



SOUTH GRANVILLE NATUROPATHIC CLINIC Ltd.

Dr. Michael Lederman, LL.B., N.D.

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NATURAL MEDICINE*DETOXIFICATION*IV NUTRIENT THERAPY* MESOTHERAPY*PROLOTHERAPY

PERSONAL INFORMATION:

Name _____	Today's Date _____
Homes Address _____	Age _____ Birthdate _____
City _____	Home Phone _____
Postal Code _____	Work Phone _____
Email Address _____	Occupation _____
Do you have Extended Health? Yes No	Who referred you to our office? _____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us in writing to do so.

What are your health concerns that you would like help with?

How do you rate your overall health from 0-10 (0 = Poor, 10 = Excellent): _____
What is your level of commitment to address the cause of your health concerns? (0-10) : _____

Is a physician treating you for any condition now? Yes No
Condition & Name of Physician:

CURRENT SUPPLEMENTS:

Please list all your vitamins/supplement:

CURRENT MEDICATIONS

*Please list all your **prescription** medications (such as sleeping pills, birth control pills) and **non-prescription medications** (such as aspirin, antacids, laxatives, antihistamines):*

KNOWN ALLERGIES

*Please list any known allergies to **medicines**, (such as penicillin, sulpha drugs, aspirin), or **other substances** such as foods, animals, chemicals, and pollens:*

HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES

Please state the Date and Reason for Hospitalization:

MEDICAL HISTORY

Please circle those that apply to you.

- | | | |
|---|----------------------------|--------------------------|
| Alcohol Abuse | Allergies | Anemia |
| Arthritis | Asthma | Back, Muscle, Joint Pain |
| Bladder/Urinary Problems | Colitis | Depression |
| Gynecological Problems | Gallstones | Gum/Teeth Problems |
| Ulcers | Heart Problems | High Blood Pressure |
| Kidney Problems | Suicidal | Lung Problems |
| Overweight | Psychological Difficulties | Stroke |
| Skin Problems | Liver Problems | Rheumatoid Fever |
| Diabetes | Tuberculosis | Heart Attack |
| Venereal Diseases (AIDS, herpes, syphilis, etc) | | Other |

FAMILY MEDICAL HISTORY

	Age	Health Problems	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Siblings				
Children				

CONSENT

I, _____, consent to have treatment with Dr. Lederman at the South Granville Naturopathic Clinic Ltd. Dr. Lederman will answer my questions to the best of his ability and explain risks and benefits of any recommended treatments.

Patient Signature: _____ Date: _____