Dr* Andréa Proulx *ND, RAc

Welcome to your initial naturopathic-**ACUPUNCTURE** consultation. Please take the time to fill out this form in order to give me background information needed to fully address all of your concerns. This will take approximately 15 minutes.

Name: ________________________________

Date of Birth: ____________________ (d/m/y)

Gender: _FEMALE____MALE ___OTHER_

Address:______________________________
____
____
____

Tel #: _(____)_________________ Home
_(____)_________________ Cell

Email: ________________________________

Occupation: ___________________________

Employer: _____________________________

Work tel #: _(____)______________________

Emergency Contact:______________________

Emergency Contact Tel #:_(___)___________

Contact relationship: ____________________

EMAIL	TEL	Preferred method of communication
YES	NO	May the clinic leave messages relating to your visits?
YES	NO	Can we send you my quarterly newsletter via email? (Your contact information will not be shared.)
YES	NO	Are you currently seeing another member of the Active Health Institute team? If so, whom: ___________________________________

How did you hear about Dr Andréa Proulx ND, R.Ac?: ____________________

Members of your ***Current*** Health Care Team:

Medical Doctor

Name: _Dr._________________________

Tel #: _(___)________________________

Address: ___________________________
____

Fax #: (___)_________________________

Circle all that apply

Dentist Periodontist Other Dental

Massage therapist Physiotherapist

Personal trainer Coach Kinesiologist

Chiropractor Osteopath Pedorthist

Internist Rheumatologist Endocrinologist

ObGyn Midwife Doula Fertility Clinic

Dr **Andréa Proulx** ***ND, RAc***

Your Health Concerns

What are your health concerns, or reasons for coming to the clinic, in order of importance to you. Give a brief description of each of these concerns.

1)
2)
3)
4)

Personal Medical History

Please list *current* prescriptions & supplements

Medication / Supplement	*Dosage/Brand*	*Prescribing Physician*	*Condition Treated*	*Start date*

Approximately how many times have you been treated with antibiotics? ___________________________

Do you receive regular screening tests by another doctor (pap, blood tests, etc.)? Yes No

Do you have any surgical implants, surgical metal pins or plates? If so, where? ____________________

____

Dr* Andréa Proulx *ND, RAc

Family Medical History

Illness	*Circle*		*Family member*	*Comments (if needed)*
Alcoholism	Yes	No		
Anemia	Yes	No		
Arthritis	Yes	No		
Asthma	Yes	No		
Hay fever	Yes	No		
Cancer	Yes	No		
Depression	Yes	No		
Drug abuse	Yes	No		
Diabetes	Yes	No		
Food allergies	Yes	No		
Digestive problems	Yes	No		
Glaucoma	Yes	No		
Heart disease	Yes	No		
High blood pressure	Yes	No		
Kidney disease	Yes	No		
Mental illness	Yes	No		
Seizure / epilepsy	Yes	No		
Stroke	Yes	No		
Thyroid disorders	Yes	No		
Other	Yes	No		
Family history unknown	Yes	No		

Anything else I should know about your health?

Thank you.

TCM QUESTIONNAIRE: Answer yes or no to the following questions – if they apply. Don't worry about what the symptoms mean; just note whether you experience them. This is a comprehensive way to look at the body from a Chinese Medical Perspective and will help us understand where your imbalances lie and how to proceed with treatment. Thank you. (Please allow shaded questions to be answered by Dr.Andréa Proulx ND RAc)

	YES	NO
1. Do you have lower back or knee weakness, soreness, pain?	☐	☐
2. Do you have ringing in your ears or dizziness?	☐	☐
3. Is your hair prematurely gray?	☐	☐
4. Do you have vaginal dryness?	☐	☐
5. Is your midcycle fertile cervical mucus scanty or missing?	☐	☐
6. Do you have dark circles under your eyes?	☐	☐
7. Do you have night sweats?	☐	☐
8. Are you prone to hot flashes?	☐	☐
9. Would you describe yourself as afraid a lot?	☐	☐
10. Does your tongue lack coating? Does it appear shiny or peeled?	☐	☐
KI YIN (-):	☐	☐

1. Do you have lower back pain before your period?	☐	☐
2. Is your low back sore or weak?	☐	☐
3. Are your feet cold, especially at night?	☐	☐
4. Are you typically colder than those around you?	☐	☐
5. Is your libido low?	☐	☐
6. Are you often fearful?	☐	☐
7. Do you wake up at night or early in the morning to pee?	☐	☐
8. Do you urinate frequently, and is the urine diluted and/or profuse?	☐	☐
9. Do you have early morning loose, urgent stools?	☐	☐
10. Do you have profuse vaginal discharge?	☐	☐
11. Does your menstrual blood tend to be dull in colour?	☐	☐
12. Do you feel menstrual cramps that are better with heat?	☐	☐
13. Is your pale tongue, moist, and swollen?	☐	☐
KI YANG (-):	☐	☐

1. Are your menses scanty and / or late?	☐	☐
2. Do you have dry flakey skin?	☐	☐
3. Are you prone to getting chapped lips?	☐	☐
4. Are your fingernails or toenails brittle?	☐	☐
5. Are you loosing hair on your head (not in patches, but all over?)	☐	☐
6. Is your hair brittle or dry?	☐	☐
7. Do you have diminished night time vision?	☐	☐
8. Do you get dizzy or light-headed around your period?	☐	☐
9. Lips, the inner side of your lower eyelids, tongue pale in colour?	☐	☐
BL (-):	☐	☐

1. Do you wake early and have trouble getting back to sleep?	☐	☐
2. Do you have heart palpitations, especially when anxious?	☐	☐
3. Do you have nightmares?	☐	☐
4. Do you seem low in spirit or lacking in vitality?	☐	☐
5. Are you prone to agitation or extreme restlessness?	☐	☐
6. Do you fidget?	☐	☐
7. Is the tip of your tongue red?	☐	☐
8. Midline crack of tongue that extends to the tip?	☐	☐
9. Do you sweat excessively, especially on your chest?	☐	☐
HT (-):	☐	☐

	YES	NO
1. Are you often fatigued?	☐	☐
2. Do you have a poor appetite?	☐	☐
3. Is your energy lower after a meal?	☐	☐
4. Do you feel bloated after eating?	☐	☐
5. Do you crave sweets?	☐	☐
6. Do you have loose stools, abdominal pain or digestive problems?	☐	☐

7. Are your hands and feet cold? ☐ ☐
8. Is your nose cold? ☐ ☐
9. Are you prone to feeling heavy or sluggish? ☐ ☐
10. Are you prone to feeling heaviness or grogginess in the head? ☐ ☐
11. Do you bruise easily? ☐ ☐
12. Do you think you have poor circulation? ☐ ☐
13. Do you have varicose veins? ☐ ☐
14. Are you lacking strength in your arms and legs? ☐ ☐
15. Are you lacking in exercise? ☐ ☐
16. Are you prone to worry? ☐ ☐
17. Have you been diagnosed with low blood pressure? ☐ ☐
18. Do you sweat a lot with out exerting yourself? ☐ ☐
19. Dizzy, light-headed or visual changes when you stand up fast? ☐ ☐
20. Is your menstruation thin, watery, profuse, or pinkish in colour? ☐ ☐
21. Are you more tired around ovulation and menstruation? ☐ ☐
22. Do you ever spot a few days or more before your period comes? ☐ ☐
23. Have you ever been diagnosed with uterine prolapse? ☐ ☐
24. Period cramps with a feeling of bearing down in your uterus? ☐ ☐
25. Are you often sick, or do you have allergies? ☐ ☐
26. Have you been diagnosed with hypothyroid or anemia? ☐ ☐
27. Do you have hemorrhoids or polyps? ☐ ☐
28. Does your tongue look swollen, with teeth marks on the sides? ☐ ☐
29. Do you have a pale, yellowish complexion? ☐ ☐

SP QI (-): ☐ ☐

YES NO

1. Is your menstrual flow ever brown or black in colour? ☐ ☐
2. do you feel midcycle pain around your ovaries? ☐ ☐
3. Do you have painful, unmovable breast lumps? ☐ ☐
4. Do you get umbness of your hands and feet (especially at night?) ☐ ☐
5. Do you have varicose veins or spider veins? ☐ ☐
6. Do you have red hemangiomas (cherry red spots) on your skin? ☐ ☐
7. Does your complexion appear dark and “sooty”? ☐ ☐
8. Do you have chronic hemorrhoids? ☐ ☐
9. Does your menstrual blood contain clots? ☐ ☐
10. Have you been diagnosed with endometriosis or uterine fibroids? ☐ ☐
11. Is your lower abdomen tender to palpation (resisting touch)? ☐ ☐
12. Can you feel any abnormal lumps in your lower abdomen? ☐ ☐
13. Do you have piercing or stabling menstrual cramps? ☐ ☐
14. Does your tongue look dark? ☐ ☐
15. Do you have dark spots on your tongue? ☐ ☐
16. Are the veins beneath your tongue twisty and tortuous? ☐ ☐
17. Do you have dark spots in your eyes? ☐ ☐
18. Have you been diagnosed with any vascular or clotting disorder? ☐ ☐

BL STAG: ☐ ☐

1. Are you prone to emotional depression? ☐ ☐
2. Are you prone to anger and / or rage? ☐ ☐
3. Do you become irritable premenstrually? ☐ ☐
4. Do you feel bloated or irritable around ovulation? ☐ ☐
5. Does it feel as if your ovulation lasts longer than it should? ☐ ☐
6. Are your breasts sensitive / sore at ovulation? ☐ ☐
7. Do you experience nipple pain or discharge from your nipples? ☐ ☐
8. Do you have a lot of premenstrual breast distention or pain? ☐ ☐
9. Have you been diagnosed with elevated prolactin levels? ☐ ☐
10. Do you become bloated premenstrually? ☐ ☐
11. Are your pupils usually dilated and large? ☐ ☐
12. Do you have difficulty falling asleep at night? ☐ ☐
13. Do you have heart burn or wake up with bitter taste? ☐ ☐
14. Are your menses painful? ☐ ☐
15. Do you feel your menstrual cramps in the external genital area? ☐ ☐
16. Is the menstrual blood thick and dark, or purplish in colour? ☐ ☐
17. Is your tongue dark or purplish in colour? ☐ ☐

LV QI STAG: ☐ ☐

1. Is your pulse rate rapid? ☐ ☐
2. Are your mouth and throat usually dry? ☐ ☐
3. Are you thirsty for cold drinks most of the time? ☐ ☐
4. Do you often feel warmer than those around you? ☐ ☐
5. Do you wake up sweating or have hot flashes? ☐ ☐
6. Do you break out with red acne (especially premenstrually)? ☐ ☐
7. Do you have a short menstrual cycle? ☐ ☐
8. Do you have vaginal irritations or rashes? ☐ ☐

HEAT: ☐ ☐

1. Do you feel tired and sluggish after a meal? ☐ ☐
2. Do you have fibrocystic breasts? ☐ ☐
3. Do you have cystic or pustular acne? ☐ ☐
4. Do you have urgent, bright or foul-smelling stools? ☐ ☐
5. Does your menstrual blood contain stringy tissue or mucus? ☐ ☐
6. Are you prone to yeast infections and vaginal itching? ☐ ☐
7. Do your joints ache, especially with movement? ☐ ☐
8. Are you overweight? ☐ ☐
9. Do you have a wet, slimy tongue? ☐ ☐

DAMP: ☐ ☐

1. Do you have signs from the above two categories? ☐ ☐
2. Do you have foul-smelling, yellow, or greenish vaginal discharge? ☐ ☐
3. Are you prone to vaginal and/or rectal itching during your PMS phase? ☐ ☐

DAMP HEAT: ☐ ☐

1. Do you fit the Kidney Yang deficiency picture?
2. Do you fall into the Blood Stasis pattern ☐ ☐
3. Your lower abdomen feels cooler to the touch than the rest of your trunk ☐ ☐

COLD UTERUS: ☐ ☐

OBJECTIVE:

TONGUE:

LU

SP

YANG

HT

LV

YIN

ASSESSMENT:

ACTIVE HEALTH INSTITUTE
Dr Andréa Proulx *ND*

PRIVACY POLICY FORM

Privacy of your personal information is an important part of our Health Centre, while providing you with quality care. We understand the importance of protection 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.

Consent Declaration
Dr Andréa Proulx ND understands the importance of protecting your personal information. To demonstrate our commitment to you, please find below an outline of how the office is using and disclosing your information.
This office will collect, use and disclose only necessary information about you for the following purposes:

- To collect information for all services offered by Dr Andréa Proulx ND.
- To collect fees relating to the services offered by Dr Andréa Proulx ND.
- To provide a means of communication between Dr Andréa Proulx ND and the Patient (via email or Canada Post mail) regarding services being offered at that time.
- To provide information on seminars and workshops offered by Dr Andréa Proulx ND via email or Canada Post mail.
- To provide handouts and additional relevant health information via email or Canada Post mail.
- To establish and maintain contact with you, including reminders of upcoming appointments.
- To assist this Health Centre to comply with all regulatory requirements and comply generally with the law.
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for practice sale.

DISCLOSURE:

1. to the Patient's/Client's doctor/health practitioner(s).
2. to colleagues of Andréa Proulx ND for the purposes of supporting Patient/Client health (all Patient/Client confidentiality is maintained).

We will only share your information with your consent. Storage, retention and destruction of your personal information complies with existing legislation and privacy protocols.
The privacy officer of this office is Dr Andréa Proulx ND. A copy of the privacy policy is available on request.

Patient/Client Consent
I have reviewed the above information that explains how your Health Centre will use my personal information, and the steps your Health Centre is taking to protect my information.

______________________________	______________________________
(Signature)	(Print Name)
______________________________	______________________________
(Date)	(Signature of Witness)

Dr Andréa Proulx *ND*

CONSENT TO TREATMENT FORM

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Your Naturopathic Doctor will take a thorough case history, do a complete physical examination as indicated, and may take blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee.
I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications.

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (Please Print)

____

Date:

____

Signature of Patient (or Guardian):

____

Naturopathic Doctor, Registered Acupuncturist:
Dr Andréa Proulx, ND. #1575, Rac #4795

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