Somerton Natural Health Inc.
John Somerton BSc.
Holistic Health and Wellness

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Helping you achieve true health-naturally...

PATIENT INTAKE FORMS

The concept of *natural healing* centres around stimulating the body to heal itself. This is accomplished by addressing "imbalances" in the body which lead the patient to their diseased state. Symptoms produced by an individual are not the disease (as viewed in western medicine) but instead are an expression of the body's attempt at cure, and as such, can be used to heal. After successful treatment, not only will the patient find themselves symptom free, with no side effects, they will also be healthier and more vital as a whole; because the body's own attempt at cure, in terms of symptoms produced, was honoured and not suppressed. It's a wonderfully unique and extremely effective means of healing, the likes of which are unparalleled to this day!

Please find enclosed medical intake forms and fee schedule that I require you to read, complete and sign where appropriate, prior to our initial consultation. Please bring these forms with you at that time. I ask that you review what symptoms you wish to discuss: mental, emotional or physical. Include specifics as to what makes your symptom(s) better or worse, the time of day that symptoms predominate, any particular sensations associated with the presenting symptoms and any other parts of the body that are also affected in some way from the main complaint. To assist you to this end, please refer to and complete the two handouts provided, titled "Reporting Symptoms" and "Your Personality Profile". As well, I ask that you have someone close to you, write down perhaps 5-10 words which might best describe you as a person. Some patients find it helpful to start a journal prior to our meeting to effectively plot out their symptoms over time, noting on a time line, any significant points in their past when their complaints appeared, disappeared or changed. Corresponding events in your life at these times of change can also be useful. In general, the more information I can obtain from you regarding your issues, the more accurate I can be at finding the appropriate remedy.

Pre-consultation Questionnaire

Client Information

Determining the proper remedy involves investigating and evaluating all the subjective and objective symptoms that you are experiencing in the context of your individual life circumstances and environment. In order to develop an accurate picture of your circumstances, and to make our time spent in consultation most effective, I request that you complete the following information form as in-depth and accurately as possible. If you have any questions, feel free to contact me.

Please note that all information provided is kept in strict confidence.

Surname _____ First name _____

Address _____

City _____ Province _____ Postal Code _____

Date of Birth _____

Sex _____

Height _____

Weight _____

Weight (last year) _____

Hair colour _____

Eye colour _____

Marital Status _____

Occupation _____

Family Doctor:

Surname First name

Address

City Province Postal Code

Phone Fax E-mail

Referred By:

Surname First name

Address

Medical Complaints
(Please list your medical issues in order of importance)

Immunizations

- ☐ Diphtheria
- ☐ Polio
- ☐ Tetanus
- ☐ Whooping Cough
- Arthritis
- ☐ Other

Have you / are you suffering from?

- ☐ Abortion
- ☐ Alcoholism
- ☐ Depression
- ☐ Drug Abuse
- ☐ High / Low
- ☐ Blood Pressure
- ☐ Miscarriage
- ☐ PMS

Do you use the following?

- ☐ Alcohol
- ☐ Antacids
- ☐ Carbonated Bvgs
- ☐ Coffee
- ☐ Distilled Water
- ☐ Fast Foods (often)
- ☐ Fried foods
- ☐ Laxatives
- ☐ Margarine
- ☐ Nonsugar Sweet
- ☐ Salt(without tasting)
- ☐ Sweets
- ☐ Tea
- ☐ Tobacco

List of Nutritional Supplements

What major injuries have you had during the course of your life?

What medications have you taken in the last year?

What treatments have / are you currently receiving?

What surgeries have you had during the course of your life?

Family Health History

	Age (at death)	Major Ailments
Mother		
Father		
Sister(s)		
Brother(s)		
Mat. GM		
Mat. GF		
Mat. U/A		
Pat. GM		
Pat. GM		
Pat. GF		
Pat. U/A		

Note: GM=Grandmother, GF=Grandfather,

Have you suffered from any of the following conditions?

- ☐ Abscesses
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Frequent Colds
- ☐ Gallstones
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV
- ☐ Influenza
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lyme Disease
- ☐ Malaria
- ☐ Measles
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Parasites
- ☐ Pelvic Inflamm. Dz.
- ☐ Peritonitis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Prostatitis
- ☐ Psoriasis
- ☐ Rheumatic Fever
- ☐ Rubella
- ☐ Scarlet Fever
- ☐ Sexually Trans. Dz.
- ☐ Skin Diseases
- ☐ Sinusitis
- ☐ Step Throat
- ☐ Stroke
- ☐ Sunstroke
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Venereal Warts
- ☐ Warts
- ☐ Whooping Cough
- ☐ Worms
- ☐ Yellow Fever
- ☐ Other

Rate the following symptoms (where applicable) on a scale of 1 to 10 in relation to the Intensity of the particular symptom, where "1" implies slight discomfort and/or its affects are mild in severity and not limiting and "10" implies extreme discomfort and/or its affects are severe and limiting. Beside the symptom intensity, rate the Frequency at which you experience the symptom:
"O"= Occasionally "F"= Frequent "C"= Continual

- **Energy / Activity**
- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness

- **Emotions**
- Mood swings
- Anxiety, fear or nervousness
- Anger, irritability, aggressiveness
- Depression

- **Mind**
- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical co-ordination
- Difficulty in making decisions
- Stuttering or stammering
- Slurred speech
- Learning disabilities

- **Head**
- Headaches / Migraines
- Faintness
- Dizziness
- Insomnia

- **Eyes**
- Watery or itchy eyes
- Swollen, reddened or sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel vision

- **Ears**
- Itchy ears
- Earaches or ear infections
- Drainage from ear
- Ringing in ears, hearing loss

- **Nose**
- Stuffy nose / Sinus problems
- Hay Fever / Allergies
- Sneezing attacks
- Excessive mucous formation

- **Mouth / Throat**
- Chronic coughing
- Gagging, frequent need to clear throat
- Sore throat, hoarseness, loss of voice
- Swollen or discoloured tongue, gums, lips
- Canker sores

- **Heart**
- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest Pain

- **Lungs**
- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficulty breathing

- **Digestive Tract**
- Nausea or vomiting
- Bloated feeling
- Belching
- Heartburn

- **Elimination**
- Diarrhea / Constipation (please circle)
- Intestinal cramps
- Passing gas
- Frequent urination
- Painful urination
- Blood in waste products
- Mucous in waste products

- **Joints / Muscles**
- Pain or aches in joints
- Arthritis
- Stiffness or limitation of movement
- Pain or aches in muscles
- Feeling of weakness or tiredness

- **Skin**
- Acne
- Hives, rashes or dry skin
- Hair loss
- Flushing or hot flashes
- Excessive sweating

- **Weight**
- Binge or compulsive eating / drinking
- Craving certain foods
- Excessive weight
- Water retention
- Underweight

YOUR PERSONALITY PROFILE

(Please indicate which of the following words **strongly** define your character)

Animated	Adventurous	Analytical	Adaptable
Playful	Persuasive	Persistent	Peaceful
Sociable	Strong-willed	Self-sacrificing	Submissive
Convincing	Competitive	Considerate	Controlled
Resourceful	Respectful	Reserved	Spirited
Self-reliant	Sensitive	Satisfied	Positive
Planner	Patient	Spontaneous	Confident
Scheduled	Shy	Optimistic	Outspoken
Orderly	Obliging	Funny	Forceful
Faithful	Friendly	Delightful	Daring
Detailed	Diplomatic	Cheerful	Cultured
Consistent	Inspiring	Independent	Idealistic
Demonstrative	Decisive	Deep thinker	Dry humour
Musical	Mediator	Talker	Tenacious
Thoughtful	Tolerant	Lively	Leader
Loyal	Listener	Chart maker	Contented
Popular	Productive	Perfectionist	Permissive
Bold	Behaved	Balanced	

Brassy	Bossy	Bashful	Blank
Undisciplined	Unsympathetic	Unforgiving	Unenthusiastic
Repetitious	Resistant	Resentful	Reluctant
Forgetful	Blunt	Fussy	Fearful
Interrupts	Impatient	Insecure	Indecisive
Unpredictable	Unaffectionate	Unpopular	Uninvolved
Haphazard	Headstrong	Hard to please	Hesitant
Permissive	Proud	Pessimistic	Plain
Angered easily	Argumentative	Alienated	Aimless
Naive	Nervy	Negative attitude	Nonchalant
Wants credit	Workaholic	Withdrawn	Worrier
Tactless	Too sensitive	Timid	Inconsistent
Intolerant	Introvert	Indifferent	Messy
Manipulative	Moody	Mumbles	Show-off
Stubborn	Sceptical	Slow	Loud
Lord over others	Loner	Lazy	Scatterbrained
Short-tempered	Suspicious	Sluggish	Restlessness
Revengeful	Reluctant	Changeable	Crafty
Critical	Compromising		

REPORTING SYMPTOMS

1. Describe in detail, the onset of your symptoms. Outline any related mental, emotional or physical symptoms and/or any external condition(s) that may have contributed to your state of being at that time.

2. Outline all previous illnesses. Include any childhood diseases and if applicable, any lasting effects from these aliments. Were there any extensive therapies employed in the healing of these conditions? Did you have any reactions or long-term side effects to any such therapies?

3. Describe any symptom you are experiencing in terms of its location in the body. Does this symptom shift from one place in your body to another? Related symptoms elsewhere in the body? Particular sensations associated with the symptom? How it feels/looks/smells/tastes? Anything that makes the symptom unique, striking or unusual? If pain is involved, describe the pain you endure ex. a dull ache vs. a sharp stabbing pain, a constant or periodic pain etc. Describe the onset of your pain; slow vs. sudden? How intense is the pain?

4. Write down when your symptoms feel better or worse: time of day/ when hot or cold/ month/ season/ before or after eating/ sleep/ moving/ resting/ certain positions/ when occupied/ specific mental/emotional states.

5. Are you affected in any way by different kinds of weather? Dryness/ humidity/ approaching storms/ thunderstorms/ frost/ cloudiness/ low or high altitudes/ being by large bodies of water.

6. Urination (if of concern): Colour/ odour/ sediment/ quantity/ frequency/ urgency.

7. Stool (if of concern): Number of stools per day/ colour/odour/ hard/ dry/ large/ pasty/ bloody/ frothy/ slimy/ thin/ watery/ slender/ flat/ difficult or incomplete/ urging without stool.

8. Menses: Length of cycle/ length of period/ significant pain associated with menses/ length of period/ nature of the flow/ clotting/ cramping/ PMS/ mood swings/ bloating/ swollen tender breasts/ cravings/ vaginal discharge with or without menses.

9. Sex: Desires/aversion/ painful intercourse/ vaginal dryness/ impotency.

10. Perspiration: Profuse/ scant/ odour.

11. Body Temperature: Hot vs. cold body type/ hot or cold hands or feet/ hot flashes.

12. Sleep: Do you wake up at night? When? Why? How do you feel in the morning on rising? What position do you sleep-side/back/front? Are parts of the body covered or exposed with sleep? Do you have recurring dreams in your sleep? Are there any prominent themes to your dreams? Night terrors?

13. What motivates you in life? Are there lasting traits or issues from childhood that are still an issue today? Are there running themes in your life? eg. “All my life I’ve been...”.

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FEE SCHEDULE / LIABILITY WAIVER AND RELEASE SOMERTON NATURAL HEALTH INC.

I, , the undersigned understand that John Somerton is not a medical doctor. As such, I acknowledge that it is my right and responsibility, at any time throughout my treatment with John Somerton, to seek medical counsel and diagnosis, if so desired, from a medical doctor, for any present and/or future condition(s). I also reserve the right to terminate treatment at any time if so inclined. I acknowledge that the state of my health is my own responsibility and that I am exercising my right to choose an alternative methods of treatment that addresses my health in its entirety.

FEE SCHEDULE *(July 1, 2024)*

BIO-MAGNETIC RE-BALANCING	$ 40.00
BODY CHARGING	$ 40.00
BODY DETOX MASSAGE	$ 80.00
CASE TAKING (Initial Assessment)	$ 50.00
COLD LASER PAIN / SKIN THERAPY	$ 40.00
EMOTIONAL CENTERING THERAPY	$ 40.00
HAIR LOSS RESTORATIVE THERAPY	
Individual Sessions	$ 45.00
Groups of 10 Sessions	$ 400.00
IONIC FOOT BATH DETOXIFICATION	$ 45.00
JOINT MASSAGE	$ 80.00
STOP-SMOKING CONSULTATION	$ 50.00
WARM SCULPTING (FAT LOSS) THERAPY	$ 50.00
WEIGHT LOSS CONSULTATION	$ 50.00

Please Note:

- ❑ All fees are payable at the end of each consultation (Visa / Mastercard / Cheque / Cash). Fees do not include HST.
- ❑ Patients are required to notify Somerton Natural Health Inc. if they are unable to make an appointment at least 24 hours before their scheduled appointment time, otherwise a $ 50.00 service charge or session value equivalent will be applied to their account.
- ❑ Results will vary. There is no guarantee of cure.

I AGREE NOT TO HOLD SOMERTON NATURAL HEALTH INC., IT'S OWNERS, DIRECTORS, OFFICERS, EMPLOYEES, THERAPISTS, PRACTITIONERS, AGENTS, SUPPLIERS OR ASSOCIATES liable for any injury, damage, reaction, illness and/or mental or emotional trauma that I may sustain as a result of my ongoing treatments / therapies at Somerton Natural Health Inc. ... of which are all done entirely at my own risk and by my choice. I release, waive and forever discharge Somerton Natural Health Inc. of and from all claims, demands, damages, costs, expenses, actions and causes of action, in respect of death, injury, loss or damage to my person or my property, arising by reason of my attendance at or participation in activities at Somerton Natural Health Inc. I acknowledge that I have read the above acknowledgement, waiver and release agreement.

Patients Signature: _____ _____
(If under 18 yrs of age, a parent or guardian must sign on your behalf) Date