VIRIDITAS CLINIC

John Redden RH
Medical Herbalist

2775 Dundas St. W. Toronto, ON M6P 1Y4

Tiffany Wyse ND RH
Naturopathic Doctor|Medical Herbalist

CONFIDENTIAL ADULT PATIENT INTAKE FORM

Today's Date: _____

Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home phone: _____ Work or Other phone: _____
E-mail address: _____
Can messages be left confidentially? YES / NO
Age: _____ Date of birth: _____
Identify As: M F Other (please specify):: _____
Sex Assigned at birth: M F Other (please specify): _____
Height: _____Weight: _____
Education: _____
Circle one: • Married • Single • Widowed • Divorced • Separated • Common-law • Same sex
Live with: • Spouse • Partner • Parents • Children • Friends • Alone
Occupation: _____ Hours per week: _____
Do you have extended medical insurance? _____

Person to notify in an emergency? _____ Relation: _____
Phone: _____ Address: _____
How did you hear about this clinic? _____

Main Reason (s) for visit? (Diagnosis, Chief Complaints & Symptoms)
List as many as you can in order of importance.
1) _____ length of time :_____
2) _____ length of time :_____
3) _____ length of time :_____
4) _____ length of time :_____
5) _____ length of time :_____
Other Health Issues:
_____
_____
Do you have any known contagious diseases at this time? YES / NO
If yes, what? _____

Are you currently receiving healthcare? YES / NO
Other health care providers (name and phone number);
1. _____ Phone_____
2. . _____ Phone_____

Please note which of the following types of health care practitioners you have seen.
Use **P** if you have seen them in the past and **C** if you are currently under their care:

__ Ayurvedic Practitioner	__ Bodywork Practitioner	__ Chiropractor	__ Counsellor
__ Herbalist	__ Medical Doctor (type) ____	__ Homeopath	__ Massage Therapist
__ Naturopathic Doctor	__ Physical Therapist	__ Psychiatrist	__ Psychologist
__ Social Worker	__ Spiritual Counsellor	__ Traditional Chinese Medical Doctor	

Western Medical Diagnosis known (**please include any significant lab reports**):
_____
_____
Other Diagnosis:_____

John Redden RH
416-767-3428
redden@viriditasherbalproducts.com

Tiffany Wyse ND
416-519-4166
tiffanywyse@gmail.com

CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives Pain relievers Antacids Cortisone Blood Pressure medication
Antibiotics Tranquilizers Sleeping Pills Thyroid Medication
Birth Control Pills Hormone Replacement Heart medication

Please list any prescription medications or over the counter medications you are taking:

1) _____ length taken: ____ 5) _____ length taken: ____
2) _____ length taken: ____ 6) _____ length taken: ____
3) _____ length taken: ____ 7) _____ length taken: ____
4) _____ length taken: ____ 8) _____ length taken: ____

Please list any prescribed medication that you have had an adverse reaction to.

Drug name: _____ _____ Reaction: _____
Drug name: _____ _____ Reaction: _____
Drug name: _____ _____ Reaction: _____

CURRENT SUPPLEMENTS

Do you take or use any of the following (please circle):

Vitamins Minerals Probiotics Essential Fatty Acids

Please list any vitamins or other supplements you are taking:
Please place a CHECK next to those prescribed by a Health care practitioner.

1) _____ length taken: _____ 5) _____ length taken: _____
2) _____ length taken: _____ 6) _____ length taken: _____
3) _____ length taken: _____ 7) _____ length taken: _____
4) _____ length taken: _____ 8) _____ length taken: _____

HEALTH HISTORY

Have you ever been diagnosed or experienced symptoms of the following?
Please CHECK

__ AD(H)D __ AIDS __ Alcoholism __ Allergies
__ Anaemia __ Anxiety __ Arthritis __ Asthma
__ Bloating __ Cancer __ Candida __ Chemical sensitivities
__ Chronic fatigue __ Common cold __ Constipation __ Depression
__ Diabetes __ Diarrhoea __ Dizziness __ Drug abuse
__ Eczema __ Environmental sensitivities __ Epilepsy __ Epstein-Barr virus
__ Excess stress __ Eyesight problems __ Fatigue __ Gallstones
__ Gout __ Gum/Teeth problems __ Gynaecological problems
__ Headaches __ Hearing problems __ Heart disease __ Hepatitis A, B, or C
__ High Blood Pressure __ HIV __ Hives __ Hyperglycaemia
__ Hypoglycaemia __ Immune disorders __ Influenza __ Injuries
__ Kidney problems __ Low Blood Pressure __ Malaria __ Male health problems
__ Memory loss __ Menopause problems __ Menstrual irregularities
__ Mononucleosis __ Numbness __ Overweight __ Painful joints
__ Pneumonia __ Rashes __ Respiratory problems
__ Rheumatic fever __ Seizures __ Shingles __ Shortness of Breath
__ Sleep problems __ Sore throats __ Stiffness __ Stomachaches
__ Stroke __ Swelling __ Tumours __ Urinary Tract Infection

Other: _____
_____

Blood Type (if known, please circle) A AB B O Rh factor: + -

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CHRONOLOGICAL HEALTH HISTORY

Childhood _____
_____
Puberty _____
_____
Adulthood _____
_____
Elder _____
_____

What was your mother's state of health during her pregnancy with you? If you know, please describe:
_____

How was your birth? Any complications? Any interventions (forceps, C-section, epidural, anesthesia, etc.) _____

Were you breastfed at all? YES / NO If yes, for how long? _____

HOSPITALIZATIONS/SURGERY/IMAGING

Any hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs, blood tests, etc…?

_____ year _____ _____ year _____
_____ year _____ _____ year _____
_____ year _____ _____ year _____

IMMUNIZATIONS

Please CHECK if you have had any of the following immunizations:

Hep. B __ HPV (Guardasil) __ flu shot __ other: _____

IMMUNE SYSTEM

Have you ever been diagnosed with any of the following terms?

__ Adenitis __ Allergies __ Autoimmune disorders __ Chronic fatigue
__ Enlarged Spleen __ Graves disease __ Hashimoto's thyroiditis __ Immunodeficiency
__ Infections __ Lupus (SLE) __ Mononucleosis __ Myasthenia gravis
__ Pernicious anaemia __ Rheumatoid arthritis __ Swollen lymph glands Other: _____

Have you ever experienced symptoms of the following?

Please write **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER:

__ Allergies __ Cold/Flu __ Delayed healing __ Fatigue
__ Sore throat __ Low grade fever

CHILDHOOD DISEASES AND SYNDROMES

Please CHECK any of the below diseases you have experienced.

__ Allergies __ Asthma __ Atopic eczema __ Bronchitis
__ Chicken pox __ Ear infections __ German measles (Rubella) __ Measles
__ Mononucleosis __ Mumps __ Rheumatic fever __ Tonsillitis
__ Whooping cough (Pertussis) Other: _____

FAMILY MEDICAL HISTORY

Please note Severe Medical Conditions of close family members:
parents, grandparents, children, sisters, brothers, aunts and uncles.
For example, a history of any of the following: Cancer, Diabetes, Heart Disease, High Blood Pressure, Kidney disease, Epilepsy, Arthritis, Glaucoma, Tuberculosis, Stroke, Anemia, Mental Illness, Asthma

Member	Age	Health Condition
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Any other relevant family history?
_____

What is your family heritage?
_____

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GENERAL HEALTH

Are you satisfied with your energy levels? Please describe: _____
When during the day is your energy the best? _____ Worst? _____
Have your energy levels changed markedly? YES / NO
Exercise: Y / N If so, what kind and how often: _____
Watch TV/COMPUTER USE: Y / N If so, how many hours? _____
Read: Y / N If so, how many hours? ____
Do you have a religious or spiritual practice? Y / N
If so, what kind (Prayer, Meditation, Temple, Yoga, etc…)? _____
_____
_____

BODY TEMPERATURE

Please write **H** for HOT and **C** for COLD, if applicable to these body areas:

__ General Body	__ Arms	__ Hands	__ Palms
__ Fingers	__ Legs	__ Feet	__ Genital region
__ Head	__ Chest	__ Stomach	Other: _____

Using **L** for LIKE AND **D** for DISLIKE check off these weather conditions:
__ Hot __ Very Hot __ Cold __ Very Cold __ Dry __ Damp __ Humid

EMOTIONAL

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on the emotions listed below:

__ Angry	__ Anxious	__ Content	__ Depressed	__ Dreamy
__ Enthusiastic	__ Fearful	__ Forgetful	__ Grumpy	__ Happy
__ Inspired	__ Lethargic	__ Nervous	__ Sad	__ Worry

Other: _____
Are you an **extrovert** / **introvert**
How would you describe your emotional health?
_____
_____

MEMORY AND CONCENTRATION

How is your long term memory? GOOD / AVERAGE / POOR
How is your short term memory? GOOD / AVERAGE / POOR
Has your memory changed noticeably in the past few years?_____
How is your concentration? GOOD / AVERAGE / POOR
Has it changed? If so, when and in what way? _____

HEADACHES

Do you ever have headaches? YES / NO
If so, using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on the conditions listed below:

__ After eating	__ Afternoon	__ Around eyes	__ Around temples
__ Aversion to stimuli	__ Back of head	__ Band around head	__ Before eating
__ Chronic	__ Cluster	__ Constant	__ Dull
__ Evening	__ Front of head	__ Left side	__ Migraine
__ Morning	__ Night	__ Pounding	__ Premenstrual
__ Right side			Other: _____

Are there any other symptoms associated with the headache? Please check:

__ Auras	__ Lights	__ Stomach pain	__ Congestion

Other: _____

SLEEP PATTERNS

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these conditions:

__ Fall asleep quickly	__ Sleep through the night	
__ Hard to fall asleep, but stay asleep	__ Hard to fall asleep AND stay asleep	
__ Wake often	__ Wake up to urinate	__ Hard to wake
__ Restless sleep	__ Go to bed late	__ Other:_____

Which are your favourite hours to sleep? _____

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Generally, how many hours of sleep do you need to feel rested? _____
Do you feel rested when you wake in the morning? _____
DREAMS
Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these types:
__ active __ anxious __ interesting __ lucid __ nightmares __ pleasant
__ probing __ scary __ do not remember other: _____

SKIN

Mark any of the conditions below that pertain to you.
Please mark **P** for previous condition, **C** for current and **?** if unsure:

__ Acne	__ Boils	__ Brittle, Cracking nails	__ Bruise easily
__ Dry Hair	__ Dry skin	__ Eczema	__ Hair Loss
__ Impetigo	__ Itchy	__ Lines, Ridges on nails	__ Moles
__ Oily hair	__ Oily skin	__ Pimples	__ Psoriasis
__ Rashes	__ Scars	__ Sensitive to Chemicals	__ Skin tags
__ Slow to Heal	__ Varicose veins	Other: _____	
__ Hot	__ Cold	__ Wet	__ Dry

EYES, EARS, NOSE, MOUTH and THROAT

EYES

Have you ever been diagnosed with any of the following? If so, please CHECK:
__ Cataracts __ Glaucoma
Do you wear corrective lenses/glasses? YES / NO
Does the prescription for these change often? YES / NO
Please mark **P** for previous condition, **C** for current and **?** if unsure:
__ Blurred vision __ Eye pain __ Spots in front of eyes Other: _____
Date of last eye examination: _____

EARS

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these conditions:
__ Earaches __ Ear infections __ Hearing loss __ Overly sensitive
__ Tinnitus/Ringing __ Wax build up Other: _____
How is your hearing? Has it changed in the past years? Please explain: _____

NOSE, MOUTH & THROAT

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these conditions:

__ Bleeding gums	__ Canker sores	__ Cavities	__ Constant dryness
__ Difficulty swallowing	__ Excess saliva	__ Grinding teeth	__ Lip sores
__ Loose teeth	__ Loss of sense of smell	__ Mouth sores	__ Mucous in throat
__ Oral herpes/Cold sores	__ Sinus congestion	__ Sore gums	__ Sore Throats
__ Painful/Tight/Clicking jaw		__ Swollen glands	__ Swollen tongue

CARDIOVASCULAR HEALTH

Have you ever been diagnosed with any of the following? If so, please CHECK:

__ Angina	__ Arrhythmias (irregular heartbeat)	__ Arteriosclerosis
__ Black and blue easily	__ Blood clots	__ Cholesterol issues
__ Congenital deformities	__ Congestive heart failure	__ Edema
__ Fast Heart beat (Tachycardia)	__ Heart flutter	__ Heart irregularities
__ High Blood Pressure	__ Heart murmur	__ Heart attack (Myocardial infarction)
__ Ischemia	__ Low Blood Pressure	__ Mitral Valve Prolapse
__ Palpitation	__ Pericarditis	__ Phlebitis
__ Poor circulation	__ Rheumatic fever	__ Slow Heart Beat (Bradycardia)
__ Stroke	__ Varicose veins	

Do you ever experience any of the following? If so, please CHECK:
__ bleed easily __ chest pains __ dizziness __ fainting
__ pins & needles __ swollen ankles &/or hands __ pain/cramping in legs when walking
__ shortness of breath on exertion Other: _____

ENDOCRINE SYSTEM

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these conditions:

__ Thyroid problems __ Intolerance to heat or cold __ Excessive thirst
__ Easy weight gain __ Hard to gain weight __ Light Headedness/Dizziness
__ Irritability/Disoriented __ Hot Flashes __ Sweatiness
__ Sudden Energy Drops __ Symptoms when missed a meal (please list): _____

MUSCULOSKELETAL SYSTEM

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these conditions:

__ Joint pain __ Muscle pain __ Muscle weakness __ Neck pain
__ Stiffness __ Swollen joints Other: _____

Have you had an injury or surgery on bone, muscle, tendon, cartilage or related issue?
Do you have any pins or other such items still? If so, when and where? _____

RESPIRATORY SYSTEM

Have you ever been diagnosed with any of the following? If so, please CHECK:

__ Laryngitis __ Pleuritis __ Tuberculosis

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these symptoms:

__ Asthma __ Bronchitis __ Chest pain or pain when breathing
__ Common cold __ Coughing __ Difficulty smelling __ Fluid in lungs
__ Hayfever __ Respiratory inflammation __ Runny nose __ Shortness of Breath
__ Sneezing __ Stuffy nose __ Tight around lungs
__ Trouble breathing in __ Trouble breathing out __ Wheezing
Other: _____

Have you identified foods, environmental factors or situations that worsen your breathing?
If so, what are they? _____

Mucous?

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these types:

__ Clear __ Green __ Yellow
__ Thick/Sticky __ Thin/Runny
__ Worse in morning, afternoon, evening and/or night (circle)
Is there a season where you suffer more? _____

Cough?

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these types:

__ Bloody __ Dry cough __ Hacking __ Itchy throat
__ Painful __ Persistent __ Regularly __ Wet cough
__Worse at morning, afternoon, evening and/or night (circle)
Do you know of anything that triggers the cough? _____

URINARY SYSTEM

Have you ever been diagnosed with any of the following? If so, please CHECK:

__ Kidney/Bladder stones

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these symptoms:

__ Blood in urine __ Burning urination __ Frequent urge to urinate __ Kidney pain
__ Lower Back Pain __ Strong smelling urine __ Water retention
__ pain when urinating __ inability to hold urine Other: _____
Approximately how many times a day do you urinate? _____
Describe your urine. What colour is it? _____ Is it cloudy or clear? (circle)
Smell? _____ Do you wake up at night to urinate? _____
After urinating, does it feel like you still have urine in your bladder? _____
Have you had urinary tract infections? How often? _____

GASTROINTESTINAL SYSTEM

Digestion

Have you ever been diagnosed with any of the following? If so, please CHECK:

__ Anorexia nervosa __ Bulimia __ Crohn's disease __ Diverticulitis
__ Gallstones __ I.B.S. (Irritable Bowel) __ Parasites (ie. Giardia) __ Ulcerative colitis

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these conditions:

__ Abdominal cramps __ Alternating constipation/diarrhea __ Bladder & Kidney infections
__ Bloating __ Burping __ Changes in bowel habits

__ Chronic abdominal pain __ Constipation __ Diarrhea
__ Difficulty Belching __ Difficulty gaining weight __ Difficulty losing weight
__ Dysentery __ Eating Disorders __ Fatigue after eating
__ Flatulence/Gas __ Food allergies __ Food unappetizing
__ Foul smelling stool __ Fullness long after meals __ Frequent infections (colds)
__ Headaches after eating __ Heartburn __ Hemorrhoids/Rectal Pain
__ Indigestion __ Indigestion 1-3hrs. after eating __ Intolerance to greasy food
__ Large Appetite __ Liver problems __ Lower bowel gas
__ Nausea __ Pain in right side under rib cage __ Poor appetite
__ Sour taste in mouth __ Stomachaches __Stomach Pains
__ Stomach Pains after meals __ Stomach upsets easily __ Stool poorly formed
__ Sudden acute indigestion __ Sudden Weight Change __ Ulcer
__ Vomiting __ 3 or more large bowel movements a day

Bowel Movements (check the symptoms that pertain to you):

__ black stools __ blood in stools __ diarrhea __ floating stools
__ hard stools __ loose stools __ mucous in stools __ sinking stools
__ shiny stools __ stools poorly formed
__ oily film on stools or in toilet bowl __ white or light grey stools
Other: _____
How many times a day do you have a bowel movement/defecate? _____
Is your need to defecate urgent? _____

DIET

Special Diets: current and/or previous (Blood Type, Diabetic, Celiac, Paleo, GAPS, Vegetarian, Vegan, etc…)?
_____
_____
What are your favourite and least favourite foods?
_____
What food did you have yesterday?
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To drink: _____
* Please fill out the **diet & activity** report attached to these forms *

NERVOUS SYSTEM & STRESS –

If you have severe anxiety LINK to Hamilton test
http://psychology-tools.com/hamilton-anxiety-rating-scale//
https://www.outcometracker.org/library/HAM-A.pdf

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these conditions:

__ Anxiousness __ Bipolar __ Butterflies in stomach
__ Cannot stay asleep __ Constant feeling of stress __ Depression
__ Diminished taste __ Fear of facing a new day __ Fluctuating vision
__ Hard to concentrate __ Involuntary spasms __ Mania
__ Memory loss __ Nervousness __ Numbness
__ Panic attacks __ Pain – constant __ Seasonal Affective Disorder
__ Seizures __ Sudden Mood Swings __ Trouble Falling Asleep
__ Twitching __ Worsening coordination/balance
__ foggy/spacey feeling __ irritable Other: _____

Describe your stress levels on a scale of 1 (not stressed) to 10 (really stressed): _____
What goes wrong with your body when stress levels are elevated? _____

Please list the five most significant stressful events in your life:
1) _____ date :_____
2) _____ date :_____
3) _____ date :_____

REPRODUCTIVE SYSTEM

Have you been diagnosed with any of the following conditions?
Have you ever been diagnosed with any of the following? If so, please CHECK:

__ AIDS __ Candida __ Chlamydia __ Crabs/Lice
__ Gardnerella vaginalis __ Genital warts __ Gonorrhea __ HIV
__ Syphilis __ STD's __ Trichomonas __ Urethritis
__ HPV (Human Papilloma Virus) Other: _____

MALE ♂

Have you been diagnosed with any of the following conditions? If so, please CHECK:
__ BPH (Benign Prostatic Hyperplasia) __ Prostate Cancer __ Infertility __ Peyronie's disease

Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these conditions:

__ Blood in semen __ Blood in urine
__ Difficulty getting urine flowing __ Dribbling __ Erectile dysfunction
__ Excessive sexual thoughts __ Frequent urination __ Impotence
__ Interrupted flow of urine __ Low back pain __ Low libido
__ Painful ejaculation __ Painful to urinate __ Prostate pain
__ Penis pain __ Testicle pain __ Vitality low

Other: _____
Do you get up at night to urinate? YES / NO If so, how often? _____
Does your prostate region ever hurt? YES / NO
If yes, is the pain __ dull __ constant __ throbbing or __ sharp?
Is it ever painful to urinate? YES / NO If so, describe the pain: _____
Does the urge to urinate interfere with your daily activities? _____
Do you have any health concerns about your sexuality or vitality? _____

FEMALE ♀

Pregnancy

Are you pregnant? YES / NO If so, how many months? _____
Are you trying to become pregnant? YES / NO If so, how long have you been trying? _____
Number of pregnancies: ___Number of births: ___ Premature births: ___ Miscarriages: _____

Have you been diagnosed with any of the following conditions? If so, please CHECK:

__ Cervical dysplasia __ Cysts __ Endometriosis
__ Fibroids __ Infertility __ Pelvic inflammatory disease
__ Tumours __ Unusual PAP __ Vaginitis
Other: _____

Have you had any of the following symptoms or conditions?
Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these conditions:

__ Breast pain __ Breast discharge __ Breast lumps
__ Miscarriage __ Painful intercourse __ Vaginal discharge
__ Vaginal dryness __ Vaginal infection Other: _____

Menstrual Cycle

Have you had any of the following symptoms or conditions?
Using **O** for OFTEN, **S** for SOMETIMES and **N** for NEVER, please comment on these conditions:

__ Acne __ Bleeding between cycles __ Bloating (hands, stomach)
__ Bloating (feet, hands, ankles) __ Irregular cycle
__ Mid cycle discomfort, bloating, pressure __ Mood swings __ Painful menses
__ PMS + please check any associated symptoms:

PMS + __ Mood changes __ Nervous tension __ Anxiety __ Insomnia __ Crying/Sadness
PMS + __ Food cravings __ Crave sugar/carbs __ Irritable if hungry __ Fatigue
PMS + __ Abdominal bloating __ Weight gain __ Breast fullness __ Swollen hands/feet
PMS + __ Period pain __ Breast pain __ Aches & pain
PMS + __ Tiredness __ Mental fatigue __ Hot flushes __ Headaches/Migraine

Other symptoms: _____
Age of first menses: _____
Length of cycle: _____ days Duration of menses:_____ days

Menstrual Blood

__ Bright red __ Clots __ Dark colour __ Heavy flow
__ Profuse flow __ Red __ Red brown __ Scanty flow
__ Slow flowing __ Mucousy __ Watery Other: _____

Menopause

Are you currently in pre, peri or post menopause? _____
Age when menopause began: _____

__ Dry vaginal mucosa __ Hormone Replacement Therapy __ Hot flashes
__ Mood swings __ Night sweats __ Osteoporosis
__ Sore muscles Other: _____

Contraception Method

__ Birth Control Pills type: _____ __ IUD __ Diaphragm
__ Temperature/Cervical Mucous method Other: _____

ENVIRONMENTAL HEALTH

Is your home damp or mouldy? YES / NO
Do you have specialized air filtration at home? YES / NO
Do you live/work in the city? YES / NO
Do you work in an office building? YES / NO
Are you exposed to toxic materials? YES / NO
Do you smoke or are you exposed to second hand smoke? YES / NO
What do you use as drinking water? tap bottled filtered reverse osmosis spring
Do you filter your showers? YES / NO

Do you live: URBAN SUBURBAN HIGH RISE LOW RISE HOUSE
How long is your commute? _____ By: car public transit bicycle walking
Do you spend time in nature?
CITY PARK PROV. PARK FOREST GARDEN LAKE BEACH

DENTAL HISTORY

Date of last dental check up _____ for what? _____
Do you have **root canals**? YES / NO If YES, how many? _____
cavities? YES / NO If YES, how many? _____
gum disease? YES / NO _____

Thank you for your time and effort filling out these forms. We look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so on the rest of this page.

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