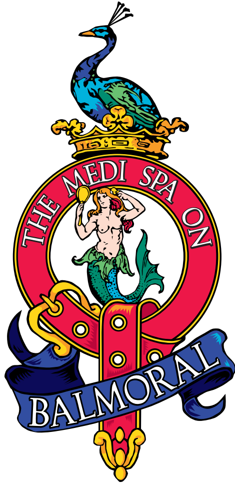

THE MEDI SPA ON BALMORAL

Patient Pre-assessment Report Form

To be prepared for an assessment, please complete this form beforehand, sending it by email or mail using the contact information below:

Susan Peacock-Hacking, H.D., R.Hom., M.N.H.Sc., C.H.P., N.H.C., N.D. (QC)
153 Balmoral Place, Ottawa, ON K1H 1B2
Cell: (613) 286-6285
Email: naturalhealththerapies@magma.ca
Web site: www.naturalhealththerapies.ca

Last name: ____________________ First name: ____________ Blood type: ____

Name of parents (for children living at home): ______________________________

Mailing address: ______________________________

Home telephone: __________ Work telephone: __________ Cell: ____________

In case of emergency, please contact: ______________________________

Email: ______________ Today's date: ____________ Date of birth: ____________

Marital status: __________ Number of children: ________ Occupation: ____________

Private health insurance provider (include policy #): ______________________________

Prosthetic devices (i.e. - cane, false teeth, implants, etc.): ______________________________

Special assistance you may require: ______________________________

Allergies or sensitivities diagnosed or un-diagnosed (Food, meds, textiles, chemicals, plants, animals, etc.):

____

Accidents–

What occurred?	When occurred?	Associated complaint(s):

Surgeries–

What surgery?	When performed?	Post-operative complaint(s):

Illnesses/complaints/shocks/symptoms/diseases diagnosed or un-diagnosed—

(in order of occurance and score in order of severity, where 1 is very low and 10 is very high)

Condition:	When occurred?	Cause, if known:	Score:

Medications/vaccinations/supplements/herbs/homeopathic medicines taken presently—

Name/potency/frequency /taken with(out) food?	Why taken?	Adverse reaction(s)?

Treatments/therapies taken presently (including exercise)—

Type/frequency/duration?	Performed since?	Beneficial effect(s)?

Your presonality traits (both positive and negative): ______________________________

____

Biological family health history (briefly list known notable health conditions, age and cause of death, if applicable)—

Mother: ______________________________

Father: ______________________________

Siblings: ______________________________

____

Maternal grandmother: ______________________________

Maternal grandfather: ______________________________

Maternal aunts/uncles: ______________________________

Maternal cousins: ______________________________

Paternal grandmother: ______________________________

Paternal grandfather: ______________________________

Paternal aunts/uncles: ______________________________

Paternal cousins: ______________________________