



A Total Approach to Health and Wellness



NATUROPATHIC HEALTH HISTORY

Name _____ Date _____

Date of birth _____ (M/D/Y) Height: _____ Weight: _____ Sex: M F

Address: _____

City: _____ Province: _____ Postal Code: _____

E-mail Address: _____

Ph: (H) _____ (W) _____ (C) _____

(Check your preferred phone number above)

Emergency contact: Name: _____

Phone number: _____ Relation: _____

E-Mail Address: _____ Check if you want to receive any of the following through e-mail:

- Appointment Reminders Health Newsletters Special Offers Special Events

How did you find out about us?

- Healthcare Provider Lawyer Employer Clinic Materials
- Special Event Here Before Website Special Offer
- Can Pages Yellow Pages Family/Friends Signage

Who referred you?

Other health care providers you are seeing:

- 1. _____ 2. _____
- 3. _____ 4. _____

What are your health concerns, in order of importance to you?

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

What is the goal of your visit today?

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

Please list all current medications and supplements (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.).

Please list past prescription medications.

When was the last time you were treated with Antibiotics? _____

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often _____

Please indicate what immunizations you have had.

DPT (diphtheria, pertussis, tetanus) Haemophilus influenza B Hepatitis A

Tetanus booster; when? _____ "Flu" Hepatitis B

MMR (measles, mumps, rubella) Polio Smallpox

Other: _____

Any adverse reactions?: _____

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

If you are female, are you currently pregnant? Yes No

Please list allergies and your symptoms to allergen exposure: _____

Family History

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

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

I don't know my family medical history

Environment

Occupation: _____

Hobbies: _____

Do you exercise regularly? Yes No What do you do for exercise, how much, how often? _____

Are you exposed to significant tobacco smoke (work, home, etc.)? Yes No
Are you frequently exposed to animals (work, pets, etc.)? Yes No
Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?

Please describe: _____

Sleep Habits

Hours per night ____ Do you wake refreshed? _____ If not, Why? _____

Do you have problems: falling asleep staying asleep waking up

Energy Levels (average per week; circle one)

1 2 3 4 5 6 7 8 9 10
(Lowest energy) (Highest energy)

Stress Levels (average per week; circle one)

1 2 3 4 5 6 7 8 9 10
(Lowest stress) (Highest stress)

How do you cope with stress? _____

Who do you talk with about your problems? _____

What do you do for fun and how often? _____

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

Below are groups of symptoms. Please identify any that you may have experienced in the last 6 months with an "R", those long ago with a "P". Please also indicate number of times you have experienced them.

GENERAL:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Bleed/bruise easily | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Peculiar taste/smells | |
| <input type="checkbox"/> Sudden Energy Drop (time of day) _____ | | |

SKIN AND HAIR:

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Non-healing wounds | |
| <input type="checkbox"/> Recent changes in moles | <input type="checkbox"/> Itching | |

HEAD, EYES, EARS, NOSE AND THROAT:

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Colour blindness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Tooth pain |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Mercury fillings |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Using glasses | <input type="checkbox"/> Sores on lip/tongue | <input type="checkbox"/> Facial pain |

CARDIOVASCULAR:

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blood clots | |

RESPIRATORY:

- | | | |
|--|---|---|
| <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain with a deep breathe | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Production of Phlegm | <input type="checkbox"/> Other |

GASTROINTESTINAL:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Abdominal pain/cramps | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Nausea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bad breathe | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Diarrhea |
- Bowel movements _____ per day formed / loose / hard

URINARY:

- | | | |
|---|---|--|
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Odd colour/smell | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Other |

GYNAECOLOGICAL:

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Age of first menses | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Heavy flow |
| <input type="checkbox"/> Duration of menses | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Light flow |
| <input type="checkbox"/> Days between menses | <input type="checkbox"/> Breast tenderness | |
| <input type="checkbox"/> Date of start of last menses | <input type="checkbox"/> Vaginal discharge | |
| <input type="checkbox"/> Date of last PAP | <input type="checkbox"/> Vaginal sores | |

Are there changes in body or emotions prior to or during menstruation?

Describe: _____

Do you practice birth control? Y / N

What type of birth control and for how long? _____

Are you content with this method? _____

Number of pregnancies Number of births Miscarriages Abortions

NEURO-PSYCHOLOGICAL:

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Lack of co-ordination | <input type="checkbox"/> Anxiety |

Have you ever been treated for psychological issues before? _____

Do you fear causing any harm to yourself or others? _____