

Your Past Medical History (Please check and date)

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|---|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Prostate Conditions |
| <input type="checkbox"/> Anorexia/Bulemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Infection | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> STI |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pace maker | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Colitis or Chron's | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> TB |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> MS | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV | <input type="checkbox"/> Parkinson's | |

Please check all symptoms that apply to you now. (If they occurred in the past mark with a "P"):

General

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- | | | | |
|---|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | |

How would you describe your sleep? _____

How would you describe your energy level? High ___ Moderate ___ Low ___ Up and down ___

Skin and Hair

-
- | | | | |
|---------------------------------|----------------------------------|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Loss of hair |
|---------------------------------|----------------------------------|---------------------------------|---------------------------------------|

Head, Eyes, Ears, Nose and Throat

-
- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Tooth pain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> "Silver" mercury tooth fillings | |

Heart and Circulation

-
- | | | | |
|---|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Irregular heart beat | | | |

Lungs and Breathing

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- | | | |
|---|-------------------------------------|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | |

Digestion and Elimination

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- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Indigestion/Heart burn | <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Chronic laxative use |

How often do you have a bowel movement? _____ Quality? (formed, hard, soft, loose, etc.) _____

Is your urinary frequency more than 6x/day _____

Do you experience night time urination? _____ Number of times/night? _____

Women

Are you Pregnant? _____ How many months? _____ Number of Children Birthed/Ages _____

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Light periods |
| <input type="checkbox"/> Clots | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Breast lumps |

Changes in your body or emotions prior to menstruation? _____ Length of Menses _____

Do you practice birth control? What type and for how long? _____

Brain / Emotions

- Depression Anxiety Quick temper/irritable Poor memory Loss of balance
- Have you ever been treated for emotional problems?
- Any other neurological or psychological problems?

Current Stress Level 1 to 10 (10 being highest, 0 being no stress) At Work _____ At Home _____
 How long have you felt like this? At Work _____ At Home _____

What would you describe as the three dominant emotions in your life at this time? (Examples include Happiness, Fear, Sadness, Anxiety, Frustration, Anger, Grief, Heartache, Contentment, Excitement, Lethargic, Moody, Stressed, etc.): _____

Lifestyle

Exercise

Do you exercise? _____ List type and how often _____

Habits

How much coffee do you drink per week? _____
 How much alcohol do you drink per week? _____
 How much pop do you drink per week? _____
 Do you smoke? _____ How much per day? _____
 Recreational drugs? _____ Type and how often? _____

Diet

Do you follow a specific diet? (Example: vegetarian, vegan, gluten-free, macrobiotic, meat & potatoes, etc.) _____
 What do you usually eat for breakfast? _____

Family History

Please list the state of health and major illnesses that members of your family have had.
 If relevant, include at what age they died (and what they died of).

Father: _____
 Father's mother: _____
 Father's father: _____
 Mother: _____
 Mother's mother: _____
 Mother's father: _____
 Brothers and Sisters: _____
 Your children: _____
 Other family information: _____

If there is anything you would like to add, please feel free to do so. If you have any questions or concerns you would like addressed, you may write them here.

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Statement of Acknowledgement
&
Consent to Treatment

Welcome to our clinic. This system of health care is supportive to your body's own natural ability to heal. Ryan Carnahan works within a Homeopathic scope of practice in conjunction with herbal medicine, energetic medicine, and structural therapies. This non-invasive approach to healing integrates these therapies for total body/mind health and balance.

Ryan Carnahan is not a medical doctor and will not provide a diagnosis, treatment, prescription or recommendation for any medical condition that you may have. He encourages you to maintain your relationship with your medical doctor and hopes to be a part of your wellness team.

There is an emphasis on patient education as ultimately the responsibility for your health is your own; Ryan's role as a practitioner is to support and guide you as well as educate you in the prevention of disease. He looks forward to working with you on your journey towards health and encourages you to ask questions along the way.

You are responsible for any fee incurred during the treatment and agree to fully pay this amount at the time of the visit. The fee schedule is as follows (fees do not include hst):

Initial Visit: \$150
Follow Ups: \$105

Homeopathic remedies and supplements are additional if required for your case. (A fee of \$10 plus tax is charged for supplements sent 2 day Canada Xpresspost.)

**cash and debit are accepted for in-office visits. (Visa and Mastercard are accepted for phone consultations only.)

Cancellation Policy

Please provide 24 hrs. notice to change your appointment so others may use your spot. Appointments cancelled without 24 hrs. notice will be charged half the visit fee.

I, _____ (please print name) have read, understood, and acknowledge the above statements and give consent to consultation and treatment.

Patient's Signature (or parent or guardian)

Date