DR. TERESA AMBRA, ND

1047 Gerrard Street East
Toronto, ON
M4M 1Z7
(647)-725-7733
www.movementmedicine.ca

MOVEMENT MEDICINE
NATUROPATHIC SPORTS MEDICINE CLINIC

Today's Date: _____

Adult Patient Information		
Name: _____ (First) (Middle) (Last) Preferred Name (if different): _____		
Age:	DOB: ____/____/_____ M D Y	Sex: ☐ M ☐ F Other:
Marital Status:	Occupation:	
Contact Information		
Home Address:		
City:		Postal Code:
Home Phone(s):	Cell Phone(s):	Work Phone(s):
May we leave voicemails at the above phone numbers? If so, please select which ones. No confidential information is left on voicemails. ☐ Home ☐ Cell ☐ Work		
E-mail Address:		
Would you like to receive our newsletter for news, events and special offers (sent out quarterly) ☐ Yes ☐ No	Preferred method of contact: ☐ Phone ☐ E-mail	
Emergency Contact Information		
Primary Contact:		
Relationship:		
Phone number(s) for emergency contact:		
Other Healthcare Providers		
Medical Doctor:	Location:	Date of last visit:
Specialist:	Location:	Date of last visit:
Specialist:	Location:	Date of last visit:

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Clinic Information

How did you hear about Dr. Teresa Ambra, ND?

If you were referred by another patient of the ND, who referred you?

If you found out about the clinic on the Internet, how did you find it? (Specific search terms, websites etc.)

Context of Care Review

As a naturopathic doctor, I believe comprehensive and effective healthcare is only possible when a doctor has a complete understanding of the patient on a physical, mental and emotional level. The responses you provide to the following questions will assist me in understanding your health care needs and goals. Your time, thoughtfulness and honesty in completing this form is appreciated, and will provide me with great insight in order to help you feel better, sooner!

Have you been to a naturopathic doctor before? ☐ Yes ☐ No

Health Concerns

What are your most important health concerns? Please list as many as you have in order of importance.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Do you have any known contagious diseases at this time? ☐ Yes ☐ No
If yes, what?

Please list any diagnoses you have received (presently or in the past), who diagnosed the condition and relevant dates.

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Medications and Supplements	
Please list any prescription medications, over-the-counter medications, vitamins or other supplements you are taking **with dosage and frequency.**	
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Allergies and Sensitivities (please list)		
1. _____	3. _____	5. _____
2. _____	4. _____	6. _____

Context of Care Review

What 3 expectations do you have from *your first* visit?

1. _____
2. _____
3. _____

What *long-term* expectations do you have for working with a 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% to 100% committed.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

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What behaviours or lifestyle habits do you currently engage in regularly that you believe **support and benefit** your health?
What behaviours or lifestyle habits do you currently engage in regularly that you believe **do not support or benefit** your health?
What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and adhering to the therapeutic protocols that I will be sharing with you?
What do you love to do?
On a scale of 1-10 (10 being unbearable), what level of personal stress are you experiencing right now? 1 2 3 4 5 6 7 8 9 10 What is your main stressor? ☐Financial ☐Job related ☐Marriage ☐Health ☐Interpersonal ☐Unfulfilled expectations ☐Family ☐Other: _____

General Information

Height: _____ Weight: _____	Please rate the following on a satisfaction scale of 0-10, 10 being the most satisfied: Energy _____ Sleep _____ Mood _____	Do you exercise regularly? ☐ Yes ☐ No If so, what type?	How many hours do you sleep per night? Do you wake rested? ☐ Yes ☐ No

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Family History

Do you or anyone in your family have a history of any of the following? Please check and indicate who.
M = Mother, F = Father, GM = Grandmother, GF = Grandfather, S = Sister, B = Brother, C = Child

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hives
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Psoriasis
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Other: _____

What is your family heritage?

Personal Medical History

- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Back, Muscle, Joint Pain
- ☐ Bladder/Urinary Problems
- ☐ Cancer
- ☐ Candida
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Female Reproductive Problems
- ☐ Gallstones
- ☐ Gout
- ☐ Gum/Teeth Problems
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Malaria
- ☐ Measles
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Overweight
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Psychological Problems
- ☐ Rubella
- ☐ Sinusitis
- ☐ Skin Problems
- ☐ Stroke
- ☐ Suicidality
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

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Sport Specific:

Bone Breaks (location, type, sidedness, approximate year)

Concussions (# and approximate year)

Other Injuries (location, type, sidedness, approximate year)

Do you get regular SCREENING tests done by another doctor? (PAP, blood work, breast exams, colonoscopy etc.)

☐ Yes ☐ No

Personal Health Habits

Please describe your typical daily diet, including beverages:

Breakfast:	Lunch:	Dinner:	Snacks:

Do you, or have you ever been a smoker?	Do you consume alcohol?
If so, how many packs per day?	How many drinks per week (on average)?
How long have you, or did you smoke?	

Is there anything that has not been asked that I should be aware of, or that you would like me to know regarding your life or your health?

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Chronological Health History
This sort of history helps to establish trends in a person's health that may be relevant to present conditions. Indicate below any accidents, broken bones, falls, illnesses, hospitalizations, surgeries, and any emotional traumas (deaths, loss of jobs, divorces etc.)
Age 1-5
Age 6-10
Age 11-15
Age 16-20
Age 21-25
Age 26-30
Age 31-35
Age 36-40
Age 41-45
Age 46-50
Age 51-55
Age 56-60
Age 61-65
Age 66-70
Age 71-75
Age 76-80
Age 81-85
85 and older

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SYMPTOMS REVIEW

Please check (√) Y if you have the symptom now, and P if the symptom is in the past.

SKIN	Y	P
Rashes		
Hives		
Acne		
Boils		
Eczema		
Psoriasis		
Dry skin		
Itching		
Lumps		
Night sweats		
Other		

HEAD	Y	P
Tension headaches		
Migraine headaches		
Head injury		
Dizziness		
Other		

EYE	Y	P
Impaired vision		
Use of contact lenses		
Eye pain		
Tearing		
Dryness		
Double vision		
Glaucoma		
Cataracts		
Blurring		
Light sensitive		
Itching		
Redness		
Discharge		
Blind spot		
Other		

EARS	Y	P
Impaired hearing		
Earache		
Dizziness		
Discharge		
Infections		
Excessive wax		
Other		

NOSE & SINUSES	Y	P
Frequent colds		
Nose bleeds		
Stuffiness		
Hay fever		
Infections		
Other		

MOUTH & THROAT	Y	P
Hoarseness		
Gum problems		
Difficulty swallowing		
Dental problems		
Sores		
Dryness		
Sore throat		
Loss of taste		
Other		

NECK	Y	P
Lumps		
Swollen glands		
Goiter		
Pain or stiffness		
Other		

RESPIRATORY	Y	P
Cough		
Sputum		
Spitting up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Difficulty breathing		
Pain on breathing		
Shortness of breath		
Shortness of breath at night		
Shortness of breath when lying		
Positive tuberculin test		
Last TB test		
Last chest X-ray		
Other		

CARDIOVASCULAR	Y	P
Angina		
Murmurs		
Chest pain		
Swelling in ankles		
Palpitation, fluttering		
Last ECG		
Other		

BREASTS	Y	P
Do you do breast self exam?		
Lumps		
Pain (or tenderness)		
Nipple discharge		
Last mammogram		
Other		

GASTROINTESTINAL	Y	P
Trouble swallowing		
Heartburn		
Change in appetite		
Nausea		
Vomiting		
Vomiting blood		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		
Constipation		
Blood in stool		
Hemorrhoids		
Black, tarry stool		
Jaundice		
Liver disease		
Gallbladder disease		
Food allergy		
Hiatus hernia		
Last colonoscopy		
Other		

BLOOD/LYMPHATIC	Y	P
Anaemia		
Easy bleeding/bruising		
Past transfusions		
Lymph node swelling		
Other		

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URINARY	Y	P
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced urine flow		
Other		

MALE REPRODUCTIVE	Y	P
Hernia		
Testicular masses		
Testicular pain		
Impotence		
Premature ejaculation		
Venereal disease		
Discharge of sores		
Sexually active		
Check sexual preference:		
Heterosexual		
Homosexual		
Bisexual		
Last prostate exam		
Last PSA level		
Other		

FEMALE REPRODUCTIVE	Y	P
Age of first menses		
Last menstrual period		
Number of days of menses		
Length of cycle		
Bleeding between periods		
Irregular cycles		
Pain during intercourse		
Painful menses		
Excessive flow		
PMS		
Number of pregnancies		
Number of life births		
Number of miscarriages		
Number of abortions		
Difficulty conceiving		
Sexual difficulties		
Vaginal discharge		
Vaginal itching		
Sexually active		

FEMALE REPRODUCTIVE	Y	P
Check sexual preference:		
Heterosexual		
Homosexual		
Bisexual		
Menopause		
Age of onset		
Hormone therapy		
Last gynaecological exam		
Last pap smear		
Other		

MUSCULOSKELETAL	Y	P
Broken bones		
Muscle spasms/cramps		
Weakness		
Joint swelling		
Backache		
Other		

PEREPHERAL VASCULAR	Y	P
Deep leg pain		
Cold hands/feet		
Varicose veins		
Thrombophlebitis		
Leg cramps		
Extremity numbness		
Extremity coldness		
Extremity swelling		
Extremity ulcers		
Other		

NEUROLOGIC	Y	P
Fainting		
Seizure/Convulsions		
Paralysis		
Muscle weakness		
Numbness or tingling		
Loss of memory		
Involuntary movements		
Loss of balance		
Speech problems		
Other		

ENDOCRINE	Y	P
Heat or cold intolerance		
Thyroid trouble		
Excessive thirst		
Excessive hunger		
Excessive urination		
Excessive sweating		
Diabetes		
Hypoglycemia		
Hormone therapy		
Other		

EMOTIONAL	Y	P
Depression		
Angry		
Mood swings		
Anxiety		
Nervousness		
Tension		
Phobias		
Insomnia		
Sexual difficulties		
Drug abuse		
Psychiatric care		
Psychological counselling		
Other		

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Athletic History:

Please list all sports and activities you were and/or are involved in (including # of years played and level of competitiveness and if you are currently still involved in this activity)

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Consent to Treatment of Naturopathic Medicine

This form must be signed prior to your first appointment

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic doctors 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. Dr. Teresa Ambra, ND will take a thorough case history, perform a focused physical examination and complete laboratory testing, if necessary.

It is very important that you inform Dr. Ambra immediately of any disease process that you are suffering from and any medications/over-the-counter medications that you are taking. Please advise Dr. Teresa Ambra, ND immediately if: you are pregnant, suspect you are pregnant, are trying to get pregnant, or if you are breast-feeding.

There are some slight health risks associated with treatment by naturopathic medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reaction to supplements or herbs
- Pain, bruising or injury from venipuncture, acupuncture or parenteral therapy
- Fainting or puncturing of an organ with acupuncture needles
- Muscles strains and sprains, disc injuries from spinal manipulation
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened prior to manipulating the neck.

I understand:

- An electronic medical record will be kept of the health services provided to me. This record will be kept in strictest confidentiality and will not be released to others unless law requires it or I give my written consent. I realize in rare instances courts may subpoena my medical records, which means that my records will have to be released.
- Dr. Teresa Ambra, ND will have to report me in the following instances: when I am in imminent danger of harming myself or others, when there is reasonable suspicion that I am neglecting and/or emotionally, physically or sexually abusing a minor, and if I engage in sexual relations with any of my healthcare providers.
- I may access my medical records at any time and can request a copy by paying the appropriate fee.
- Dr. Teresa Ambra, ND does not guarantee treatment results. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and potential complications. I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list, if any):

_____

I recognize that this consent form covers the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have read this statement and agree to work within its guidelines, including the limits of confidentiality.

Patient Name (please print): _____

Signature of Patient or Patient's Guardian: _____ Date: _____

Signature of Dr. Teresa Ambra, ND: _____ Date: _____

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Patient Consent for Collection, Use and Disclosure of Personal Information

Privacy and protecting your personal information is an important part and consideration of my practice as a naturopathic doctor. This privacy policy outlines what I do to ensure that:

- Only necessary information is collected about you;
- I only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols (this includes cloud-based electronic medical records that are housed within Canada and are compliant with such legislation and privacy protocols);
- Privacy protocols comply with privacy legislation and standards of naturopathic doctor's regulatory body

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To assess your health concerns, provide health care and advise you of treatment options;
- To establish and maintain contact with you;
- To remind you of upcoming appointments;
- To efficiently follow-up with you for treatment;
- To complete claims for insurance purposes;
- To invoice for goods and services;
- To process credit card payments;
- To collect unpaid accounts and follow-up on billing, as required;
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable disease and individuals who may be an imminent threat to harm themselves or others;
- To be used for educational and research purposes (this includes case summaries and reports, photographs, lab results and other pertinent medical information). Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances.

Patient Consent

I, _____have reviewed the above information that explains how Dr. Teresa Ambra, Naturopathic Doctor, will use my personal information and the steps that are taken to protect my information.

I agree that Dr. Teresa Ambra, Naturopathic Doctor, can collect, use and disclose personal information about my case as set out above regarding privacy policies.

Patient Signature: _____

Date: _____