***Complete Wellness Clinic***
327 Bronte.St.South, Unit 14
Milton, ON. L9T 4A4 **(905) 875-2288**

**KIM VIVIAN BSc, ND**

**total health, naturally…**

Welcome! The information package provided below will help you to prepare for your first visit. Please read and fill out the information requested.

If your initial visit is for **Naturopathic treatment**, please bring any of the following available to you for your first visit:

- ***all current medications, supplements, vitamins, homeopathics, etc, or comprehensive list of said items***.
- completed forms which include checking the appropriate boxes on the **Review Of Systems (ROS)** and completing the **Intake Form** and the **Informed Consent Form.**

Your first visit will typically be between 1 – 1 ¼ hours. During this time a comprehensive health assessment is usually done including a physical examination and thorough review of all of your chief complaints. Treatment may begin at this time depending on the complexity of your situation.
Ideally, after the first visit I will review your ROS, chief complaints and health history. An individualized treatment plan will then be formulated, which will be discussed with you and implementation will begin on your second visit. This visit can take approx. ½ an hour.

If your initial visit is for **Acupuncture** or **Bowen Therapy***, please complete the **Intake Form** and the **Informed Consent Form.**
* for the **Bowen Therapy** only, please bring a t-shirt & shorts to the initial visit

Your first visit will be approx. 1 hr. During this time you will receive a treatment and a comprehensive health assessment.

I look forward to your first visit and to begin working together to address your health concerns. If you have any questions regarding the procedures described above or otherwise, please feel free to call me.

Sincerely,

*Kim Vivian BSc, ND*

# REVIEW OF SYSTEMS

Y A condition you have **NOW**
N A condition you have **NEVER** had
P A condition you have had in the **PAST**

**Responses and Comments**:

| **1. GENERAL** | | | | **PLEASE USE THE SPACE BELOW TO ELABORATE IF YOU CIRCLED 'Y'. For example, details such as ONSET time, what makes that symptom better or worse, how frequently does it occur, etc.** |
|---|---|---|---|---|
| Weight | | | | |
| Weight 1 year ago | | | | |
| Maximum weight | | | | |
| When | | | | |
| Height | | | | |
| Fatigue/weakness | Y | P | N | |
| Fever/Chills | Y | P | N | |

| **2. SKIN** | | | | |
|---|---|---|---|---|
| Rashes | Y | P | N | |
| Eczema, hives | Y | P | N | |
| Acne, boils | Y | P | N | |
| Itching | Y | P | N | |
| Color change | Y | P | N | |
| Lumps | Y | P | N | |
| Night sweats | Y | P | N | |
| Dryness/moistness | Y | P | N | |
| Temperature | Y | P | N | |
| Nail changes | Y | P | N | |
| Change in Mole | Y | P | N | |
| Skin Cancer | Y | P | N | |

| **3. HEAD** | | | | |
|---|---|---|---|---|
| Headache | Y | P | N | |
| Head injury | Y | P | N | |
| Dizziness | Y | P | N | |

| **4. EYES** | | | | |
|---|---|---|---|---|
| Impaired vision | Y | P | N | |
| Glasses/Contacts | Y | P | N | |
| Eye pain | Y | P | N | |
| Tearing/dryness | Y | P | N | |
| Double vision | Y | P | N | |
| Glaucoma | Y | P | N | |
| Cataracts | Y | P | N | |
| Blurring | Y | P | N | |
| Bothered by sun | Y | P | N | |
| Itching | Y | P | N | |
| Redness | Y | P | N | |
| Discharge | Y | P | N | |
| Blind spot | Y | P | N | |
| | | | | |
| | | | | |

| 5. EARS | | | | |
|---|---|---|---|---|
| Impaired hearing | Y | P | N | |
| Earache | Y | P | N | |
| Dizziness | Y | P | N | |
| Discharge | Y | P | N | |
| Infections | Y | P | N | |

| 6. NOSE and SINUSES | | | | |
|---|---|---|---|---|
| Frequent colds | Y | P | N | |
| Nose bleeds | Y | P | N | |
| Stuffiness | Y | P | N | |
| Hay fever | Y | P | N | |
| Sinus problems | Y | P | N | |

| 7. MOUTH and THROAT | | | | |
|---|---|---|---|---|
| Frequent sore throat | Y | P | N | |
| Sore tongue/mouth | Y | P | N | |
| Gum problems | Y | P | N | |
| Hoarseness | Y | P | N | |
| Dental cavities | Y | P | N | |
| Loss of taste | Y | P | N | |

| 8. NECK | | | | |
|---|---|---|---|---|
| Lumps | Y | P | N | |
| Swollen glands | Y | P | N | |
| Goiter | Y | P | N | |
| Pain or stiffness | Y | P | N | |

| 9. RESPIRATORY | | | | |
|---|---|---|---|---|
| Cough | Y | P | N | |
| Sputum | Y | P | N | |
| Spitting up blood | Y | P | N | |
| Wheezing | Y | P | N | |
| Asthma | Y | P | N | |
| Bronchitis | Y | P | N | |
| Pneumonia | Y | P | N | |
| Pleurisy | Y | P | N | |
| Emphysema | Y | P | N | |
| Difficulty breathing | Y | P | N | |
| Pain on breathing | Y | P | N | |
| Shortness of breath (SOB) | Y | P | N | |
| SOB at night | Y | P | N | |
| SOB lying down | Y | P | N | |
| Tuberculosis | Y | P | N | |
| Tuberculin Test | Y | P | N | |
| Last Chest -ray | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| 10. CARDIOVASCULAR | | | | |
|---|---|---|---|---|
| Heart disease | Y | P | N | |
| Angina | Y | P | N | |
| High blood pressure | Y | P | N | |
| Murmurs | Y | P | N | |
| Rheumatic fever | Y | P | N | |
| Chest pain | Y | P | N | |
| Swelling in ankles | Y | P | N | |
| Rapid heart beat | Y | P | N | |
| Cyanosis (bluish color to lips or nails) | Y | P | N | |
| Past ECG | Y | P | N | |
| Other heart tests | | | | |

| 11. BREASTS | | | | |
|---|---|---|---|---|
| Do you do self exams? | Y | P | N | |
| Lumps | Y | P | N | |
| Pain (or tenderness) | Y | P | N | |
| Nipple discharge | Y | P | N | |

| 12. GASTROINTESTINAL | | | | |
|---|---|---|---|---|
| Trouble swallowing | Y | P | N | |
| Heartburn | Y | P | N | |
| Change in thirst | Y | P | N | |
| Change in appetite | Y | P | N | |
| Nausea | Y | P | N | |
| Vomiting | Y | P | N | |
| Vomiting blood | Y | P | N | |
| Belching or passing gas | Y | P | N | |
| Jaundice (yellow skin) | Y | P | N | |
| Liver disease | Y | P | N | |
| Gall Bladder disease | Y | P | N | |
| Ulcer | Y | P | N | |
| Indigestion | Y | P | N | |
| Diarrhea | Y | P | N | |
| Rectal bleeding | Y | P | N | |
| Hemorrhoids | Y | P | N | |
| Black, tarry stool | Y | P | N | |
| Abdominal pain | Y | P | N | |
| Food allergy | Y | P | N | |
| Hernias | Y | P | N | |

| 13. URINARY | | | | |
|---|---|---|---|---|
| Pain on urination | Y | P | N | |
| Increased frequency | Y | P | N | |
| Frequency at night | Y | P | N | |
| Unable to hold urine | Y | P | N | |
| Frequent infections | Y | P | N | |
| Kidney stones | Y | P | N | |
| Blood in urine | Y | P | N | |
| Urgency | Y | P | N | |
| Hesitancy | Y | P | N | |

| 14. MALE REPRODUCTIVE | | | | |
|---|---|---|---|---|
| Hernias | Y | P | N | |
| Testicular masses | Y | P | N | |
| Testicular pain | Y | P | N | |
| Sexually active? | Y | P | N | |
| Sexual difficulties | Y | P | N | |
| Venereal disease | Y | P | N | |
| Discharge or sores | Y | P | N | |
| Other relevant information about your fertility or sexual life you feel relevant? Please use space on right side. | | | | |

| 15. FEMALE REPRODUCTIVE | | | | |
|---|---|---|---|---|
| Age menses began | | | | |
| Average number of days | | | | |
| Length of cycle | | | | |
| Bleeding between periods | Y | P | N | |
| Are cycles regular | Y | P | N | |
| Pain during intercourse | Y | P | N | |
| Painful menses | Y | P | N | |
| Excessive flow | Y | P | N | |
| PMS | Y | P | N | |
| Birth control? | Y | P | N | |
| What type? | | | | |
| Number of pregnancies | | | | |
| Number of live births | | | | |
| Number of miscarriages | | | | |
| Number of abortions | | | | |
| Difficulty conceiving | Y | P | N | |
| Are you sexually active? | Y | P | N | |
| Sexual difficulties | Y | P | N | |
| Venereal Disease | Y | P | N | |
| Other relevant information about your fertility or sexual life you feel relevant? Please use space on right side. | | | | |
| Last menstrual period | | | | |
| Vaginal discharge | Y | P | N | |
| Vaginal itching | Y | P | N | |
| Last PAP - (date) | | | | |

| 16. MUSCULOSKELETAL | | | | |
|---|---|---|---|---|
| Joint pain or stiffness | Y | P | N | |
| Broken bones | Y | P | N | |
| Muscle spasm or cramps | Y | P | N | |
| Weakness | Y | P | N | |
| Joint swelling | Y | P | N | |
| Backache | Y | P | N | |

| 17. PERIPHERAL VASCULAR | | | | |
|---|---|---|---|---|
| Deep leg pain | Y | P | N | |
| Cold hands/feet | Y | P | N | |
| Varicose veins | Y | P | N | |
| Thrombophlebitis | Y | P | N | |
| Extremity numbness | Y | P | N | |
| Extremity coldness | Y | P | N | |
| Extremity swelling | Y | P | N | |
| Extremity ulcers | Y | P | N | |

| 18. NEUROLOGIC | | | | |
|---|---|---|---|---|
| Fainting | Y | P | N | |
| Seizures/Convulsions | Y | P | N | |
| Paralysis | Y | P | N | |
| Numbness or tingling | Y | P | N | |
| Loss of memory | Y | P | N | |
| Involuntary movement | Y | P | N | |
| Loss of balance | Y | P | N | |
| Speech problems | Y | P | N | |

| 19. ENDOCRINE | | | | |
|---|---|---|---|---|
| Heat or cold intolerance | Y | P | N | |
| Thyroid trouble | Y | P | N | |
| Excessive thirst | Y | P | N | |
| Excessive hunger | Y | P | N | |
| Excessive urination | Y | P | N | |
| Excessive sweating | Y | P | N | |
| Diabetes | Y | P | N | |
| Hypoglycemia | Y | P | N | |
| Hormone therapy | Y | P | N | |

| 20. BLOOD/LYMPHATIC | | | | |
|---|---|---|---|---|
| Anemia | Y | P | N | |
| Easy bleeding or bruising | Y | P | N | |
| Past transfusions | Y | P | N | |
| Lymph node swelling | Y | P | N | |

| 20. ALLERGIC HISTORY | | | | |
|---|---|---|---|---|
| Drug sensitivity | Y | P | N | |
| Reaction to vaccine | Y | P | N | |
| Allergies? Please list | | | | |

| 21. EMOTIONAL | | | | |
|---|---|---|---|---|
| Depression | Y | P | N | |
| Mood swings | Y | P | N | |
| Anxiety or nervousness | Y | P | N | |
| Tension | Y | P | N | |
| Phobias | Y | P | N | |
| Alcohol/Drug abuse | Y | P | N | |
| Insomnia | Y | P | N | |

| 22. HOBBIES/HABITS | | | | | |
|---|---|---|---|---|---|
| Please answer yes (Y) or no (N) | | | | | |
| | | | | | |
| Do you awake rested? | Y | N | | | |
| Do you sleep well? | Y | N | | | |
| Do you average 6-8 hours sleep? | Y | N | | | |
| Do you enjoy your work? | Y | N | | | |
| Do you watch television? | Y | N | | | |
| How many hours/day? | | | | | |
| Do you read? | Y | N | Do you exercise? | Y | N |
| How many hours/day? | | | What forms? | | |
| Do you take vacations? | Y | N | | | |
| Have you been treated for drug dependence? | Y | N | | | |
| Do you use recreational drugs? | Y | N | | | |
| Do you use alcoholic beverages? | Y | N | | | |
| Have you been treated for alcoholism? | Y | N | How often? | | |