

Doctor of Naturopathic Medicine

Current Fee Schedule¹

1. First Office Call (60 minutes): \$160.00. This fee does not cover the costs of necessary in-house tests, medical procedures, and any additional laboratory/diagnostic tests.
2. Lifestyle Counseling (60 minutes): \$100.00
3. Extended Return Office Call (60 minutes): \$100.00
4. Return Office Call -1 (30 minutes): \$60.00. This fee does not cover the costs of necessary in-house tests, medical procedures, and any additional laboratory/diagnostic tests.
5. Return Office Call - 2 (20 minutes): \$50.00. This fee does not cover the costs of necessary in-house tests, medical procedures, and any additional laboratory/diagnostic test
6. Return Office Call - 3 (15 minutes): \$40.00. This fee does not cover the costs of necessary in-house tests, medical procedures, and any additional laboratory/diagnostic test
7. Vitamin B-12 Injections: \$10.00
8. Medical Letters/Reports: \$10.00
9. Additional laboratory tests through Gamma-Dynacare Medical Laboratories must be paid at the time of the office visit. There will be a separate receipt for laboratory tests since the Canadian College of Naturopathic Medicine/Robert Schad Naturopathic Clinic processes the billing/payment.
10. There are typically no charges for telephone consultations. If necessary, I may request that you set-up an appointment as soon as possible.

¹ All fees are subject to change.

Your Medical History: Place an "X" mark by any problems you now have. Place a "P" for any medical problems you may have had in the past.

General-Infectious

- Measles
- Scarlet Fever
- Whooping Cough
- Mumps
- Tuberculosis
- Typhoid Fever

Immunizations: Up to Date? Y N ?

- Chicken Pox
- Malaria
- Rheumatic Fever
- DPT
- Polio
- Tetanus
- MMR
- Hepatitis B

Allergies

- Hayfever
- Skin
- Food
- Medications: List any medication allergies: _____

Skin

- Open Sore/Ulcer
- Nail Problem
- Bruise Easy
- Eczema
- Acne
- Psoriasis
- Itching
- Warts
- Corns
- Rashes
- Hives

Eyes, Ears, Nose & Throat

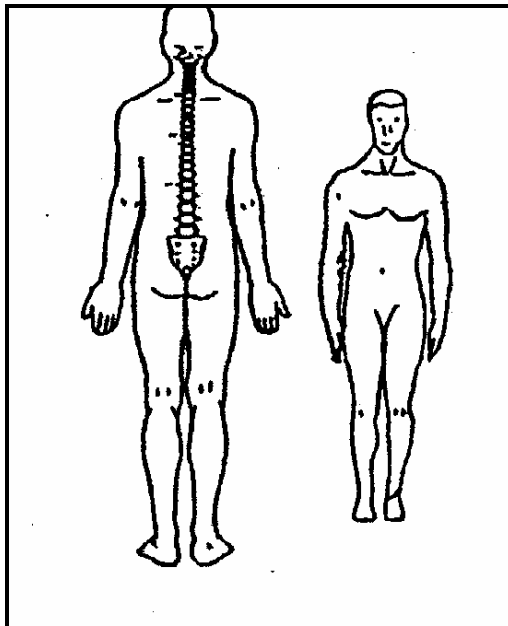
- Last Eye Exam _____
- Last Dental Exam _____
- Eye Infections
- Dental Problems/Dentures
- Vision Problems
- Ringing in Ears
- Ear Wax Problems/Ear Aches
- Sore Throat/Tonsillitis
- Oral Herpes
- Nose or Sinus Problems
- Nose Bleeds
- Nasal Congestion
- Hearing Loss

Nervous System

- Paralysis
- Fainting
- Convulsions
- Loss Of Sleep
- Depression
- Alcoholism
- Drug Addiction
- Numbness in Thumbs
- Numbness in Fingers
- Burning Sensations
- Forgetfulness
- Hyperactivity

Musculo-Skeletal

- Neck Pain/stiffness/pressure
- Upper Back Pain
- Pain Between Shoulders
- Shoulder Pain
- Lower Back Pain/stiffness/pressure
- Arthritis
- Gout
- Joint Pain, Stiffness, Bursitis
- Walking Problems
- Tail Bone Pain
- Hip Pain
- Clicking Jaw
- Leg/Knee Pain or Swelling
- Difficulty Chewing



Please indicate on the drawings the location and type of symptoms that you are currently experiencing.

Aching	XXXX
Burning	*****
Stabbing	////////
Pins/needles	00000
Numbness	-----
Spasm/Tight	SSSSS
Other	#####

- Pain, Tingling, Weakness or Numbness in Arms/Hands
- Pain, Tingling, Weakness or Numbness in Legs/Feet
- Chronic Sprains
- Spinal Curvature
- Gout
- Poor posture

Gastrointestinal

- Poor or Excessive Appetite
- Excessive Thirst
- Gas/Bloating After Meals
- Fatigue after Eating
- Colon Trouble/Colitis
- Hiatal Hernia

How many Bowel movements per day? _____

- Liver Trouble
- Gall Bladder Trouble
- Vomiting
- Heartburn
- Stomach Cramps
- Hemorrhoids
- Jaundice/Hepatitis
- Frequent Nausea
- Diarrhea
- Constipation
- Weight Trouble
- Ulcers

Cardiovascular/Respiratory

- Hardening of Arteries
- Chronic Cough
- Spitting up Blood
- Chest Pain/Angina
- Short of Breath
- Difficulty Breathing
- Irregular Heartbeat
- Poor Circulation
- Pleurisy
- Emphysema
- Cold Hands/Feet
- Heart Problems
- Varicose Veins
- Ankle Swelling
- Asthma
- Pneumonia

Genitourinary

- Bed Wetting
- Genital Herpes
- Venereal Disease
- Bladder Infections
- Kidney Infections
- Excessive Urination
- Frequent Urination
- Discolored Urine
- Discharges
- Kidney Stones
- Venereal Disease

Endocrine/Hematology

- Diabetes Adult/Childhood
- Anemia
- Hypoglycemia/low blood sugar
- Thyroid Gland Trouble
- Pituitary Gland Trouble

Female Only

- Date Last PAP _____
- Date Last Mammogram _____
- Date Last Period Began _____
- Age 1st Period _____
- Period Length _____
- Cycle Length _____
- Menstrual Cycles Regular? Y N
- Number of Pregnancies _____
- Number of Births _____
- Unable To Get Pregnant
- Are You Pregnant Y N
- Premenstrual Tension
- Menstrual Cramps/Backache
- Excessive Flow
- Vaginal Discharge
- Menopause Age _____
- Hysterectomy Total Partial
- Do you do monthly Breast Self Exams? Y N
- Birth Control pills y/n _____

Male Only

- Prostate Problems
- Dribbling of Urine
- Urgency to Urinate
- Retention of Urine
- Sexual Dysfunction

Breasts (Male & Female)

- Breast Pain
- Breast Lumps
- Discharge/Swelling

List All Surgeries & Hospitalizations
(and age at time):

Broken Bones (and age at time):

_____	_____
_____	_____
_____	_____
_____	_____

Family History: If any blood relatives have had any of the following please circle.
Diabetes, hypoglycemia, heart disease, kidney disease, cancer, TB, allergies, bleeding disorders, glaucoma, seizures, mental illness, sickle cell anemia. Approximate age is O.K.

Grandparents: L=Living D=Deceased

Fathers Side

Grandmother: L/D Age: _____

Grandfather: L/D Age: _____

Mothers Side

Grandmother: L/D Age: _____

Grandfather: L/D Age: _____

Parents: L=Living D=Deceased

Father: L/D Age: _____

Mother: L/D Age: _____

List Brothers/Sisters and ages: Medical Problems: L=Living D=Deceased

B/S L/D	B/S L/D	B/S L/D	B/S L/D	B/S L/D	B/S L/D
Age: _____	Age: _____	Age: _____	Age: _____	Age: _____	Age: _____

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Your Children and ages: Medical Problems: M=Son F=Daughter L=Living D=Deceased

M/F L/D	M/F L/D	M/F L/D	M/F L/D	M/F L/D	M/F L/D
Age: _____	Age: _____	Age: _____	Age: _____	Age: _____	Age: _____

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Social History: The following is important and will help the doctor determine how your lifestyle affects your health: **On an average day how much?**

Coffee Cups per day_____ Alcohol per day/week (oz) _____
Tea Cups per day_____ Do you smoke? Y N # per day_____
Milk Cups per day_____ Do you use other tobacco products? Y N
Juice Cups per day_____ Do you use recreational drugs? Y N
Soda Cups per day_____ Hours of sleep per night: _____
Water Cups per day_____

What do you typically eat for

Breakfast?	Lunch?	Dinner?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What do you snack on? _____

Do you have an exercise program? ___ Yes ___ No _____

Marital Status:(Circle one):

Married Widowed Divorced Single Living With Significant Other

Employment:

Who is your employer? _____

What activities do you do at work? _____

Do you handle chemicals: _____

Do you like your Job? Yes No Don't Know How long at this job? _____