
Plantar warts	□	□
TB	□	□
HIV / AIDs	□	□
Cancer	□	□
Allergies	□	□
Muscles and Joints		
Stiff neck	□	□
Backache	□	□
Swollen joints	□	□
Painful tail bone	□	□
Foot trouble L / R	□	□
Shoulder pain L / R	□	□
Elbow pain L / R	□	□
Wrist pain L / R	□	□
Hip pain L / R	□	□
Knee pain L / R	□	□
Arthritis	□	□
Weakness / loss strength		□
Women's Health		
Painful menstruation	□	□
Excessive flow	□	□
Irregular cycle	□	□
Hot flushes	□	□
Cramps or backache	□	□
Vaginal discharge	□	□
Swollen breasts	□	□
Lumps in the breast	□	□
Are you pregnant	Yes □	No □
On birth control	Yes □	No □
# of pregnancies _____		
# of children _____		

Please list anything not covered above:

_____

_____