

	Women's	Fertility Intake Date:_				
Please complete the for require to ensure you r	•	o provide us with the back care.	ground information we			
Name:		Occupation:				
Date of Birth:		Employer:				
Home Address:		Work Tel #:				
		Emergency Contac	tt #:			
Home Tel #:		Contact Relationsh	ip:			
Cell #:		Marital Status:				
E-Mail Address:						
Please list any other m	edical providers:					
Type of Medical Provider	Name	Phone #	Address			
MENSTRUAL HISTO	RY:					
Age at which menses b	egan:					
Date of last menstrual	period:					
How many days does y	our menses last for?_					
Are your menstrual cyc	les spaced irregularly?	? □ Yes □ No				
How many days are the	ere from one period to	the next?				
Are your periods painfu	ıl: 🛘 Yes 🗘 No; If yes	how many days does the	pain last?			
How heavy is the bleed	ling? 🗆 Light 🗖 Norm	al 🛘 Heavy				
What color is the blood	? ☐ Light red ☐ Brigh	nt Red 🛭 Dark Red 🖵 Pur	ole □ Brown □ Black			
Is there clotting? Ye	s 🗆 No					
Do you bleed or clot be	tween periods? 🗖 Yes	s 🗖 No				
Have your cycles chan	ged since they began?	Yes □ No				



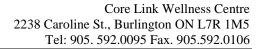
If yes, describe how?
Do you ovulate on your own? ☐ Yes ☐ No
On what day of your cycle do you ovulate?
Do your breasts become tender during your menses? ☐ Yes ☐ No
Do your breasts become tender pre-menstrually ☐ Yes ☐ No
Do you get premenstrual low back pain? ☐ Yes ☐ No
Do your bowel movements become loose at the beginning/during your period? \square Yes \square No
Do you have premenstrual symptoms? ☐ Yes ☐ No; If YES: describe
Does your face break out before or during your period? ☐ Yes - before ☐ Yes -during ☐ No
Do you have nipple discharge? Yes No
, , , , , , , , , , , , , , , , , , , ,
Do you chart your cycles? ☐ Yes ☐ No
Do you chart your Basal Body Temperature? ☐ Yes ☐ No
MEDICAL HISTORY:
How many pregnancies have you had?
How many children do you have?
Have you had any abortions? ☐ Yes ☐ No
If YES, when did the abortion take place:
How many abortions have you had:
Have you had any miscarriages? ☐ Yes ☐ No
If YES, when was the last miscarriage:
How many miscarriages have you had:
Have you had any D&C performed? ☐ Yes ☐ No
Have you ever had an abnormal pap smear? ☐ Yes ☐ No
Have you ever had a cervical biopsy, operation, cauterization or conization? ☐ Yes ☐ No Please specify:
Have you ever had an STI (Sexually Transmitted Infections)? ☐ Yes ☐ No
Have you ever been diagnosed with a Chlamydia infection? ☐ Yes ☐ No
Have you ever been diagnosed with a Herpes genitalis? ☐ Yes ☐ No
Do you get yeast infections regularly? ☐ Yes ☐ No
Do you have chronic vaginal discharge? ☐ Yes ☐ No
Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No



Were you treated for it? \(\bigcup \)How? \(\bigcup \)	☐ Yes ☐ No	
Have you ever been diagnosed		
If YES: when were they of	liagnosed:	
Have you ever been diagnosed	with endometriosis? 🗆 Yes 🗅 N	lo
If YES: when were they of	liagnosed:	
Have you ever been diagnosed	with pelvic adhesions? ☐ Yes ☐	1 No
Have you ever been diagnosed	with pelvic abnormalities? Yes	s □ No
Have you been diagnosed with a	thyroid condition? Yes No)
If YES: are you on any m	edications?	
Do you experience fatigue? ☐ Y	es 🗆 No	
Have you ever taken any medica	ations for gynecological condition	ns other than contraceptives?
Medication	Reason	When/How Long
Are you taking any medications	currently?	
If YES: specify:		
PERSONAL HISTORY:		
How long have you been trying t	o conceive?	
Have you had a diagnosis relating What was the diagnosis	ng to infertility? ☐ Yes ☐ No sis?	
Have you had fertility treatments If YES: when and who	? □ Yes □ No ere?	
What types?		
Date of last PAP smear:		
Have you taken medication to he When:	elp you ovulate? ☐ Yes ☐ No How long?	
Have your fallopian tubes been e What were the results	evaluated medically? Yes !	



Have you had any tubal operations? ☐ Yes ☐ No								
Have you had any hormone What were the res		ned? Yes No						
Please indicate any serious i	Ilnesses, conditions, or	reasons for hospitaliza	tions					
Medical Date of Diagnosis Is the condition Symptoms Condition/Hospitalization still present?								
Condition/Hospitalization		•						
CONTRACEPTIVE USE H	ISTORY:							
Have you taken oral contract When?	eptives? ☐ Yes ☐ No How lon	g?						
 Reason for oral co 	ontraceptive use:							
Have you ever used an IUD? When?		g?						
 Reason for IUD u 	se:							
Have you ever taken Depo-F When?		ng?						
PARTNER INFORMTATIO	N:							
Has your partner had a comp	olete fertility workup?	l Yes □ No						
Has your partner undergone semen analysis? ☐ Yes ☐ No								
Is your partner supportive of	your wish to conceive?	Yes No						
OTHER:								
Current Weight:								
Current Height:								
Is there a family history of ar	y congenital birth defe	cts? ☐ Yes ☐ No						
How is your sexual desire?	🛘 Low 🖵 Normal 🗖 Hig	ıh						
Do you have a stressful occu	ıpation? ☐ Yes ☐ No							





Do you exercise	e regularly? Yes No How often:							
Have you recen	tly gained or lost weight? ☐ Yes ☐ No; Weight gained/lostlbs							
Do you have ex	cessive facial hair? ☐ Yes ☐ No							
Have you exper	ienced excessive loss of head hair? ☐ Yes ☐ No							
Have you notice	ed discharge from your nipples? ☐ Yes ☐ No							
Have you been	Have you been exposed to any known environmental toxins or hormones? ☐ Yes ☐ No							
Are you present	ly taking any steroids? □ Yes □ No							
Do you smoke?	☐ Yes ☐ No							
Do you consum	e alcohol? □ Yes □ No							
Do you consum	e caffeine? ☐ Yes ☐ No							
Do you use recr	reational drugs? Yes No							
	g that you feel is important that has not been covered?							
Where did you I	earn about this clinic?							
Internet:	name: Google OAND/CAND Yellow pages (online) Canadian Naturopaths website							
	book I Naturopathic Clinic							



CORELINK WELLNESS CENTRE

INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES

Name		
Address		
City and Postal C	Code	
Attending N.D		
(Filled in at visit)	RECOMMENDED THERAPEUTIC PROCEDURE(S (Including those by referral to another practition	
recommended the any requests for his/her office or conformed of and expected benefit	ed, do hereby acknowledge that I have been informed herapeutic procedure(s)/ plan and have discussed to related information with the naturopathic doctor namelinical assistant(s). I further acknowledge and confirmed assistant the therapeutic procedure(s)/plan with rest, potential risks and side effects the likely consequent the procedure(s)/plan, and what alternative course(s)	my satisfaction this and ed above and/or with n that I have been spect to the financial costs, nces of not
therapeutic proce	nereby voluntarily consent/ withhold/ my informed cor edure(s)/plan as specified above. I also understand t untary consent at any time.	
Signature	Print Name	
Date	Witness Signature	

PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our clinic while providing you with quality naturopathic care. We understand the importance of protecting 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.

In this clinic, Payam Kiani, ND acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.



Our privacy policy outlines what our Clinic is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards or our regulatory body, the Board of Directors of Drugless Therapy — Naturopathy.

How our clinic collects, uses and discloses patients' personal information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our clinic is using and disclosing your information.

This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy — Naturopathy acting under the authority of the *Drugless* Practitioners Act
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this clinic to comply with all regulatory requirements
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

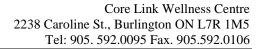
By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient Consent

I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information.

I agree that the Core Link Wellness Clinic can collect, use and disclose my personal information as set out above in the information about the clinic's privacy policies.

Signature	Print Name	
Date	Witness Signature	
Date	Withess Dignature	

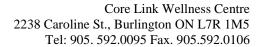




7 Day Diet Diary

Name: _	
Date:	

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Breakfast							
Lunch							
Dinner							
Snacks							
Fluids							
Comments							
Commonts							





Name:	Date:

Check the conditions that you are currently experiencing, or have experienced often in the past. If more space is required please use the reverse side of this sheet.

	current	previous		current	previous	C	urrent	previous
General Symptoms			<u>Cardiovascular</u>			Infections / Illness	ses	
Loss of conscious	sness		High blood pressu	ure		Herpes		
Numbness / tingli	ng 🗆		Low blood pressu	ire		Hepatitis		
Fever			Bleeding disorder	'S □		Plantar warts		
Sweats			Chest pain			TB		
Fainting			Stroke			HIV / AIDs		
Dizziness			Artery hardening			Cancer		
Loss of sleep/inso	omnia		Varicose veins			Allergies		
Frequent colds / f	lus□		Swelling of the an	ıkles		Muscles and Join	<u>ts</u>	
Loss of weight			Poor circulation			Stiff neck		
			Angina			Backache		
Head / Neck			Heart disease			Swollen joints		
Headaches						Painful tail bone		
Type			<u>Genitorurinary</u>			Foot trouble L/R		
			Trouble urinating			Shoulder pain L/	R□	
Vision problems			Blood in the urine			Elbow pain L/R		
TMJ concerns			Kidney infections			Wrist pain L/R		
Earaches			Bed wetting			Hip pain L/R		
Decreased hearing	ıg □		Prostate trouble			Knee pain L/R		
Sinus problems						Arthritis		
Difficulty swallowi	ng □		<u>Gastrointestiona</u>	<u>al</u>		Weakness / loss st	rength) 🗆
			Poor digestion					
<u>Skin</u>			Indigestion			Women's Health		
Rashes / Eczema	l 🗆		Excessive hunger			Painful menstruation	n 🗆	
Itching			Belching or gas			Excessive flow		
Bruise easily			Nausea / Vomiting	g□		Irregular cycle		
Dryness			Abdominal pain			Hot flushes		
Boils / Hives	🗆		Constipation			Cramps or backach	ne 🗆	
Contagious skin of	lisease		Diarrhea			Vaginal discharge		
			Hemorrhoids			Swollen breasts		
Respiratory			Liver concerns			Lumps in the breas		
Chronic cough	. 🗆		Gall bladder troub			Are you pregnant	Yes	⊐ No
Shortness of brea	ıth □		Bladder concerns					
Smoking			Ulcer			On birth control	Yes □	No No
Breathing problem			Diabetes					
Asthma / Bronchit	tis 🗆					# of pregnancies _		
						# of children		

Please list anything not covered above:		