



DR. STEPHANIE PELTZ, ND

Confidential Adult Case History

Please fill in the following form to the best of your ability. If you have questions, please make a note.

Name: _____ Date: _____ Care Card Number: _____
Address: _____ City: _____ Postal Code: _____
Home #: _____ Work #: _____ Cell #: _____
Date of Birth: ____/____/____ Age: _____ Sex: M / F Occupation: _____
(m) (d) (yr)

Email Address: _____
(to send out receipts, handouts and newsletters. This information will never be sold, or shared)

Would you like to receive a quarterly electronic newsletter? Y / N (please circle)
Are you: ___ Single ___ Partnership ___ Married ___ Separated ___ Divorced ___ Widowed
Living with: ___ Alone ___ Partner ___ Parents ___ Friends ___ Children ___ Relatives
Number of Children: _____ Husband or Wife's Name: _____

Person to Contact in Emergency:

Name _____ Relationship _____ Home #: _____ Alternate #: _____
How did you hear about Dr. Peltz? _____

Names of Other Healthcare Providers:

MD (Medical Doctor) _____
ND (Naturopathic Doctor) _____
Chiropractor/ Acupuncturist _____
Other _____

List your main health concerns in order of importance:

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Past Medical History: Please check and date (year) if any of these apply to you.

Cancer _____ Diabetes _____ Hepatitis _____ Seizures _____
Heart Disease _____ Rheumatic Fever _____ Thyroid Disease _____ Venereal Disease _____
Other _____
Surgeries/Hospitalizations _____
Significant Trauma (auto accidents, falls, etc.) _____
Your Birth (Prolonged labor, forceps delivery, etc.) _____

Current History

Height _____ Weight _____ Weight 1Yr ago _____ Max Weight _____
Smoker: Y / N Smoked: _____ years Amount/day: _____ Years stopped: _____
Drink coffee/cola/tea: Y / N _____ cups/day Use alcohol / drugs: Y/N Amount: _____
Exercise: Types _____ Duration _____ Frequency _____
Allergies _____
Are any of these known life threatening allergies? _____

Diet: List any food groups that you avoid _____
 Are you currently taking any medications? If so please list _____
 Are you currently taking any vitamins/supplements? _____

Family History

Please circle if any of these apply to you or your family.

Glaucoma	Diabetes	Kidney disease	High blood pressure	Anemia
Heart disease	Seizures	Tuberculosis	Depression	Schizophrenia
Arthritis	Dementia	Osteoporosis	Liver disease	Stroke
Allergies	Thyroid issues		Asthma	Hayfever/Hives

Cancer (type _____) Other _____

Review of Systems

Check/circle any symptoms that are current or recurring concerns. If there are any additional problems please describe them in the margin.

General

sudden energy change	strong thirst	night sweats	tremors	bleed easily
bruise easily	fatigue	poor balance	fever	chills
poor sleep	cravings	localized weakness	weight/gain	sweat easily
change in/poor appetite	thyroid problems	hypoglycemia	seasonal depression	

Skin and Hair

rashes	ulcerations	hives	itching	eczema
dry/scaling skin	dandruff	loss of hair	recent moles	acne

Head, Eyes, Ears, Nose and Throat

dizziness	glasses/contacts	sinus problems	sore throats	nose bleeds
concussions	spots in front of eyes	poor hearing	swollen glands	loss of smell
headaches	recent vision change	ringing in ears	cavities	hayfever
migraines	blurred vision	earaches	copious saliva	
facial pain	cataracts	colour blindness	grinding teeth	jaw clicks
night blindness	eye pain/strain	canker sores	sore lips/tongue	cold sores
sensitive to light	hoarseness	frequent colds		

Cardiovascular

high blood pressure	low blood pressure	heart murmurs	chest pain
swelling of feet	swelling of hands	irregular heart beat	rheumatic fever
fainting	blood clots	difficulty giving blood	cold hands/feet
difficulty breathing	palpitations		

Respiratory

cough	coughing blood	production of phlegm	pneumonia	asthma
pleurisy	wheezing	bronchitis	shortness of breath at night	

Gastrointestinal

nausea	indigestion	repeated laxative use	diarrhea	constipation
vomiting	belching/gas	black in stools	gallbladder disease	bad breath
ulcers	rectal pain	abdominal pain	liver disease	hemorrhoids

How often do you have a bowel movement? _____ is this a change? Y / N

Genitourinary

pain on urination frequent urination urgency to urinate blood in urine
 inability to hold urine kidney stones decrease in urine flow frequent infections
 Do you wake to urinate? (how often)? _____ colour/odour of urine? _____

Male

hernias testicular pain premature ejaculation discharge or sores
 impotency prostate disease testicular masses low sperm count
 low libido herpes sexually transmitted disease (type) _____
 are you sexually active? Y / N Have you had difficulty conceiving? Y/N
 Do you practice birth control? Y/N. What type and for how long? _____

Female

age of 1st menses: _____ date of last pap _____ history of abnormal pap Y/N if so, when _____
 are you sexually active? Y/N low libido pain during intercourse vaginal sores
 sexually transmitted disease (type) _____ ovarian cysts endometriosis
 # of pregnancies _____ # of births _____ # of miscarriages _____ # of abortions _____
 breast lumps self breast exams nipple discharge

If you are premenopausal:

date of last menses: _____ length of cycle: _____ duration of menses _____
 heavy menses irregular periods painful periods bleeding in between periods
 clots in menses abnormal bleeding vaginal discharge light menses
 perimenopausal PMS Have you had difficulty conceiving? Y/N
 Do you practice birth control? Y / N. What type and for how long? _____

If you are menopausal:

age of last menses: _____ vaginal bleeding since menopause? Y / N
 menopausal syptoms? Y / N if so, what type: _____

Musculoskeletal

neck pain/stiffness shoulder pain hip pain knee pain hand/wrist pain
 foot/ankle pain muscle weakness muscle pain back pain sciatica
 arthritis broken bones

Neurological

seizures tingling anxiety poor memory quick temper
 concussions loss of balance depression susceptible to stress irritable
 paralysis numbness lack of coordination nervousness

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

CONSENT FORM

Dear patients:

Naturopathic examination includes: physical and clinical diagnosis, traditional Chinese medical diagnosis and lab work. Therapeutic procedures include: homeopathy, spinal adjustment, botanical medicine, acupuncture, manual muscle therapy, craniosacral therapy, clinical nutritional, lifestyle counselling, and intravenous nutritional therapy.

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, stroke, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side effects. I also understand that there is no guarantee or warranty for a specific cure result.

I am aware that 24 hours notice must be given for all cancelled appointments or a cancellation fee of the full cost of my missed visit will be applied. I understand that I am responsible for payment at the time services are rendered. Dispensary items must be paid for in full before leaving the office.

Signature x _____ Date x _____

Doctor's Signature x _____ Date x _____

PARENTAL CONSENT (if applicable)

If you are under the age of 19 parent consent is required for naturopathic treatment.

Signature of Parent/Guardian x _____ Date x _____

Welcome!

Thank you for filling out this extensive questionnaire.