



# DR. LISA WEEKS

## NATUROPATHIC DOCTOR

### Naturopathic Medicine Welcome Package

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This package has been designed to assist you through the process of achieving your personal wellness goals. Please read carefully and bring a completed hard copy (or email me a scanned soft copy) of the *Health History Form* (pages 6-10) to your first visit.

Congratulations on taking this first step on your journey to optimal health. Personal wellness is a lifestyle choice and I am here to be your guide.

You may be reaching out to improve energy and vitality, recover from a specific illness or health concern, seek out natural alternatives or ways to complement your current prescriptions/treatments, prevent disease, and/or bring the body back into balance. Whatever your reason is, be prepared for a journey that can change your life for the better, *permanently*.

A Naturopath works to seek out the *root cause* of your symptoms using therapies that support the healing power of the body and nature that do not suppress your symptoms.

My intention is to guide you on your healing journey so that you can *live life to your fullest potential*.

### *Services*

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My services include: clinical nutrition, homeopathic medicine, herbal medicine, acupuncture, vitamin and mineral therapies, lifestyle counseling, hydrotherapy, drainage and detoxification.

Naturopathic Medicine can benefit the whole family. I treat all ages, including: infants, children, teens, adults and seniors.

Please follow me for regular health tips, articles and recipes on:

Twitter: @drlisaweeksND

Facebook: [www.facebook.com/DrLisaWeeksNaturopathicDoctor](https://www.facebook.com/DrLisaWeeksNaturopathicDoctor)

LinkedIn: [ca.linkedin.com/pub/lisa-weeks/5/aa4/a40/](https://ca.linkedin.com/pub/lisa-weeks/5/aa4/a40/)

If, after several visits, you are happy with my services, please feel free to refer your friends, family members and co-workers. I am currently accepting new patients.

## Frequently Asked Questions

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### What are some reasons to see a Naturopathic Doctor?

- You are sick of feeling sick
- You are looking to complement your existing medical treatments
- You are not feeling your best but are unsure why
- You want a simple yet effective exercise and nutrition plan
- You are worried about and want to prevent diseases that run in your family to be proactive about your health
- You are working towards a specific health goal that you want to achieve.

### What conditions can benefit from Naturopathic Medicine?

**Digestive:** IBS, GERD/acid reflux/heartburn, diarrhea, constipation, gas, bloating, inflammatory bowel diseases, parasites, Candida, hemorrhoids, fissures

**Immune:** autoimmune conditions, allergies, colds, flus, sore throats, ear infections, lung infections, urinary tract infections

**Skin:** eczema, psoriasis, acne, hives, dry skin, anti-aging, rashes, fungal infections

**Pain:** arthritis, injuries, strains, sprains, headaches, migraines, neck-pain, back pain, stress-related pain

**Hormonal Imbalances:** PMS, menopause, infertility (males and females), andropause, stress, thyroid conditions

**Sleep Disorders:** insomnia, trouble falling or staying asleep, not waking rested, restless sleep

**Fatigue,** exhaustion, burnout

**Mood Disorders:** depression, anxiety, seasonal affective disorder

**Pediatric Health:** immune disorders, frequent illnesses, skin conditions (eczema, diaper rash), digestive issues, sleep disorders, ADHD/ADD

**Disease Prevention** and health optimization

### How can Naturopathic Medicine help me if I am already healthy?

Much like a car gives you warning signs when the oil needs to be changed, your own body give you warning signs before things start to shutdown or malfunction. Naturopathic Medicine recognizes these symptoms and *determines the underlying cause of disease*, treating the problem before it becomes more serious.

### How is a Naturopathic Doctor trained?

Naturopathic Doctors (NDs) must complete at least 3 years of pre-medical sciences in University before completing the four-year full-time Naturopathic Medicine program from one of six accredited Naturopathic Colleges in North America. The Naturopathic program includes over 4200 hours of classroom training, over 1200 hours of supervised clinical training and studies in bio-medical sciences and naturopathic modalities. NDs must successfully pass 2 intensive licensing exams and obtain yearly continuing medical education credits.

### What can I expect during a visit to a Naturopathic Doctor?

Initial Visit – 90 minutes (adults); 60 minutes (kids)

Includes a discussion about your health concerns and goals, a review of your health history, a thorough physical examination and a Chinese medicine tongue and pulse diagnosis.

Second Visit – 60 minutes

Held approximately two weeks after your initial visit. We will review your complete personalized treatment protocol.

Third Visit - 45-60 minutes

Held approximately four weeks after your second visit. This visit is important as it is a chance to check in, make sure that the treatment protocol is understood and being followed, and to monitor any changes that may have occurred.

Follow-up Visits – 45-60 minutes

Conducted monthly, but may vary depending on the concern and the treatment plan decided on. As you progress on your treatment plan, you may only need to book in for an appointment every few months.

*NOTE:*

- Dr. Weeks is also available for follow-up appointments via Skype or by phone. The initial visit must be conducted in-person.

## What can I expect during an acupuncture visit to a Naturopathic Doctor?

### Initial Visit – 90 minutes

We will review your health concerns, I will perform a basic physical examination including a Chinese medicine tongue and pulse diagnosis, and you will receive a 20-minute initial acupuncture treatment.

### Follow-up Visits - 30-45 minutes

Visits are typically conducted once a week for 4-6 weeks, depending on the severity and duration of your health concern. After the initial 4-6 week appointments, maintenance treatments are typically conducted every 2-4 weeks depending on your health condition.

### *NOTES:*

- *If you are suffering from an acute illness, like a cold, flu, sore throat, headache or infection, you can book in for a short visit, phone or Skype appointment to help you recover quicker and reduce the chance that you will need antibiotics or medications.*
- *Seasonal visits are also recommended for detoxification in the fall and spring, immune support in the fall/winter and treatment for allergy prevention in the spring/summer*
- *A yearly physical exam and blood/lab test review is recommended to schedule with your Naturopathic Doctor. NDs can order blood tests or fax an "Authorization for Release of Records" form to your MD to receive your most recent results.*

## ***Appointment Booking***

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You can reach me by email ([lisaweeks.nd@gmail.com](mailto:lisaweeks.nd@gmail.com)) or by phone (647-667-2209) to schedule an appointment

## ***Naturopathic Fees***

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*\*As of Feb 12, 2014, NDs are no longer required to charge HST on Naturopathic visits. HST still applies to supplement sales and lab tests*

### **ADULTS:**

Initial Consultation:	90 minutes	\$190
Second Visit:	60 minutes	\$140
Subsequent Visits:	45 minutes	\$100
Subsequent Visits:	60 minutes	\$140
Subsequent Visits:	30 minutes	\$75

### **KIDS < 12**

Initial Consultation:	60 minutes	\$160
Second Visit:	45-60 minutes	\$140
Subsequent Visits:	30-45 minutes	\$100

### **ACUPUNCTURE**

Initial Consultation:	90 minutes	\$190
Sub. Acupuncture:	30 minutes	\$75
Sub. Acupuncture	45 minutes	\$100

## ***Payment***

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You can pay by cash, cheque or email transfer for Naturopathic visits, NOT credit/debit. Cheques can be made payable to "Lisa Weeks". Email transfers can be made to [lisaweeks.nd@gmail.com](mailto:lisaweeks.nd@gmail.com).

## ***24 Hour Cancellation Policy***

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I have a policy of 24-hrs notice. If I do not receive 24-hrs notice of cancellation, you will be invoiced for the full appointment fee. Please respect my time and let me know if you can't make an appointment

## *Introduction to Naturopathic Medicine*

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Your Naturopathic Doctor can draw from a wide range of therapies, and will develop a treatment plan specially designed for you. The most common modalities, which may be used individually or in combination, are described below:

### **Herbal (Botanical) Medicine**

Medicines derived from plants have been used for centuries in the treatment and prevention of disease. They are increasingly becoming the subject of a growing number of clinical research studies. While the active ingredients of some plant medicines are extremely powerful, they are safe and highly effective when administered by a trained Naturopathic Doctor.

### **Clinical Nutrition**

There is an intrinsic relationship between nutrition and wellness. Naturopathic Doctors deal with a wide range of problems relating to poor nutrition, including food sensitivities or reactions and factors that interfere with the body's absorption and utilization of vitamins and minerals. They can also diagnose and treat numerous conditions that result from nutrient deficiencies.

### **Traditional Chinese Medicine and Acupuncture**

Chinese pulse and tongue diagnosis, acupuncture, and the use of eastern botanical medicines comprise Asian Medicine, a system of health care that has been used effectively for thousands of years in Asia, but which has only been introduced to North America in the 20th century. Naturopathic Doctors complete over 300 hours of acupuncture training as part of their Naturopathic Medical degree. Small, sterile, non-reusable needles are inserted into specific points on the body and have been clinically tested in the treatment of headaches, pain and muscle tension, infertility, nausea, stress/anxiety, addictions to nicotine; caffeine; and other drugs, and to rebalance the body.

### **Homeopathic Medicine**

Originally developed during the 18th century by the physician Samuel Hahnemann, this unique form of medicine is used widely by medical practitioners in Europe but is just beginning to take hold in North America. Homeopathic medicine uses very dilute amounts of botanical, mineral, or other substances to treat specific ailments.

*"An ounce of prevention is worth a pound of cure." -Benjamin Franklin*

### **Hydrotherapy and Physical Medicine**

Hydrotherapy, or the stimulation of blood and lymphatic fluid circulation using hot and cold water, is also prescribed to patients extensively for boosting immune function and supporting detoxification, skin health, and overall vitality. Naturopathic Doctors are trained in the assessment and treatment of musculoskeletal disorders such as joint pain, back pain, neck pain, muscle tension, injuries, strains, and sprains and commonly work with physical therapists, chiropractors, massage therapists, and osteopathic doctors to support the healing process.

### **Lifestyle Counseling**

The foundations of health are clean air, clean water, exercise, healthy foods, and freedom from excess stress. Naturopathic Doctors are committed to educating and guiding their patients in making powerful positive lifestyle changes to achieve optimal health. Whatever your diagnosis, you can expect to receive some lifestyle counseling every time you visit a Naturopathic Doctor. Daily healthy habits including reducing stress and negative emotions will positively influence your health and contribute to your success.

### **Supplementation and Dietary Review/Counseling**

You are what you eat! Through tracking your food via a food journal and testing for food sensitivities and vitamin deficiencies, your Naturopathic Doctor will ensure you are getting the right foods and supplements to fuel your body. You will be provided with nutritional guidelines that are unique to you and your health concerns.

### **Disease Prevention**

By reviewing your family's health history, your Naturopathic Doctor can give you nutritional, supplemental, lifestyle, and herbal recommendations to help prevent or reduce symptoms of certain diseases. In addition, your Naturopathic Doctor can order and monitor certain blood values to ensure you are on the right path to prevention.

## *Additional Naturopathic Services*

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(Fees apply: not covered by OHIP)

### Online Naturopathic Dispensary

I offer an online Naturopathic dispensary for you to purchase your vitamins, herbs and supplements. This saves you time and money (prices are competitive with local health food stores). Shipping takes approximately 3-4 days.

<https://healthwavehq.ca/welcome/1weeks>

### Nebulized Glutathione

A non-invasive, effective inhalation therapy used for upper and lower respiratory tract infections, bronchitis, allergies, the common cold, lung repair after quitting smoking, chronic mucous/congestion and COPD. An essential part of any detoxification plan as glutathione is a powerful detoxifying agent.

### B12 Injections

An intramuscular injection in your upper arm or buttocks to boost energy levels, replace deficiencies, reduce numbness and tingling, and support memory, mood and concentration.

### Pascoleucyn Immune Booster Drink

A safe and effective natural immune booster to be given in the fall and winter to prevent or reduce recovery time of illnesses. With over 60 years of use, this herbal and homeopathic combination provides broad-spectrum support against viruses and bacteria by boosting immunity.

### Lab testing

An important part of your Naturopathic assessment: includes blood, urine and stool testing to determine food sensitivities (IgG), male/female/thyroid and stress hormone levels, nutrient deficiencies, digestive disorders and parasites.

## Adult Naturopathic Health History Form

LISA WEEKS HBSc., ND

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YY)

Name: \_\_\_\_\_  
Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YY) Age: \_\_\_\_\_ Sex: (circle one) M / F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Postal code: \_\_\_\_\_  
Telephone: (Home) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Work) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email: \_\_\_\_\_  
Marital status: (circle one) Single Married Divorced Separated Other: (please specify): \_\_\_\_\_  
May we send clinic-related information to your mailing/email address? Y / N Initial: \_\_\_\_\_  
May we leave voice-mail messages related to your visits? Y / N Initial: \_\_\_\_\_  
Emergency Contact: Name: \_\_\_\_\_  
Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relation: \_\_\_\_\_  
How did you hear about our Clinic? \_\_\_\_\_

Other HEALTH CARE PROVIDERS you are seeing:

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
(_____) _____	(_____) _____	(_____) _____

Please list your PRIMARY HEALTH CONCERNS, in order of importance to you:

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

### Health History

How would you describe your overall state of health? (circle one) Very poor Poor Fair Good Very good Excellent

List any SERIOUS MEDICAL CONDITIONS, DIAGNOSES AND/OR ILLNESSES: (including type and year of occurrence).

Condition/Diagnosis/Illness	Month/Year	How does this still affect you?

List any ACCIDENTS, INJURIES, SURGERIES AND/OR HOSPITALIZATIONS (including type and year of occurrence).

Accident/Surgery/Hospitalization	Month/Year	How does this still affect you?

List any known ALLERGIES (including food, drugs, insects, herbs, environmental). \_\_\_\_\_

Have you ever seen a Naturopathic Doctor before? Y / N If yes, for what reason? \_\_\_\_\_

What other treatments have you used, or are currently using (both conventional and alternative; ie. Chiropractic, Physiotherapy, Massage, etc.) \_\_\_\_\_

Do you have any of the following?

Amalgam (mercury) fillings? Y / N If yes, how many? \_\_\_\_\_

Root Canal? Y / N If yes, how many? \_\_\_\_\_

Periodontal disease? Y / N Grind your teeth at night? Y / N Sleep apnea? Y / N

Which of the following conditions apply to you? N = Now P = Past X = Never

<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	Chills	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Headache	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Change in thirst/appetite?
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Gall stones
<input type="checkbox"/>	Weakness	<input type="checkbox"/>	Eye problems	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	Change in mole	<input type="checkbox"/>	Glasses or contacts	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	Angina or chest pain	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	Rash	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	Skin cancer	<input type="checkbox"/>	Impaired hearing	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	Skin problems	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Murmurs	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Backache	<input type="checkbox"/>	Muscle spasms or cramps	<input type="checkbox"/>	Extremities Numb/swollen	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	Loss of memory	<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	Seizures or convulsions	<input type="checkbox"/>	Speech problems	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Phobias	<input type="checkbox"/>	Chicken pox	<input type="checkbox"/>	Cold sores	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Malaria	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Parasites
<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Herpes Genitalia	<input type="checkbox"/>	Sexually Transmitted Dz	<input type="checkbox"/>		<input type="checkbox"/>	

Please indicate what immunizations you have had (check all that apply):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Haemophilus influenza B |
| <input type="checkbox"/> Hepatitis A                          | <input type="checkbox"/> Tetanus booster               | <input type="checkbox"/> Smallpox                |
| <input type="checkbox"/> Hepatitis B                          | <input type="checkbox"/> Influenza ("Flu shot")        | <input type="checkbox"/> Polio                   |
| <input type="checkbox"/> Other _____                          |  |  |

Did you experience any adverse reactions to past immunizations? Y / N If yes, what was the reaction/side effects? \_\_\_\_\_

Have you traveled outside of Canada in the past year? \_\_\_\_\_

Do you get regular screening tests done by another doctor (Pap, blood tests): Y / N

## ***Women's Health***

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Are you currently on the Birth Control Pill? Y / N Brand? \_\_\_\_\_ Length of time on the Pill? \_\_\_\_\_  
Age of first period \_\_\_\_\_ Last menstrual period \_\_\_\_\_  
Length of monthly cycle (days) \_\_\_\_\_ Average length of flow (days) \_\_\_\_\_  
Last PAP exam (days) \_\_\_\_\_ Have you had an abnormal PAP? Y / N  
Last breast exam \_\_\_\_\_ Do you do self breast exams? Y / N  
Age of onset of menopause (if applicable): \_\_\_\_\_ Symptoms? \_\_\_\_\_  
Are you currently sexually active? Y / N  
Current forms of contraception? \_\_\_\_\_  
Number of: pregnancies? \_\_\_\_\_ Live births? \_\_\_\_\_ Miscarriages? \_\_\_\_\_ Abortions? \_\_\_\_\_  
Have you had any of the following concerning your breasts? (circle) Pain Lumps Infections Cysts Nipple discharge  
Do you have any sexual problems or concerns? Y / N If yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Are you currently pregnant? Y / N

## ***Men's Health:***

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Do you have difficulty achieving or maintaining an erection? Y / N  
Last prostate exam? \_\_\_\_\_ Was a blood test (PSA) done? Y / N  
How many times a night do you wake to urinate? \_\_\_\_\_  
Have you had any of the following symptoms with urination? (circle one)  
Pain Dribbling Incomplete Urgent Increased frequency  
Are you currently sexually active? Y / N  
Current forms of contraception? \_\_\_\_\_  
Have you had any of the following? (circle one) Testicular pain Hernia Penile discharge Sores STDs  
Do you have any sexual problems or concerns? Y / N If yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## ***Medication History***

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### **Medications:**

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Daily dose	How long	Medication	Daily dose	How long
1.			4.		
2.			5.		
3.			6.		

### **Supplements:**

Please list all current vitamins, minerals, herbs, homeopathics or other supplements, the daily dose and how long you have taken it.

Supplement	Daily dose	How long	Supplement	Daily dose	How long
1.			4.		
2.			5.		
3.			6.		



Please list all past prescription medications and supplements.

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How many courses of antibiotics have you had in the past 10 years? \_\_\_\_\_

Have you ever had a bad reaction to any medication or supplement? \_\_\_\_\_

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### *Family Health History*

Indicate if a close relative (parent, grandparent, sibling or child) has had any of the following:

Condition	Who?	Condition	Who?
Allergies		High blood pressure	
Alcoholism		High cholesterol	
Arthritis		Kidney Disease	
Asthma		Mental illness	
Cancer		Osteoporosis	
Chronic bronchitis		Rheumatic fever	
Depression		Skin diseases	
Diabetes		Stroke	
Emphysema		Thyroid condition	
Heart disease		Tuberculosis	
Hepatitis		Other	

☐ I don't know my family medical history

Has any family member passed away (parents, siblings, grandparents?) Y / N

If yes, who \_\_\_\_\_; age \_\_\_\_\_; how? \_\_\_\_\_

### *Diet*

Have you LOST / GAINED any weight lately? Y / N If yes, how much? \_\_\_\_\_

Please describe a typical day's diet

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Beverages \_\_\_\_\_

How many glasses of water do you drink per day? \_\_\_\_\_

Is your drinking water (circle): Tap Bottled Filtered Other: \_\_\_\_\_

Do you have any food allergies or sensitivities? Please list. \_\_\_\_\_

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Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? \_\_\_\_\_

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## *Lifestyle / Environment*

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Occupation \_\_\_\_\_

How stressful is your work or other aspects of your life? How do you handle these stresses? \_\_\_\_\_

\_\_\_\_\_

Are you regularly exposed to toxins or other hazardous substances (work, home, hobbies, etc.)? Please describe.

\_\_\_\_\_

Are you frequently exposed to animals (at work, home, etc.)? Y / N

Please indicate which of the following substances, if any, pertain to you. N= use NOW P= used in the PAST

Substance	N / P	Amount	Started?	Substance	N / P	Amount	Started?
Tobacco				Soda			
Coffee				Alcohol			
Black Tea				Recreational Drugs			
Appetite suppressants				Sleeping pills			

Are you frequently exposed to tobacco smoke (home, work)? \_\_\_\_\_

Have you ever been treated for alcohol/drug dependence? Y / N If yes, when? \_\_\_\_\_

How often do you participate in physical activities/exercise? (circle one) Daily 2-3X/week 4-5X/week Daily less than 1X/week

What types of activities/exercise? \_\_\_\_\_

\_\_\_\_\_

How many hours of television do you watch in a day? \_\_\_\_\_ Do you have a television in your bedroom? Y / N

What are your hobbies? What do you enjoy in life? \_\_\_\_\_

\_\_\_\_\_

How would you describe the emotional climate of your home? \_\_\_\_\_

\_\_\_\_\_

How would you rate your overall level of energy? (1=poor, 10=excellent) \_\_\_\_\_

How many hours of sleep do you get per night? \_\_\_\_\_

How would you rate your overall quality of sleep? (1=poor, 10=excellent) \_\_\_\_\_

Do you have trouble falling asleep? Y / N Staying asleep? Y / N

Do you awake rested? Y / N

Is there anything else you feel I should know? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THANK YOU for taking the time to fill out this form. The information provided will be used to assess your health care needs.**