

# Busy Light Clinic

Dr. TANYA RAMPERSAD, N.D. AANP Member: 1640

Full Name: \_\_\_\_\_

Birthdate: (d/m/y) \_\_\_\_\_ Sex: M [ ] F [ ] Ancestry: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Provincial Health Number: \_\_\_\_\_

Private Insurance Company: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_

## How did you hear about Dr. Rampersad and/or Busy Light Clinic?

( eg. friend, Google, flyer ): \_\_\_\_\_

Name of Referring Person: \_\_\_\_\_

### Terms of Admission

**Personal:** In signing below, I voluntarily consent to treatment with the understanding that the form of medical care I will receive is based on naturopathic principles, practices and therapies. These may include but are not limited to: nutritional counseling, herbal medicine, homeopathy, injections, counseling, soft & hard tissue manipulations, hydrotherapy, cold laser & infra red lab therapy, radio frequency & tests. Please note that there are potential risks to any health related treatment as well as benefits. You will be informed of the risks involved in any treatment that may be prescribed. No treatment will be administered without your express or implied consent.

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 me or otherwise permitted or required by law.

**Financial:** I understand that all payments are due at time of service. To receive package prices, payment must be made for the entire package prior to service. I understand that if I am providing insurance billing information, that I am responsible for all charges whether or not they are covered by my insurance. Refunds on prepaid packages are subject to deduction of fees for treatments already received plus a \$75 administration fee. Cancellation of appointments without rescheduling must be done 48 hours prior the appointment to avoid treatment fee charges.

I affirm that all information provided above is correct to the best of my knowledge.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

### Present Health Concerns

Busy Light Therapeutic Laser Clinic  
824 D Edmonton Trail NE, Calgary AB 403-453-1363  
[tanya@busylighclinic.ca](mailto:tanya@busylighclinic.ca)

List your present health issues in order of significance along with any diagnosis you've received:

1 \_\_\_\_\_  
 2 \_\_\_\_\_  
 3 \_\_\_\_\_  
 4 \_\_\_\_\_

Please list any treatments you are currently receiving; including prescription medication, vitamins, mineral, herbs, and homeopathic remedies. Please include dosages for each listing.

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_  
 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_

**-Personal Health Context-  
 Medical History**

Hospitalizations \_\_\_\_\_

Serious Illnesses/Injuries \_\_\_\_\_

Date of most recent physical exam \_\_\_\_\_ Date of most recent blood test: \_\_\_\_\_

Name of your doctor \_\_\_\_\_ Location: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Current weight \_\_\_\_\_ Weight one year ago \_\_\_\_\_ Maximum weight \_\_\_\_\_

Blood type A [ ] B [ ] AB [ ] O [ ] Don't know [ ]

**Family Medical History: please include 1st & 2nd degree relatives**

M = Maternal lineage P = Paternal lineage

Allergies	M [ ] P [ ]	Autoimmune Disease	M [ ] P [ ]	Diabetes	M [ ] P [ ]
Alzheimer's	M [ ] P [ ]	Heart Disease	M [ ] P [ ]	Eczema	M [ ] P [ ]
Arthritis	M [ ] P [ ]	Inflamm. Bowel Disease	M [ ] P [ ]	Obesity	M [ ] P [ ]
Cancer	M [ ] P [ ]	Epilepsy / Seizures	M [ ] P [ ]	Parkinson's	M [ ] P [ ]
Thyroid Condition	M [ ] P [ ]	Mental Illness	M [ ] P [ ]	Stroke	M [ ] P [ ]
Metabolic Synd.	M [ ] P [ ]	Blood disorder	M [ ] P [ ]	Osteoporosis	M [ ] P [ ]

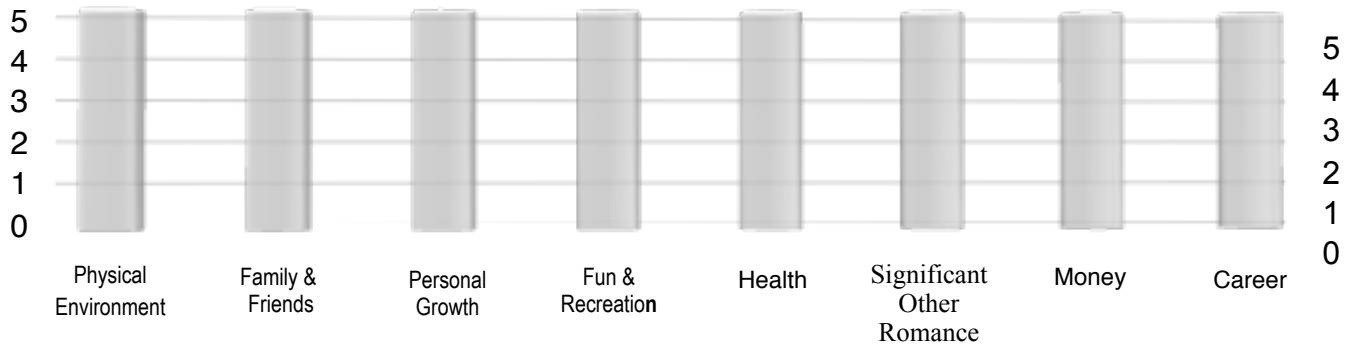
Dietary Preferences/Restrictions \_\_\_\_\_

Sleep Pattern (hours, shiftwork) \_\_\_\_\_ Exercise Pattern \_\_\_\_\_

Relationship Status (please check): S [ ] M [ ] D [ ] W [ ] Significant Other [ ]

Do you have children? Yes [ ] No [ ] if so, how many? \_\_\_\_\_ Please list their ages: \_\_\_\_\_

**Please mark the rows according to your level of satisfaction of each category.**



Smoke? Y [ ] N [ ] How many per day? \_\_\_\_\_ How many \_\_\_\_\_ years? \_\_\_\_\_ tried to quit?  
Y [ ] N [ ]

Drink Alcohol? Y [ ] N [ ] How often? daily [ ] weekly [ ] infrequently [ ]

Drink Coffee Y [ ] N [ ] How many cups/day? \_\_\_\_\_

Use recreational drugs? Y [ ] N [ ] How often? daily [ ] weekly [ ] infrequently [ ]

Have surgical or cosmetic implants? Y [ ] N [ ] Please specify: \_\_\_\_\_

How many times have you been on antibiotics? \_\_\_\_\_ When was the last time? \_\_\_\_\_

Have you been vaccinated? Y [ ] N [ ] Any adverse reactions? Y N

Please list any Occupational or Environmental Hazards \_\_\_\_\_

How many: root canals # \_\_\_\_\_ amalgam (silver) fillings # \_\_\_\_\_ amalgam fillings removed # \_\_\_\_\_

Pending dental work Y [ ] N [ ] Nature of the issue \_\_\_\_\_

Drug, environmental and food allergies/sensitivities \_\_\_\_\_

Are there any other significant events that you believe have impacted your health?  
\_\_\_\_\_

Please describe your commitment to overcoming your current health concern(s) - check one:

- I am willing to commit fully to the process of seeking wellness
- I have other priorities that may prevent me from committing myself fully to getting well
- I have little space in my life to commit effort to getting well.

In what length of time are you expecting or hoping to see significant results? \_\_\_\_\_

**Please check if the following symptoms are current or recurring**

<b>General</b>	<input type="checkbox"/> Weight-loss	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Anemia
	<input type="checkbox"/> Weight-gain	<input type="checkbox"/> Significant drop in Energy/Time of day?	<input type="checkbox"/> Heat or Cold Intolerance
	<input type="checkbox"/> Fevers	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Unusual tastes or smells
	<input type="checkbox"/> Chills		<input type="checkbox"/> Bleed or Bruise easily
	<input type="checkbox"/> Excessive Sweating		
<b>Skin Hair</b>	<input type="checkbox"/> Rashes	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Change in hair or skin texture
	<input type="checkbox"/> Itching	<input type="checkbox"/> Changes in Moles	<input type="checkbox"/> Loss of hair
	<input type="checkbox"/> Eczema or Psoriasis	<input type="checkbox"/> Ulcers	
	<input type="checkbox"/>	<input type="checkbox"/> Acne	
<b>Head Eyes Ears Nose Throat</b>	<input type="checkbox"/> Headaches	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Poor hearing
	<input type="checkbox"/> Neck masses	<input type="checkbox"/> Corrected vision	<input type="checkbox"/> Frequent colds/flu's
	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Ear aches	<input type="checkbox"/> Sinus problems
	<input type="checkbox"/> Eye pain/strain	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Frequent nose bleeds
	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Mouth pain or sores	<input type="checkbox"/> Jaw pain
<b>Heart Circulation</b>	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Fainting / Dizziness	<input type="checkbox"/> Low Blood pressure
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cold Hands/Feet	<input type="checkbox"/> Chest pain
	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Swelling in Hands/Feet	<input type="checkbox"/> Varicose Veins
<b>Respiratory</b>	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Bronchitis
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Phlegm / Colour?		<input type="checkbox"/> Cough
<b>Digestion</b>	<input type="checkbox"/> Indigestion/Heartburn	<input type="checkbox"/> Poor/Excess Appetite	<input type="checkbox"/> Abdominal pain
	<input type="checkbox"/> Gas/Bloating	<input type="checkbox"/> Change of Appetite	<input type="checkbox"/> Rectal pain
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Hemorrhoids
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Nausea	<input type="checkbox"/> Blood in Stool
	<input type="checkbox"/> Parasite infection	<input type="checkbox"/> Vomiting	
<b>Genito- Urinary</b>	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Increased urgency	<input type="checkbox"/> Impotence
	<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Decrease in flow	<input type="checkbox"/> Prostate problems
	<input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Sores on genitals
	<input type="checkbox"/> Blood in urine		
<b>Musculo- skeletal</b>	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Joint pain/stiffness
	<input type="checkbox"/> Back pain	<input type="checkbox"/> Muscle pain or weakness	<input type="checkbox"/> (ankle, wrist, hip, knee)
	<input type="checkbox"/> Hand / Foot pain	<input type="checkbox"/> Bone pain	
<b>Neurological Psychological</b>	<input type="checkbox"/> Numbness	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Stress	<input type="checkbox"/> Difficulty Concentrating
	<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Depression	
	<input type="checkbox"/> Seizures		