

Dr. Stephanie Trenciansky
 Meditrine Naturopathic Medical Clinic
 (604) 534-5756

PERSONAL HISTORY

(Confidential: All information in this form remains confidential and will be released only on your written permission)

FULL NAME _____ BIRTHDATE ^M / ^D / ^Y _____ AGE _____

NAME YOU PREFER TO BE CALLED _____ SEX _____ MARITAL STATUS S M D W

ADDRESS _____ CITY _____ POSTAL CODE _____

OCCUPATION _____ EMPLOYER _____

WORK PHONE _____ HOME PHONE _____ CELL PHONE _____

FAMILY PHYSICIAN _____ EMAIL ADDRESS _____

WHO REFERRED YOU TO THIS OFFICE? _____

HEALTH PROBLEMS: LIST YOUR MAIN HEALTH CONCERNS/SYMPTOMS

- 1) _____ WHAT TREATMENTS HAVE BEEN TRIED? _____
- 2) _____
- 3) _____

MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING? (CIRCLE)

ANEMIA	RHEUMATIC FEVER	HEART ATTACK	SURGERIES (YEAR&TYPE) _____
HEPATITIS/LIVER DISEASE	KIDNEY STONES	HIGH BLOOD PRESSURE	_____
HAYFEVER	ASTHMA	PNEUMONIA	_____
TUBERCULOSIS	CANCER OF _____	BLADDER/VAGINAL INFEC.	_____
STOMACH ULCERS	MIGRAINE HEADACHES	ABNORMAL PAP TEST	HOSPITALIZATIONS (YEAR & REASON) _____
MEASLES	MUMPS	PROSTATE PROBLEMS	_____
COLITIS	ARTHRITIS/RHEUMATISM	BLEEDING TENDENCIES	_____
BLOOD CLOTS	HIVES	MONONUCLEOSIS	_____
GALLBLADDER PROBLEMS	THYROID PROBLEMS	SEXUALLY TRANSMITTED	INJURIES/ACCIDENTS (YEAR & CAUSE) _____
ANGINA/CHEST PAIN	HEART DISEASE	DISEASE	_____
POLIO	DIABETES	ECZEMA	_____
STROKE	ALCOHOL/DRUG ABUSE	DEPRESSION	OTHER CONDITIONS _____
EPILEPSY	MENTAL DISORDER	EATING DISORDER	_____
SMOKER? (Y OR N)			

FAMILY HISTORY: INCLUDING BLOOD RELATIVES ONLY

FATHER (age)* _____ BROTHERS (ages)* _____

MOTHER (age)* _____ SISTERS (ages)* _____

*If deceased, Please list age of death and circle.

HAVE ANY OF THE ABOVE HAD THE FOLLOWING? (Circle)

DIABETES	KIDNEY DISEASE	STOMACH ULCERS
HEART DISEASE	ASTHMA	HIGH BLOOD PRESSURE
ALLERGIES	ARTHRITIS	NERVOUS BREAKDOWN
GOUT	COLITIS	BLEEDING TENDENCIES
ALCOHOLISM	TUBERCULOSIS	PSYCHIATRIC ILLNESS
CANCER	STROKE	GALLBLADDER PROBLEMS

WOMEN ONLY – CHILDBIRTH HISTORY

NUMBER OF CHILDREN _____ AGES _____

NUMBER OF PREGNANCIES _____ DELIVERIES _____

MISCHARRIAGES ___ ACCIDENTAL ___ INDUCED ___

COMPLICATIONS _____

BIRTHCONTROL METHODS: IN PAST _____

NOW _____

ARE YOU PREGNANT AT THIS TIME? _____

KNOWN ALLERGIES (including medicines, pollens, animals, foods & Chemicals): _____

CURRENT MEDICATIONS (list all prescription & over the counter medicines, vitamins, minerals, herbs that you take): _____

MEDITRINE NATUROPATHIC MEDICAL CLINIC

The doctors and staff at our clinic welcome you!

Meditrine Naturopathic Medical Clinic fees are as follows for both doctors: * not including tax.

First Office Visit (45-60 min.)	\$145.00
Return Office Visit (15-30 mins.)	\$75.00
Brief Office Visit (up to 15 mins.)	\$42.00
Extended Return Office Visit (30-45 mins)	\$110.00
Extended Return Office Visit (45-60 mins.)	\$145.00
Acupuncture (30 mins.)	\$75.00
Physical & Pap (30-45 mins.)	\$112.00
Food Sensitivity Test (EDS)	\$110.00
Food Sensitivity Re-test (EDR)	\$50.00
Blood Typing	\$15.00

We have a **24 Hour Cancellation Policy**. There is a **full fee charge fee** for missed doctor visits or for those rescheduled/cancelled with less than 24 hours notice & an additional fee of \$40 for any missed allergy test/retest. Please remember, with less than 24 hours notice, it's difficult for others to come and fill your vacant appointment time.

Fees for office visits, laboratory services and medicine items are due at the time of service.

Appointments with the doctor done over the phone have the same fees applied as visits in the office.

Most extended medical plans provide coverage for visits, lab and food sensitivity tests; please learn the details of your specific plan. Please save your receipts for this extended coverage, as we will not be able to issue another receipt. A \$10.00 charge will apply for extended reports.

Custom made or special order medicines are to be paid for before they are ordered or made. There are also no rebates on quantity of medicine items ordered.

Any natural hormone alternatives, that you may be prescribed, are refillable only under doctor authorization; otherwise a follow-up visit is required. This is a mandatory clinic policy.

Please be aware that at times prices for medicines may decrease, increase or stay the same. This reflects exact current pricing that we are charged by our suppliers and US exchange rates.

Please sign that you have read and agree to comply with the terms stated above.

Signature _____

Date _____

Enjoy your visit with us!

March 2017