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?_____

Suite 120-1020 Mainland St. | Vancouver BC | V6B 2T5
[p] 604.688.5437 | [f] 604.608.5607 | [e] info@drpeltz.com | www.drpeltz.com

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 <u>premenopausal</u>:

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 <u>menopausal</u>:

age of last menses:_____ vaginal bleeding since menopause? Y / N

menopausal symtoms? 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? _____

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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.

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