Dr. Mallory Reinthaler, ND

PATIENT REGISTRATION FORM - NATUROPATHY

Welcome to Nobleton Physiotherapy. Please take a moment to complete the following registrations forms. Thank you.

Date: _____ Title (please check): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss.

Last Name: _____ First Name: _____ Initial: _____

Age: _____ Date of Birth (d/m/y): _____ Gender: ☐ M ☐ F

Address: _____ Apt/Ste/Box#: _____

City, Province: _____ Postal Code: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Permission to leave messages? ☐ Yes ☐ No

Emergency Contact: _____ Phone #: _____ Relationship: _____

How did you hear about us? ☐ Family MD Referral ☐ Word of Mouth ☐ Website ☐ Google
☐ Friend/Family member ☐ Other _____

Email Address: _____

Canadian legislation (CASL) now requires we gain your consent to communicate with you through email. Below is a list of items we may communicate to you through email. Please check the appropriate box(es).

Appt. Reminders: For your convenience, NP can send email reminders for your upcoming appointments.
Would you like us to use your email for this service? ☐ Yes ☐ No Thanks

Health Professional Communication*:* During your treatment period your health provider may send you information regarding your injury or exercises to support your recovery.
Would you like us to use your email for this service? ☐ Yes ☐ No Thanks

Clinic Newsletter*:* On a semi-monthly basis we will be sending out a newsletter to update you on news/events within the clinic and educational tips for health and injury prevention.
Would you like us to use your email for this service? ☐ Yes ☐ No Thanks

Print Name: _____ Signature: _____

Date: _____

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Is this your first time seeing a Naturopathic Doctor? ☐ Yes ☐ No

Other Health Care Practitioners

Family Doctor:
Name: _____
Phone #: _____
Last visit: _____

Specialist:
Name: _____
Phone #: _____
Last visit: _____

Health Goals / Reason for visit (in order of importance)

1. _____
2. _____
3. _____
4. _____

Current Diagnoses, Illness, or Recent Hospitalizations

_____

_____

_____

Allergies: _____

Current Medications and Natural Health Products

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

How would you describe your general state of health? ☐ Good ☐ Fair ☐ Poor

Do you smoke? ☐ Yes ☐ No Are you Pregnant? ☐ Yes ☐ No Due Date: _____

Do you get regular screening tests (Pap, labwork, etc.)? ☐ Yes ☐ No Last blood work: _____

Immunizations

☐ DPT (diphtheria, pertussis, tetanus)
☐ MMR (measles, mumps, rubella)
☐ Polio
☐ Smallpox
☐ Other (specify) _____
☐ HiB
☐ Influenza
☐ Hepatitis A
☐ Hepatitis B
Any adverse reactions? _____

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Dietary Restrictions:

Personal and Family Medical History

Please check the "yes" box next to each condition that applies to you and/or one of your family members.
(Self) relates to you, **(F)** Father, **(M)** Mother, **(S)** Sibling, **(G)** Grandparent, and **(C)** Your Child.
Please circle **Current** if the condition is ongoing, and **Past** if the condition has resolved.

	Yes (✓)	Relation (circle)	Resolved		Yes (✓)	Relation (circle)	Resolved
Addiction		Self F M S G C	Current / Past	High Blood Pressure		Self F M S G C	Current / Past
Allergies		Self F M S G C	Current / Past	Heart Disease		Self F M S G C	Current / Past
Anemia		Self F M S G C	Current / Past	Hepatitis		Self F M S G C	Current / Past
Arthritis		Self F M S G C	Current / Past	Headaches		Self F M S G C	Current / Past
Asthma		Self F M S G C	Current / Past	Kidney Disease		Self F M S G C	Current / Past
Cancer		Self F M S G C	Current / Past	Stroke		Self F M S G C	Current / Past
Diabetes		Self F M S G C	Current / Past	Tuberculosis		Self F M S G C	Current / Past
Eczema		Self F M S G C	Current / Past	Osteoporosis		Self F M S G C	Current / Past
Epilepsy		Self F M S G C	Current / Past	Other:		Self F M S G C	Current / Past
Mental illness		Self F M S G C	Current / Past				

☐ I don't know my family medical history.

Environment

Occupation: _____
Hobbies: _____
Exercise (type, duration): _____
Tobacco exposure: _____ Exposure to animals: _____
How is your home heated? _____Regularly exposed to chemicals, paints, and metals? _____
Sensitive to smells, perfumes, and other vapours?_____
How stressful is your life? _____
How would you describe the emotional climate of your home? _____
Is there anything else important you feel has not been covered? _____
_____

Print Name: _____
Signature: _____ Date: _____