

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. Money for prepaid packages is non-refundable, however, credit for services yet-to-be delivered may be applied to receiving any other services or products offered at Busy Light Clinic (Credits are calculated on non-package pricing). 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

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 <input type="checkbox"/> P <input type="checkbox"/>	Autoimmune Disease	M <input type="checkbox"/> P <input type="checkbox"/>	Diabetes	M <input type="checkbox"/> P <input type="checkbox"/>
Alzheimer's	M <input type="checkbox"/> P <input type="checkbox"/>	Heart Disease	M <input type="checkbox"/> P <input type="checkbox"/>	Eczema	M <input type="checkbox"/> P <input type="checkbox"/>
Arthritis	M <input type="checkbox"/> P <input type="checkbox"/>	Inflamm. Bowel Disease	M <input type="checkbox"/> P <input type="checkbox"/>	Obesity	M <input type="checkbox"/> P <input type="checkbox"/>
Cancer	M <input type="checkbox"/> P <input type="checkbox"/>	Epilepsy / Seizures	M <input type="checkbox"/> P <input type="checkbox"/>	Parkinson's	M <input type="checkbox"/> P <input type="checkbox"/>
Thyroid Condition	M <input type="checkbox"/> P <input type="checkbox"/>	Mental Illness	M <input type="checkbox"/> P <input type="checkbox"/>	Stroke	M <input type="checkbox"/> P <input type="checkbox"/>
Metabolic Synd.	M <input type="checkbox"/> P <input type="checkbox"/>	Blood disorder	M <input type="checkbox"/> P <input type="checkbox"/>	Osteoporosis	M <input type="checkbox"/> P <input type="checkbox"/>

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? _____

- | | | | |
|---|--|--|---|
| General | <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 | | |
| Skin
Hair | <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"/> Acne | |
| Head
Eyes
Ears
Nose
Throat | <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 |
| Heart
Circulation | <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 |
| Respiratory | <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 |
| Digestion | <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 | |
| Genito-
Urinary | <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 | | |
| Musculo-
skeletal | <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 | |
| Neurological
Psychological | <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 | | |