

Dr. Alyson Munkley
NATUROPATHIC DOCTOR



200 St. Clair Ave. W., Suite 411
Toronto, ON, M4V 1R1
Phone/Fax: (416) 921-3837
www.alysonmunkley.com

Name _____

Gender: Male / Female

Date of birth _____ Current age _____

Height _____ Weight _____

Home street address _____

City _____ Province _____ Postal code _____

Home phone _____ Is it okay to leave a message? Yes/No

Work phone _____ Is it okay to leave a message? Yes/No

Mobile phone _____ Is it okay to leave a message? Yes/No

E-mail _____

Referred by _____

Emergency contact name and telephone number

**THE FOLLOWING INFORMATION IS CONFIDENTIAL AND WILL
ONLY BE RELEASED IF YOU AUTHORIZE US TO DO SO**

CONTEXT OF CARE

Why did you choose to come to this clinic?

What 3 expectations do you have from this visit to the clinic?

What long term expectations do you have from working with a naturopathic doctor?

What expectations do you have of me personally as your naturopathic doctor?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (rate from 0-10, with 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviours or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols that I will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes that you will be making?

What do you LOVE to do?

HEALTH INFORMATION

PRESENT HEALTH CONCERNS: Please list your most important health concerns

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident, mental upset or unusual stress in your life? If yes, please explain

ALLERGIES: Please list all food, environmental and drug allergies _____

Date of last physical exam _____

Date of last visit to dentist _____

How many silver amalgam fillings? _____ How many root canals? _____

Date last had eyes examined _____

Please list previous medical procedures, hospitalizations, major injuries and serious illnesses:

Approximate date/year	Surgery/hospitalizations/procedure/serious illness/injuries

Past medications _____

Adverse reactions to past medications _____

Were you ever on antibiotics over the last 10 years? Yes/No

Were you ever on antibiotics for an extended period of time? Please explain when and for how long _____

Have you ever used probiotics following antibiotic use? Yes/No

FAMILY HISTORY

Indicate if a close relative (mother, father, grandmother, grandfather, daughter, son, sister, brother) has had any of the following

Condition	Who	Condition	Who
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug or alcohol abuse	
High blood pressure		Kidney disease	
Cancer		Thyroid disorder	
Diabetes		Other	

- Any known genetic diseases. If yes, please explain _____
- I do not know my family medical history

HABITS AND LIFESTYLE

Do you get regular exercise? Yes/No Type _____ Frequency ___x per week

How many cups/bottles/glasses do you drink on the average day?

Coffee ___ Tea ___ Water ___ Milk ___ Fruit juice ___ Soft drinks ___

Vegetable juice ___ Herbal tea ___

What is the source of your drinking water?

Tap (city) ___ Well ___ Bottled (spring) ___ Filtered ___ Distilled ___

What level of personal stress are you experiencing right now?

Minimal ___ Average ___ Considerable ___ Unbearable ___

Is the main stressor: Financial ___ Job-related ___ Marital ___ Interpersonal ___

Health ___ Unfulfilled expectations ___ Family members ___ Spiritual ___ Other ___

Current marital status: Married ___ years Single ___ Divorced ___

Widowed ___ Cohabiting ___ Monogamous relationship ___

Educational background _____

Do you currently use tobacco products? Yes/No

If yes, how many cigarettes do you smoke per day? _____ Number of years _____

Does anyone in your household or workplace smoke? Yes/No

What is your use of alcohol and recreational drugs? Check "✓" the appropriate box

Substance	Never used	Used in past but not now	Presently using Frequency/week	Choose not to answer
Wine				
Beer				
Liquor				
Marijuana				
Other				

Have you ever received treatment for substance abuse? Yes/No

DIET

Do you follow any particular diet regimens or restrictions? e.g. religious, ethical

Describe a typical day's dietary intake

Breakfast _____

Snack _____

Lunch _____

Snack _____

Dinner _____

Snack _____