Dr. Mordy Levy & Associates | Tel 416.218.8118 | Fax 416.218.0607 | Email: info@DrLevy.ca
Integrative and Functional Medicine | 6257 Bathurst St, Toronto, Ontario, M2R2A5

Confidential and Personal Information:

Name: _____
(First, Middle, Last)
Birth Date (Day - Month - Year): _____ Age: _____ Gender: M / F
Social Insurance Number: _____Height: _____ Weight: _____
Address: _____
City: _____ Postal Code: _____
Phone: (Home) _____ (Cell) _____ (Work) _____
Fax: _____ Email: _____
Occupation: _____
Emergency Contact: _____
Phone: _____ Relationship: _____

Medical Coverage:

OHIP Card Number: _____Expiry:_____
Insurance Company: _____ Phone: _____
Policy or Group Number: _____

Family Medical Doctor:

Name: _____ Phone: _____
Address: _____ Fax: _____

How did you find out about Dr. Mordy Levy?

☐ Brochure	☐ Lecture	☐ Family Doctor	☐ Yellow Pages
☐ Television	☐ Friend	☐ Chiropractor	☐ Directory
☐ Radio	☐ Relative	☐ Specialist	☐ Newspaper
☐ Internet	☐ Coworker	☐ Health Professional	☐ Articles
Other:			

List your main health concerns in order of importance / severity?
1.
2.
3.
4.
5.

Past Medical History:

Describe your general state of health: Excellent Good Fair Poor

Indicate any ***serious conditions, illnesses, injuries, surgeries, or hospitalizations*** along with approximate dates:

☐ Surgery ☐ Hospitalization ☐ Major Illness Date: _____Details: _____
_____.
☐ Surgery ☐ Hospitalization ☐ Major Illness Date: _____Details: _____
_____.
☐ Surgery ☐ Hospitalization ☐ Major Illness Date: _____Details: _____
_____.
☐ Surgery ☐ Hospitalization ☐ Major Illness Date: _____Details: _____
_____.

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Please list all **current medications**:
(Include ALL prescriptions, over the counter (OTC) products, vitamins, herbs, homeopathic, including: dosage, and duration)

☐ OTC ☐ Prescription Drug ☐ Herbs / Vitamins / Minerals ***Name:*** _____ *Dosage:*_____ *Since:*_____
☐ OTC ☐ Prescription Drug ☐ Herbs / Vitamins / Minerals ***Name:*** _____ *Dosage:*_____ *Since:*_____
☐ OTC ☐ Prescription Drug ☐ Herbs / Vitamins / Minerals ***Name:*** _____ *Dosage:*_____ *Since:*_____
☐ OTC ☐ Prescription Drug ☐ Herbs / Vitamins / Minerals ***Name:*** _____ *Dosage:*_____ *Since:*_____
☐ OTC ☐ Prescription Drug ☐ Herbs / Vitamins / Minerals ***Name:*** _____ *Dosage:*_____ *Since:*_____

Please list **past medications** (Past 5 years)

☐ OTC ☐ Prescription Drug ☐ Herbs / Vitamins / Minerals ***Name:*** _____ *Dosage:*_____ *Since:*_____
☐ OTC ☐ Prescription Drug ☐ Herbs / Vitamins / Minerals ***Name:*** _____ *Dosage:*_____ *Since:*_____

How often do you use any of the following?

	Aspirin
	Alcohol
	Caffeine
	Diet pills
	Hormone therapy
	Laxatives
	Pain killers
	Recreational drugs
	Tobacco

How many times have you been treated with **antibiotics this past year**? ☐ Once ☐ Twice ☐ More than 3 times
How about in the past 5 years? ☐ Once ☐ Twice ☐ More than 3 times Reason: _____

What **immunizations** have you had? **Any adverse reactions?** (Rash, Anaphylaxis, Headaches, Infections, etc.)

	DPT (diphtheria / pertussis / tetanus)	Yes	No	
	Tetanus (booster)	☐	☐	Reaction:
	MMR (measles / mumps / rubella)	☐	☐	Reaction:
	Hemophilius influenza B	☐	☐	Reaction:
	"Flu"	☐	☐	Reaction:
	Polio	☐	☐	Reaction:
	Hepatitis A	☐	☐	Reaction:
	Hepatitis B	☐	☐	Reaction:
	Smallpox	☐	☐	Reaction:

Do you have any **allergies, sensitivities, or intolerances**? Please explain.

	Medications	☐ Allergy ☐ Sensitivity ☐ Intolerance	Symptoms:
	Animals	☐ Allergy ☐ Sensitivity ☐ Intolerance	Symptoms:
	Feathers	☐ Allergy ☐ Sensitivity ☐ Intolerance	Symptoms:
	Molds	☐ Allergy ☐ Sensitivity ☐ Intolerance	Symptoms:
	Perfumes	☐ Allergy ☐ Sensitivity ☐ Intolerance	Symptoms:
	Latex	☐ Allergy ☐ Sensitivity ☐ Intolerance	Symptoms:
	Nuts	☐ Allergy ☐ Sensitivity ☐ Intolerance	Symptoms:
	Milk products	☐ Allergy ☐ Sensitivity ☐ Intolerance	Symptoms:
	Eggs	☐ Allergy ☐ Sensitivity ☐ Intolerance	Symptoms:
	Wheat	☐ Allergy ☐ Sensitivity ☐ Intolerance	Symptoms:
	Any Other	☐ Allergy ☐ Sensitivity ☐ Intolerance	Symptoms:

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Please rate your current **stress level**:	(Low) 1 2 3 4 5 6 7 8 9 10 (High)
Please rate your current **energy level**: :	(Low) 1 2 3 4 5 6 7 8 9 10 (High)

Please check the following conditions you have had:

	Alcoholism		Diabetes		Heart disease		Pleurisy		Typhoid fever
	Anemia		Diphtheria		Influenza		Pneumonia		Ulcers
	Appendicitis		Eczema		Malaria		Polio		Venereal disease
	Arteriosclerosis		Emphysema		Measles		Rheumatic fever		Whooping cough
	Arthritis		Epilepsy		Miscarriage		Scarlet fever		
	Cancer		Fever blisters		Mono		Shingles		
	Chorea		Goiter		Multiple sclerosis		Stroke		
	Cold sores		Gout		Mumps		Tuberculosis		

Family History:

Please indicate which of your **close relatives** (**biological parents / siblings**) has had any of the following and at **what age**:

	Alcoholism / Drug Abuse	☐ Brother_____(age) ☐ Sister _____(age) ☐ Father_____(age) ☐ Mother _____(age)
	Allergies	☐ Brother_____(age) ☐ Sister _____(age) ☐ Father_____(age) ☐ Mother _____(age)
	Asthma	☐ Brother_____(age) ☐ Sister _____(age) ☐ Father_____(age) ☐ Mother _____(age)
	Cancer	☐ Brother_____(age) ☐ Sister _____(age) ☐ Father_____(age) ☐ Mother _____(age)
	Depression or ANY mental health	☐ Brother_____(age) ☐ Sister _____(age) ☐ Father_____(age) ☐ Mother _____(age)
	Auto immune condition	☐ Brother_____(age) ☐ Sister _____(age) ☐ Father_____(age) ☐ Mother _____(age)
	Diabetes (either type 1 or 2)	☐ Brother_____(age) ☐ Sister _____(age) ☐ Father_____(age) ☐ Mother _____(age)
	Heart / Blood Pressure / Cholesterol	☐ Brother_____(age) ☐ Sister _____(age) ☐ Father_____(age) ☐ Mother _____(age)
	Kidney problems	☐ Brother_____(age) ☐ Sister _____(age) ☐ Father_____(age) ☐ Mother _____(age)

Social History:

Do you have any dietary restrictions? (Allergic, religious, vegetarian, vegan, etc.)
_____
_____.

Have you ever been on a special diet? If so, please explain. _____
_____
_____

What do you do for a living? _____

How much **water** do you typically drink per day? ☐ Less than 2 glasses ☐ 2-5 Glasses ☐ 5-8 glasses ☐ 8 glasses or more

How many hours do you **sleep** per night? _____ Do you wake up refreshed Yes / No

Is the sleep fluid/continuous or is it interrupted? _____ Do you recall your dreams? Yes / No

Do you **exercise** regularly? Yes / No what type of exercise? ☐ Cardiovascular / Aerobic ☐ Weight-Resistance Training ☐ Both

How frequently do you exercise? ☐ Daily ☐ 3-4 times per week ☐ Less than 3 times per week

Do you use **tobacco products**? Yes / No, if yes How frequently? _____Since when? _____

Ever used **recreational drugs**? Yes / No Which ones? _____

Do you drink **alcohol**? Yes / No, if Yes how often? _____

Women's Health & OBGYN:

What age you first got your period? _____ Is it regular? Yes / No Cycle Days:_____ # "heavy days":_____

What age you reached menopause? (Cessation of periods) _____

On the heavy days of your period, how many pads or tampons are you using per day? _____

Have you ever been pregnant? Yes / No, if yes how many times? _____

Ever had abortions or miscarriages? Yes / No, if yes, how many times? _____

How many live births have you had? _____ please specify sex & age(s):_____

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Review of Systems: Please check boxes for any of the following that you have or have had previously.
O = occasional, F = frequent, C = constant

O	F	C	General
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Depression
☐	☐	☐	Nervousness
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			Muscle and Joint
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Lower back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
☐	☐	☐	Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

O	F	C	Gastro-Intestinal
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Abdominal distension
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Stomach pain
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			Eyes, ears, nose, throat
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	Cardio-Vascular
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			Respiratory
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			Skin
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			Genito-Urinary
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Poor kidney control
☐	☐	☐	Kidney infection
☐	☐	☐	Kidney stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			Women
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps / backache
☐	☐	☐	Excess menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Lumps in breasts
☐	☐	☐	Menopause
☐	☐	☐	Painful Menstruation
☐	☐	☐	Vaginal discharge

PRACTICE TYPE:

I understand that Dr. Levy is a registered Naturopathic Doctor (ND), a Doctor of Chiropractic (DC) and a registered Homeopath (HOM), and does not work as a family physician, it has therefore been strongly recommended to me by Dr. Levy that, in addition to his care, I maintain a relationship with a family physician for on-going primary care. I understand that Dr. Levy is willing to collaborate with my family physician regarding my health. Dr. Levy will therefore provide a list of recommended conventional tests that could be ordered by your GP.

FUNCTIONAL MEDICINE & NATUROPATHIC MEDICINE:

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopaths 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. A number of different approaches are used. Diet and Nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy and lifestyle counseling are the mainstays of naturopathic medicine.

I. **Individual diets and nutritional supplements** are recommended to address deficiencies, treat disease processes and promote health. The benefits include increased energy, increased gastrointestinal function, improved immunity and general well being.
II. **Botanical Medicine** is a plant based medicine using herbal teas, tinctures, capsules and other forms of herbal preparations to assist in the recovery from injury and disease. These compounds are also used to boost the body's immune system and prevent disease.
III. **Homeopathy** is a form of medicine based on the Law of Similars- that is the use of tiny extremely diluted doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal or mineral origins are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool and affects healing on a physical and emotional level.
IV. **Chinese Medicine includes acupuncture**, as well as the use of botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Sometimes moxa (a compressed herb in the form of a stick) is burned over an acupuncture point to help relieve symptoms. Botanical formulas may be given in the form of pills, tinctures or decoctions (strong teas) to be taken internally or used externally as a wash. Herbal formulas may include shell, mineral, animal and plant materials. Dietary advice is based on traditional Chinese medical theory.
V. **Hydrotherapy** refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.
VI. **Therapeutic Injections**: Refers to Injection(s) of natural compounds via SC, or IM (for example: Methylcobalamin, Folic acid)

Naturopathic medicine is a primary care, holistic approach to health & wellness, and is considered relevant to most health problems. The Doctor, will try to help you identify risk factors and make recommendations to help you optimize your physical, mental and emotional environment. Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform the doctor or clinic immediately of any disease process that you are suffering from or if you are taking any medications. If you are pregnant, suspect you are pregnant or you are breast-feeding please inform the doctor or the clinic as well.
There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Temporary aggravation of pre-existing symptoms
- Allergic reactions to Nutraceuticals, homeopathic medicines, herbs or supplements
- Bruising, fainting, nerve damage & infection: from acupuncture or therapeutic injections (SC, IM)

A record will be kept of health services provided to you. This record will be kept confidential and will not be released to others unless you give your consent or the law requires it. You may look at your medical record at any time and can request a copy of it by paying the appropriate fee for copying charges.

LAB TESTS:

The Purpose of functional medicine laboratory testing is to evaluate nutritional, hormonal, toxicology, biochemical or any potential physiological imbalances that may exist. Dr. Levy will recommend some conventional and functional lab tests in order to assess your case. Some conventional tests could be ordered by your GP, and might be covered under OHIP, however all functional lab tests are not covered under OHIP.

EMAIL COMMUNICATIONS:

As per regulatory college guidelines and the privacy act: Dr Levy will not discuss or address questions or concerns regarding your care over email. Dr. Levy and his office staff will use reasonable means to protect the confidentiality and security of email information sent and received, however due to inherited technical limitations, Dr. Levy cannot guarantee the security and confidentiality of email communication and will not be liable for improper disclosure of confidential information. Emails to or from the patient concerning treatment, diagnosis or assessment will become part of the patient's medical chart. Although Dr. Levy and or his staff will attempt to respond promptly to emails, we cannot guarantee that any particular email will be responded to within any particular period of time. Thus, the patient should NOT use email for medical emergencies or other sensitive matters.

Patient Initial: _____ Date: _____

CHIROPRACTIC & PHYSICAL MEDICINE

Medical Doctors (MD), Osteopaths (DO), Doctors of Chiropractic (DC), Doctors of Naturopathic Medicine (ND), and physical therapists (PT) that use manual therapy techniques such as Spinal Manipulative Therapy (SMT) or adjustments are required to advise patients that there may be some risks associated with such treatment. In particular you should note:

I. While rare, some patients have experienced rib fractures, or muscle and ligament strains or sprains following Spinal Manipulative Therapy.
II. Some types of spinal adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. We employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.
III. There have been rare reported cases of disc injuries following cervical or lumbar spinal manipulation although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal manipulations.
IV. Chiropractic treatment, including spinal manipulations /adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches and other symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.
V. Physiotherapeutic Modalities: I acknowledge & understand that there is a very small risk of skin burns, rash or any soft tissue irritation with utilization of ultrasound, infrared heat, ice, electro-massage, low level laser, shockwave therapy, and/or electrotherapy.

ACUPUNCTURE

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, and stuck or bent needles.

I. I have been advised that only sterilized disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment. Doctors in this office follow the clean needle technique guidelines set by the Acupuncture Council of Ontario.
II. I hereby request and consent to the performance of acupuncture & other procedures related to acupuncture, as necessary including cupping, and/or electro acupuncture by the above named doctor or another duly authorized doctor in the clinic.
III. **Female Patients**: I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

INFORMED CONSENT:

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended procedure(s) and/or necessary diagnostic procedures, and have discussed to my satisfaction this and any requests for related information with the doctor named above and/or with his office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the procedure(s) with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternate course(s) of action are available to me. As a result, I do hereby voluntarily consent to the recommended procedure(s) as specified above. I also understand that I may change the status of my voluntary informed consent at any time. I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, and is in my best interests. I understand that the results are not guaranteed. I acknowledge, I have discussed, or have had the opportunity to discuss, with my doctor, the nature and purpose of the chiropractic, naturopathic &/or acupuncture treatment, as well as the contents of this Consent. I consent to the treatments offered or recommended to me by my doctor working in this clinic.

CLINIC FEE SCHEDULE & MISSED APPOINTMENT POLICY

I. For missed appointments, no shows, or last minute cancellations, there is a 2 day cancellation policy. The fee for missed appointment, without prior notice is based on your scheduled blocked time.
II. On the day of your scheduled appointment, all charges for consultations, as well as laboratory testing and or supplementation, will be itemized and reviewed with you. Payment is due on the day of service.

I was informed, I acknowledge and understand that fees for services in this clinic may or may not be fully covered under my insurance plan.

Service fee based on duration	**Initial Visit**	**Follow –up**
Functional Medicine & Naturopathic Medicine	$300	$150
Chiropractic OR Acupuncture	N/A	$ 80

_____ _____ _____

Print Patient's Name | Signature of Patient or Parent / Guardian | Date