

Dr. Cindy Tran N.D.

Purity Health and Wellness

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Edmonton, AB T6W 2P6

Ph. (587) 759-6407

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AHC # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Confirmation: E-mail / Phone / Text

DOB (D/M/Y): \_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ Birth Sex: Male / Female

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are under 18 years of age, please list the name, relationship, and contact information of the person who is legally responsible for you:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EmergencyContact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are any other physician(s) or healthcare practitioners treating you? If yes, please list the name(s) and phone number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list your Health Concerns**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Immunizations:Please check any immunizations you have as and note any reactions**:

☐ Diphtheria, Pertussis, Tetanus, Polio, Hib

☐ MMR (Measles, mumps, rubella)

☐ Influenza (flu shot)

☐ Hepatitis A and/or B

☐ HPV (gardasil)

**Please list known allergies or sensitivities:**

Foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Environmental factors:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chemicals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all current prescription and non prescription (including birth control pills, aspirin etc.) medications with dosages:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list all current supplements with dosages if known:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list any hospitalizations, serious injuries, and/or surgeries: (date and type):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle**: Please report your utilization of the following and their frequency

**Daily Weekly**

Tobacco \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Alcohol \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Recreational Drugs \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Coffee/Caffeine \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Exercise \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Family Medical History: Please check areas pertaining to blood relatives NOT including yourself, note whether the condition is from the maternal (M) or paternal (P) side of your family:

M P M P

☐ ☐ Alcoholism ☐ ☐ Thyroid Problems

☐ ☐ Arthritis ☐ ☐ Depression

☐ ☐ Cancer ☐ ☐ Eating Disorder

☐ ☐ Epilepsy ☐ ☐ Diabetes

☐ ☐ Hay fever / Allergies ☐ ☐ Liver Disease

☐ ☐ Heart Disease / Stroke ☐ ☐ Mental Disorders

☐ ☐ High Blood Pressure ☐ ☐ Kidney Disease

**Please list anything we missed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**: Check all continuing or recurrent Problems

**General**:

☐ Night Sweats ☐ Headaches

☐ Stress ☐ Head Injury

☐ Fatigue ☐ Migraines

☐ Sleep Disturbance ☐ Jaw / TMJ Problems

☐ Dizziness

☐ Exposure to Toxic Chemicals

**Ears**:

**Endocrine**: ☐ Hearing Loss

☐ Thyroid Condition ☐ Ringing

☐ Heat or Cold Intolerance ☐ Earaches or Infections

☐ Blood Sugar Irregularities

☐ Easy Weight Gain / Loss **Nose or Sinuses**:

☐ Excessive Thirst ☐ Frequent Colds / Flus or Infections

☐ Nose Bleeds

**Mental / Emotional**: ☐ Hay Fever / Rhinitis / Congestion

☐ Depression ☐ Loss of Smell

☐ Mood Swings ☐ Sinus Problems / Congestion

☐ Anxiety or Nervousness

☐Considered / Attempted Suicide **Eyes**:

☐ Poor Concentration ☐ Recent Change in Vision

☐ Memory Problems ☐ Blurred Vision

☐ Eye Pain / Strain

**Mouth and Throat**: ☐ Redness / Itching of eyes

☐ Frequent Sore throat / Hoarseness

☐ Mouth Sores / Gum Problems **Blood / Peripheral Vascular**:

☐ Loss of sense of Taste ☐ Easy Bleeding or Bruising

☐ Dental Cavities or Infections ☐ Anemia

☐ Root Canals ☐Clots / Thrombosis / DVT

☐ Mercury Amalgam Fillings

**Neurologic**: **Cardiovascular**:

☐ Seizures / Epilepsy ☐ Angina, Heart Attack

☐ Paralysis ☐ High / Low Blood Pressure

☐ Muscle Weakness ☐ Murmurs

☐ Numbness or Tingling ☐ Chest Pain

☐ Loss of Memory ☐ Pain on Urination

☐ Vertigo or Dizziness ☐ Excessive Urination

☐ Loss of Balance ☐ Frequency at Night

☐ Inability to Hold Urine

**Skin**: ☐ Blood in Urine

☐ Rashes, Eczema, Hives ☐ Frequent Infections

☐ Infections / Fungus / Athletes Foot ☐ Kidney Stones

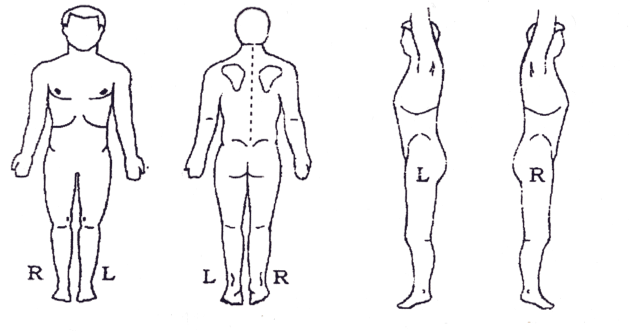
☐ Itching

☐ Moles /Growth **Musculoskeletal**:

☐ Hair / Nail Changes ☐ Joint Pain or Stiffness

☐ Dry or Scaling ☐ History of Broken Bones

☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Muscle Weakness, Spasms or Cramps

☐ Mark ares you currently feel pain:

**Head**:

☐ Palpitations / Fluttering, Irregular Beat

☐ Poor Circulation

**Respiratory**:

☐ Cough

☐ Difficult or Painful Breathing

☐ Asthma

☐ Shortness of Breath **Male**:

☐ Positive TB Test ☐ Hernias

☐ Testicular Mass or Pain

**Gastrointestinal**: ☐ Prostate Problems

☐ Constipation ☐ Discharge or Sores

☐ Diarrhea / Loose Stools ☐Difficulty in stopping or starting urination

☐ Trouble Swallowing ☐ Decreased flow or force of urination

☐ Heartburn ☐ Sexual Difficulties

☐ Change in Thirst or Appetite ☐ Sexually Transmitted Disease

☐ Abdominal Pain or Damage

☐ Belching or Gas / Bloating **Urinary**:

☐ Nausea / Vomiting ☐Recent changes in Breasts

☐ Hemorrhoids ☐ Breast Lumps / Pain / Tenderness

☐ Blood or Mucus in Stool ☐ Discharge

☐ History of Parasites

☐ Gallbladder Disease **Breast (Male + Female)**:

☐ Liver Disease / Jaundice (yellow skin) ☐ Self Exam Regularly

☐ History of eating Disorder

**Female**:

☐ Pregnant? YES NO ☐ Number of Pregnancies: \_\_\_\_\_\_\_\_

☐ Number of Births: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Date of Last PAP: \_\_\_\_\_\_\_\_\_\_\_\_\_

☐Number of Miscarriages / Abortions: \_\_\_\_\_\_\_\_\_ ☐ History of Abnormal PAP

☐ Sexual Difficulties ☐ Age of first Menses: \_\_\_\_\_\_\_\_\_\_\_

☐ History of Sexually Transmitted Diseases ☐ Abnormal Discharge

If Pre-Menopausal:

☐ Duration of Menses: \_\_\_\_\_\_\_\_\_Days ☐ Length of Cycle: \_\_\_\_\_\_\_\_\_Days

☐ Days of Flow: \_\_\_\_\_\_\_\_ Days ☐ Irregular or no Cycle

☐ Bleeding between Cycles ☐ Painful Menses

☐ PMS ☐ Heavy or Excessive Flow

☐ Birth Control? YES NO TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Menopausal:

☐ Age of last Menses ☐ Any Menopausal Symptoms

☐ BVaginal Bleeding since Menopause

​​Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors 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, perform a physical exam and may employ specific diagnostic testing, if it is deemed necessary, which will be discussed in your visit.

It is very important that you inform your Naturopathic Doctor of any disease process that you are suffering from, and 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 may be slight health risks to treatment by naturopathic medicine. These are rare, but include and are not limited to:

* Possible 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
* Muscle strains and sprains, disc injury from spinal manipulation

**Statement of acknowledgement and consent**

As a patient of Purity Health & Wellness, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read the information and understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. 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 in writing or unless law requires it. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

The information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs.

I hereby consent to naturopathic treatment from Dr. Cindy Tran, ND and intend this consent to cover the entire course of treatment for my present condition. I understand this consent is voluntary and may be revoked at any time.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation policy**

I understand that I am required to give a minimum of **24 hours notice** if I am unable to make my appointment. In the event that I miss an appointment without sufficient notice, I may be charged the full cost of the missed appointment.

**Credit Card Information**

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date: \_\_\_\_\_\_\_\_\_\_\_ CVV: \_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_