Ottawa Integrative Health Centre Inc.
1129 Carling Ave., Ottawa, ON K1Y 4G6
P: (613) 798-1000 F: (613) 798-9995 www.oihc.ca

Nutrition Consultation

Patient Information

Name_____ Date_____

Address_____

City_____ Province_____ Postal Code_____

Home Phone_____ E-Mail _____

☐ Yes, sign me up for the monthly e-newsletter

Occupation _____

Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widower

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit – please include the date it began

_____

_____

List current health problems for which you are being treated

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health overall:

☐ Diet modification ☐ Fasting ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy

☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs ☐ Other _____

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Do you experience any of these general symptoms on a regular basis? Please check.

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Fecal incontinence
☐ Bleeding	☐ Disinterest in sex	☐ Headaches	☐ Vomiting
☐ Urinary Incontinence	☐ Discharge	☐ Disinterest in eating	☐ Dizziness
☐ Diarrhea	☐ Low-grade fever	☐ Itching/rash	☐ Chronic pain/ inflammation

Current medications (prescription or over-the-counter):

_____

_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis) along with outcome of those tests:

_____

_____

_____

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

YEAR	SURGERY, ILLNESS OR INJURY	OUTCOME

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How much *alcohol* do you consume per day

Wine - # per week: _____ Liquor - # ounces per week: _____ Beer - #glasses per week: _____

How much *tobacco* do you consume per day?

Cigarettes - # per day: _____ Cigars - # per day: _____

How much *caffeine* do you consume per day?

Coffee - # 6 oz cups per day: _____ Tea- # 6 oz cups per day: _____ Soda - #cans per day: _____

How many glasses of *water* do you consume per day? _____

How much do you exercise?

☐ *5-7 days/wk* ☐ *3-4 days/wk* ☐ *1-2 days/wk*

How long do you exercise per workout?

☐ *45 minutes or more* ☐ *30-45 minutes* ☐ *Less than 30 minutes*

Please encircle your nutrition or diet regimen.

Mixed food diet (animal/vegetable sources)	Vegetarian	Vegan	Salt restriction
Fat restriction	Starch/carbohydrate restriction	The Zone Diet	Total calorie restriction

Please encircle any food restrictions.

Dairy	Wheat	Eggs
Soy	Corn	All gluten

Please list the number of servings you eat per day of:

Fruits (Citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Meat, poultry, fish _____

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Please encircle what best describes your eating habits.

Skip meals (which meals) _____	One meal a day	Three meals a day	Grace (small frequent meals)
Generally eat on the run	Eat constantly when hungry		

Please check off which supplements you are currently taking.

☐ Multivitamin and minerals	☐ Vitamin C	☐ Vitamin E	☐ EPA or DHA	☐ Evening primrose or GLA
☐ Calcium source_____	☐ Magnesium	☐ Zinc	☐ Minerals (describe) _____	☐ Friendly flora eg. acidophilus
☐ Digestive enzymes	☐ Amino acids	☐ CoQ10	☐ Anti-oxidants eg, lutein, resveratro	☐ Herbs
☐ Homeopathy	☐ Protein shakes	☐ Super-foods eg. Bee pollen, phytonutrient blends)	☐ Liquid meals	

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances):

_____

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Healthy weight Your weight: _____llbs

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months?

_____

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Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)?

What are your current health goals?

Energy and vitality

I would like to:

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flus
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

Body composition

I would like to:

- ☐ Lose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

Stress: Mental and Emotional

I would like to:

- ☐ Learn how to reduce stress
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

Life Enrichment

I would like to:

- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from treating-illness orientation to creating a wellness lifestyle

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Medical History- Parents and Siblings

☐ *Arthritis*	☐ *Cancer*	☐ *Eating disorder*	☐ *Infertility*	☐ *Migraine headaches*	☐ *Stroke*
☐ *Asthma*	☐ *Depression*	☐ *Genetic disorder*	☐ *Learning disabilities*	☐ *Neuro-logical (Parkinson's)*	☐ *Suicide*
☐ *Alcoholism*	☐ *Diabetes*	☐ *Glaucoma*	☐ *Mental illness*	☐ *Obesity*	☐ *Other* _____
☐ *Alzheimer's disease*	☐ *Drug addiction*	☐ *Heart disease*	☐ *Mental retardation*	☐ *Osteo-porosis*	

Medical History- General

☐ *Arthritis*	☐ *Chronic fatigue syndrome*	☐ *Drug addiction*	☐ *Glaucoma*	☐ *Mental illness*	☐ *Seasonal affective disorder*
☐ *Allergies or hay fever*	☐ *Carpal Tunnel Syndrome*	☐ *Eating disorder*	☐ *Gout*	☐ *Migraine problems*	☐ *Skin problems*
☐ *Asthma*	☐ *Cholesterol, elevated*	☐ *Emphysema*	☐ *Heart disease*	☐ *Neuro-logical – Parkinson's*	☐ *Tuberculosis*
☐ *Alcoholism*	☐ *Circulatory problems*	☐ *Eyes, ears, nose, throat problems*	☐ *Infection, chronic*	☐ *Sinus problems*	☐ *Ulcer*
☐ *Alzheimer's disease*	☐ *Colitis*	☐ *Environmental sensitivities*	☐ *Inflammatory bowel disease*	☐ *Stroke*	☐ *Urinary tract infection*
☐ *Autoimmune disease*	☐ *Dental problems*	☐ *Fibromyalgia*	☐ *Irritable bowel syndrome*	☐ *Thyroid trouble*	☐ *Varicose veins*
☐ *Blood pressure problems*	☐ *Depression*	☐ *Food intolerance*	☐ *Kidney or bladder disease*	☐ *Obesity*	☐ *Other* _____
☐ *Bronchitis*	☐ *Diabetes*	☐ *Gastro-esophageal reflux*	☐ *Learning disabilities*	☐ *Pneu-Monia*	
☐ *Cancer*	☐ *Diverticular disease*	☐ *Genetic disorder*	☐ *Liver or gallbladder disease (stones)*	☐ *Sexually transmitted disease*	

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Medical History (Men Only)

☐ Benign prostatic hyperplasia ☐ Prostate cancer ☐ Decreased sex drive ☐ Infertility ☐ Sexually transmitted disease ☐ Other _____

Medical History (Women Only)

☐ Menstrual irregularities ☐ Endometriosis ☐ Infertility ☐ Fibrocystic/ ovarian cysts ☐ Fibrocystic breasts ☐ PMS- Premenstrual syndrome

☐ Pelvic inflammatory disease ☐ Vaginal infections ☐ Decreased sex drive ☐ Sexually transmitted disease ☐ Other _____

Medical History – Women Only

Date of last GYN exam_____

Mammogram ☐ + ☐ —

PAP ☐ + ☐ _

Form of birth control _____ _____

# of pregnancies _____

C-section _____ _____

Age of first period _____

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)

_____

☐ Surgical menopause

☐ Menopause

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Patient/Client Agreement Form

Each patient/client is required to read the following.
Your signature below acknowledges the following:

1. I understand that Nutritional Consultation and other services provided at OIHC are not covered by the provincial government, yet their expenses may be covered by private insurance plans and may be tax deductible.

2. The fees and services have been clarified in advance. Payment is due at the end of each visit as the clinic does not bill insurance companies directly. Cash, cheque, Interac, Visa, and MasterCard (no other credit card) are acceptable methods of payment

3. Forty-eight hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 50% of the missed appointment.

4. Items purchased are non-refundable, whether or not they have been opened.

5. I understand that natural health care is a joint responsibility between me (the patient/client) and my practitioner. Improving my lifestyle can be as important as the recommendations.

6. I understand that I may contact my health care provider by phone or e-mail and that all emails will be screened by reception and forwarded to the appropriate Naturopathic doctor/practitioner.

7. I realize that integrative health care/medicine is not an isolated system and that all our health care providers welcome teamwork with NDs, MDs, DCs, RMTs, and other health practitioners.

Client Signature_____ Date_____

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Nutrition Consultation

Informed Consent

Nutritional counselling is the recommendation and prevention of diseases by natural means. Nutritional counsellors assess the whole person, taking into consideration physical, mental, emotional, and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.
Diet and nutritional supplements and lifestyle counselling are mainstays of Nutritional counselling.

As nutritional counselling is a holistic approach to health, *lifestyle* is considered relevant to nutritional counsellor's approach to most health problems. Thus, the identification of lifestyle risk factors will allow for recommendations to be made that will help to optimize physical, mental, and emotional environment.

At your first appointment you can expect a thorough history taking. Because some therapies must be used with caution when dealing with particular conditions (such as pregnancy and lactation, kidney disease, and heart disease), it is very important that you inform your Nutritional counsellor immediately of any disease that you are suffering from, as well as any forms of medication, drugs, or supplements you are taking.

There exist slight health risks when receiving recommendations by Nutritional Counselling. These risks include, but are not limited to, aggravation of pre-existing symptoms; allergic reactions to supplements or herbs.

I understand that a record will be kept of the health services provided to me, and that it will be kept confidential and will not be released to others unless so directed by me, unless the law requires it.
I understand that I may look at my medical records at any time, and can request a copy of this record by paying the appropriate fee.
I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.
I understand that the practitioner will answer any questions that I may have to the best of her ability.
I understand that results cannot be guaranteed.
I do not expect the Nutritionist to be able to anticipate and explain all risks and complications.
I will rely on the Nutritionist to exercise her judgement during the course of the procedure which she feels at the time is in my best interest, based on the facts then known.
With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above.
I intend this consent form to cover the entire course of action for my present condition.
I understand that I am free to withdraw my consent and to discontinue my participation in these procedures at any time.
I understand if I am seeing more than one doctor at the Ottawa Integrative Health Centre I imply consent for them to share and discuss my file and deemed necessary by the practitioners.

Client Name_____

Client Signature_____ Date_____

*Ottawa Integrative Health Centre care provider:*_____