TruMed
NATUROPATHIC CLINIC

www.trumed.ca
14620 Stony Plain Road
780 757 8378

Thank you for taking the time to fill out this form. It is highly detailed with the intention of understanding your past and present health so that we can choose an appropriate direction to take you.

If possible please bring relevant medical records (labs, scans, reports) with you to your first visit.
Please contact your healthcare provider and have them fax the records to 1 855 455 4235

Please print off and complete these forms and bring them to your first visit.

Date _____

First name _____ Last name _____

Date of birth_____ (M/D/Y)

Age_____ Sex M / F (circle)

Marital status _____

Current weight_____

Home Telephone Number

_____

Address _____

_____

_____

Work _____

Cell _____

E-mail _____

Alberta Health #:_____

Emergency contact:

Name _____

Phone number _____

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How did you hear about us ? _____

Other health care providers you are seeing:

1.Name:_____ 2.Name:_____ 3.Name:_____

Type(eg.GP): _____ Type_____ Type: _____

MS

Type of MS (eg. Relapsing remitting)

_____

Date of Diagnosis_____

Any symptoms from the MS? (eg. weakness?)

_____

_____

_____

Other health concerns?

1._____

_____

2._____

_____

Please list any current diagnoses or diseases you have that were not mentioned above:

_____

MS

Goals (check off):

- ☐ To help improve symptoms
- ☐ To reduce relapse frequency
- ☐ To receive a specific therapy (eg. IV Vitamins) _____
- ☐ To prevent declination
- ☐ I'm just gathering information

Do you currently take medication for your MS?

If yes what type _____

Any previous medications for your MS?

If yes what type _____

Please describe your relapse history with dates:

_____
_____
_____
_____
_____

When was your most recent scan? (MRI)

_____
_____

When was your most recent blood work?

_____
_____

Medical History

If you are female are you currently pregnant? Y / N

Please indicate any serious conditions, illnesses or injuries and any hospitalizations, along with approximate dates.

_____

_____

_____

Please list all current medications and dose (prescription, over-the-counter)

_____ - _____

_____ - _____

_____ - _____

_____ - _____

_____ - _____

Please list all supplements, herbs, vitamins, homeopathics you're currently on.

_____

_____

_____

_____

_____

Do you have any allergies (medicines, environmental, FOODS?)

_____

_____

_____

Please list past prescription medications as well as supplements, herbs, etc.

_____

_____

Do you get regular screening tests done by another doctor? (pap, blood tests, etc.)? Y ☐ N ☐

Results and date:

Pap _____ _____

Breast Exam _____ _____

Mammogram _____ _____

Bone density _____ _____

Date of last physical exam _____

Fecal blood _____ _____

Colonoscopy _____ _____

Prostate exam _____ _____

PSA _____ _____

Other _____ _____

Describe a typical day's diet:

Breakfast	Lunch	Dinner
_____	_____	_____
_____	_____	_____
Snacks	**Beverages**	**Water**
_____	_____	_____
_____	_____	_____

Alcohol—how much/day or week _____Tobacco—amount/day_____

Coffee or tea—form and amount/day_____

Recreational drugs—what and how often _____

Family History

Indicate if a close relative (parent, child, sibling) has had any serious medical condition

_____

Other

Occupation _____ Hobbies _____

Do you exercise regularly? Y/N What do you do for exercise, how much, how often?

_____

_____

How long do you sleep for? _____

Do you wake well rested? _____

Energy (1-10 where 10 is high energy):_____

Mood (1-10 where 10 is great mood):_____

Bowel movements---how often?_____

Straining or loose stools? Y/N

Review of Systems

Y = A condition you have now N = Never had P = Significant problem in the past.

Mental / Emotional								
Depression	Y	N	P	Considered or Attempted suicide	Y	N	P
Mood Swings	Y	N	P	Poor concentration	Y	N	P
Anxiety or nervousness	Y	N	P	Memory problems	Y	N	P
Seasonal depression	Y	N	P				
Endocrine								
Hypo / hyperthyroid	Y	N	P	Excessive thirst	Y	N	P
Heat or cold intolerance	Y	N	P	Excessive hunger	Y	N	P
Hypoglycaemia	Y	N	P	Fatigue	Y	N	P
Diabetes	Y	N	P				
Immune								
Chronic infections	Y	N	P	Slow wound healing	Y	N	P
Chronically swollen glands	Y	N	P	Frequent colds	Y	N	P
Neurologic								
Seizures	Y	N	P	Loss of memory	Y	N	P
Paralysis	Y	N	P	Easily stressed	Y	N	P
Muscle weakness	Y	N	P	Vertigo or dizziness	Y	N	P
Numbness or tingling	Y	N	P	Loss of balance	Y	N	P
Skin								
Rashes	Y	N	P	Colour change	Y	N	P
Eczema	Y	N	P	Hair loss	Y	N	P
Hives	Y	N	P	Lumps	Y	N	P
Acne	Y	N	P	Night sweats	Y	N	P
Itching	Y	N	P				
Head								
Headaches	Y	N	P	Jaw problems/TMJ	Y	N	P
Migraines	Y	N	P	Head injury	Y	N	P
Eyes								
Spots in Eyes	Y	N	P	Eye pain / strain	Y	N	P
Cataracts	Y	N	P	Tearing,dryness or redness	Y	N	P
Impaired vision	Y	N	P	Double vision	Y	N	P
Wear glasses or contacts	Y	N	P	Glaucoma	Y	N	P
Blurriness	Y	N	P	Bags around eyes	Y	N	P
Ears								
Impaired hearing	Y	N	P	Earaches	Y	N	P
Ringing	Y	N	P	Excess ear wax	Y	N	P
Nose								
Stuffiness	Y	N	P	Sinus problems	Y	N	P
Nose Bleeds	Y	N	P	Loss of smell	Y	N	P
Hay fever	Y	N	P				
Mouth / Throat								
Frequent sore throat	Y	N	P	Gum problems	Y	N	P
Chronic sore throat	Y	N	P	Hoarseness	Y	N	P
Teeth grinding	Y	N	P	Dental cavities	Y	N	P
Amalgums	Y	N	P	Root canals	Y	N	P
Neck								
Lumps	Y	N	P	Goiter	Y	N	P
Swollen glands	Y	N	P	Pain or stiffness	Y	N	P

Chest			
Cough	Y N P	Tuberculosis	Y N P
Phlegm	Y N P	Shortness of breath	Y N P
Spitting up blood	Y N P	Shortness of breath at night	Y N P
Wheezing	Y N P	Pain on breathing	Y N P
Asthma	Y N P	Difficulty breathing	Y N P
Bronchitis	Y N P	Emphysema	Y N P
Pneumonia	Y N P		
Cardiovascular			
Heart disease	Y N P	Phlebitis	Y N P
Angina	Y N P	Palpitations / Fluttering	Y N P
High / Low Blood Pressure	Y N P	Rheumatic Fever	Y N P
Murmurs	Y N P	Chest Pain	Y N P
Fainting	Y N P	Swelling in ankles	Y N P
Gastrointestinal			
Heartburn	Y N P	Ulcer	Y N P
Abdominal pain or cramps	Y N P	Diarrhoea	Y N P
Change in appetite	Y N P	Jaundice (yellow skin)	Y N P
Belching or passing gas	Y N P	Liver or gall bladder disease	Y N P
Nausea / vomiting	Y N P	Black stools	Y N P
Constipation	Y N P	Hemorrhoids	Y N P
Blood / Mucus in stools	Y N P	Bowel Movements: How often?	Y N P
Urinary			
Pain on urination	Y N P	Kidney stones	Y N P
Increased frequency	Y N P	Frequent infections	Y N P
Inability to hold urine	Y N P	Urgency	Y N P
Musculoskeletal			
Joint pain or stiffness	Y N P	Weakness	Y N P
Arthritis	Y N P	Easy fatigue	Y N P
Broken bones	Y N P	Muscle spasms or cramps	Y N P
Sciatica	Y N P		
Peripheral Vascular			
Easy bleeding or bruising	Y N P	Cold hands / feet	Y N P
Anemia	Y N P	Varicose veins	Y N P
Deep leg pain	Y N P	Thrombophlebitis	Y N P
Male			
Sexually transmitted disease	Y N P	Are you sexually active?	Y N
Hernias	Y N P	Impotence?	Y N P
Testicular masses	Y N P	Premature ejaculation?	Y N P
Prostate issues	Y N P	Sexual orientation	
Female			
Age at first menses		Clotting	Y N P
Length of cycle		Heavy or excessive flow	Y N P
Are cycles regular?	Y N	PMS	Y N P
Duration of bleeding		What symptoms?	
Bleeding between cycles	Y N P	Number of pregnancies	
Pain during intercourse	Y N P	Endometriosis	Y N P
		Ovarian cysts	Y N P

***Thank you for completing this form*.**

If you haven't already done so, please call 780 757 8378 to book your first visit.

Cancellation policy: Your appointment time is reserved for you.

Appointments cancelled with less than 24 hours notice may be charged $150.

Appointments cancelled the same day or missed appointments may be charged the full appointment fee.

We regret that Alberta Health does not cover Naturopathic services; therefore fees for Naturopathic services and all supplements are the responsibility of the patient, payable in full, at the time of the appointment.

Fortunately, Naturopathic Medicine is covered by many extended health care plans.

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Consent

Naturopathic medicine is a system of healthcare that takes a holistic approach to assessment, diagnosis, and treatment with a focus on prevention, restoration and health maintenance.

Naturopathic medicine is a continually evolving body of knowledge that combines ancient healing traditions with current scientific advances in health care to treat the root cause of disease. The Naturopathic approach attempts to remove the cause of disease and stimulate the body's inherent healing capacity using gentle therapies.

Initial cancer consultation will be approximately 60-90 minutes; this will allow you to express all of your health concerns, and a treatment plan will begin to be formulated. Laboratory testing and physical exam may be used to aid in diagnosis and treatment.

A number of different approaches may be used throughout the course of healing.

Primary treatment modalities include, but are not limited to, diet, lifestyle counselling, clinical nutrition (primarily via supplementation), botanical medicine, homeopathy, Traditional Chinese Medicine and acupuncture, intravenous therapy, mesotherapy and physical medicine.

Even the gentlest therapies may cause complications and unexpected reactions in certain physiological conditions; this depends greatly on individual factors such as age, genetic variation, pre-existing conditions, medications, environmental sensitivities amongst other factors.

It is very important that you inform Dr.Muradov of any disease process that you are suffering from, any allergies you have and any medications/over the counter drugs/supplements that you are currently taking.

Please advise immediately if you are pregnant, planning to be pregnant, suspect you are pregnant, or if you are breast-feeding.

By signing below, I certify that I agree and understand the above.

By agreeing below, I understand that Health risks associated with Naturopathic Medicine include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs or injections
- Pain, bruising or injury from injections/blood draws, acupuncture, manual therapy, or cupping
- Fainting or puncturing of an organ with acupuncture needles
- Muscle strains and sprains or disc injuries from spinal manipulation
- And in rare instances, death.

However, Dr.Muradov has been extensively trained in Naturopathic healing and strives to practice medicine with the greatest regard for patient safety in order to reduce the likelihood adverse reactions.

By agreeing below:

You understand that some of the diagnostic/therapeutic techniques we use, at this time, are considered non-standard.

That you are accepting or rejecting this care of your own free will and choice.

That you accept full responsibility for any fees incurred during care and treatment at the time of the visit unless prior arrangements have been made

I understand that, as in all health care, there are some risks to treatments. Although Dr. Muradov takes great care in reducing possible side effects and adverse reactions and interactions, I do not expect Dr. Muradov to anticipate or explain all the risks and potential complications.

As a patient of TruMed Clinic, I am at liberty to seek or continue medical care from a medical doctor; TruMed strongly encourages this. TruMed does not suggest or recommended that I refrain from seeking or following the advice of another licensed health care provider.

I understand that TruMed practitioners play a secondary role in my healthcare, and offer complaint oriented healthcare, and that I will regularly seek the opinion of a medical doctor as a primary care provider, for standard health oriented screening tests because I understand that these tests are not totally available for a Naturopathic doctor in Alberta to run, therefore we strongly encourage regular health screening from a medical doctor.

I understand, the treatment and therapies rendered or recommended at TruMed Clinic may be

different that those usually offered by a medical doctor or other licensed health care providers.

As a patient of TruMed Clinic, I understand that results are not guaranteed.

I understand and am informed that, as in the practice of other medicine, there are some risks to naturopathic therapies, some of which, but not all, are outlined in this document. Furthermore, as in the practice of other medicine, there is always the potential for misdiagnosis, missed diagnosis or ineffective treatment and I acknowledge that I do not hold Dr. Muradov or TruMed responsible for any of these potential mentioned possibilities. The information I have provided is complete and inclusive of all health concerns, including the possibility of pregnancy, allergy and all medications I am taking, including over-the-counter drugs and supplements.

I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic.

I acknowledge that Dr. Muradov will be playing an adjunctive role in my health care and standard screening tests and primary care should still be provided by a licensed medical doctor.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private or public agency attempting to gather information without so stating.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Signature _____

Date: _____

Collection of information and privacy:

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

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

- To assess your health concerns
- To advise you of treatment options
- To provide health care
- To distribute health care information to you
- To book and confirm appointments
- To email you about your care or to inform you about promotions or lectures at the clinic
- For teaching and publishing purposes on an anonymous basis
- To communicate with other treating health-care providers .
- To allow us to efficiently follow-up for treatment, care and billing which may include leaving information on a voicemail service.
- To establish and maintain contact with you
- To communicate to a legal guardian or a significant other or family member if a situation calls for these individuals to know more about your health.
- To invoice for goods and services
- To complete claims for insurance purposes
- To process credit card payments
- To collect unpaid accounts
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

I agree to the above:

Signature: _____

Date: _____