Optimum Wellness
INTEGRATED CLINIC

Tel: 780 439-1200 Fax: 780 434-6800

Chelation-Confidential Health Questionnaire

Date: _____

Name:_____Alberta Health Care #: _____

Address: _____

Street City Province Postal code

Telephone: (home) [____]_____(work) [_____]_____Best place to call *H or W*

E-mail:_____Cell : [____]_____Fax:[____]_____

Age: _____ Birth Date: M_____D_____Y_____ Occupation: _____

Sex: Male____Female_____Marital Status: *S M D W Sep* Number of Children: _____

Who are your other Health Care Providers?
(ie: MD, Naturopathic doctor, Chiropractor, Massage Therapist, Physiotherapist, etc)

1)_____ 2)_____ 3)_____

_____ _____ _____

_____ _____ _____

Tel: _____ Tel: _____ Tel: _____

How did you find out about our clinic? *Print Ads, Facebook, Google*
Who referred you? *Friend, Another heath care practitioner* *Name:*_____

Have you been treated by a Naturopathic Doctor before? *Y or N*

If 'yes', by whom?_____When? _____

For what reason(s)? _____

In Case of Emergency:

Contact: _____ _____ [____] _____
Full name Relation Telephone

Signature: _____ Date: _____

List your health concerns and how long they have been occurring, in order of importance:

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

Note to patient: Please complete this questionnaire with care. Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. This is a confidential record of your medical history. It will not be released without your prior authorization.

Medications

Check (✓) any of the following that you currently take or use.

□ Laxatives	□ Pain relievers	□ Antacids
□ Cortisone	□ Appetite suppressants	□ Antibiotics
□ Tranquilizers	□ Thyroid medication	□ Sleeping pills
□ Aspirin	□ Diet pills	□ Birth control pills

How many times have you been treated with antibiotics?_____When was the last time?_____

Please list all **"current"** prescription medications

Medication	Date started [m/y]	Dose	Effectiveness

Please list all **"past"** prescription medications

Medication	Date started [m/y]	Dose	Effectiveness

Please list all **"current"** vitamins, herbs, homeopathics, non-prescription, etc

Supplement / Vitamin (Brand Name)	Date started [m/y]	Dose	Effectiveness

Health History

Do you have any known contagious diseases at this time? *Y N*
If yes, what?_____

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

Please indicate any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that you have had. Include approximate dates.

_____

_____

_____

List any X-rays, CT scans, or other studies that you have had.

_____

_____

_____

Allergies

Are you sensitive or allergic to…
Any drugs?_____
Any foods?_____
Any environmentals?_____
Any chemicals?_____
Any supplements?_____

Immunizations

What immunizations have you had?

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Haemophilus influenza B
- ☐ MMR (measles, mumps, rubella)
- ☐ Chicken pox
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other: _____
- ☐ Flu shot
- ☐ Polio
- ☐ Smallpox

Please indicate any adverse reactions you have experienced from an immunization.

_____

_____

Illnesses

Which of the following conditions have you had?

	Alcoholism		Eating Disorder		Measles		Shingles
	Allergies		Gall stones		Mononucleosis		Skin disease
	Arthritis		Goiter		Mumps		Sinusitis
	Asthma		Gout		Parasites		Stroke
	Cancer		Hay fever		Pelvic inflammatory disease		Tonsillitis
	Chicken pox		Heart disease		Pneumonia		Venereal warts
	Cold sores		Hepatitis		Prostatitis		Warts
	Depression		Herpes genitalia		Rheumatic fever		Whooping cough
	Diabetes		Kidney disease		Sexual abuse		

Lifestyle

Do you meditate or use any relaxation exercises? _____

What level of personal stress are you experiencing right now? *Minimal Average Considerable Unbearable*

Circle those that apply. Main stressor: *Financial; Job related; Interpersonal; Marriage; Health; Family members; Spiritual; Unfulfilled expectations* or other: _____

Do you have regular sleeping habits? *Y or N* How many hours? _____

Circle if any apply to you: *Early riser; Difficulty falling asleep; Wake in middle of night; Nightmares*.

Do you exercise regularly? *Y or N* How often? _____

For the following, **circle "Y" for yes, "N" for no, or "P" for in the past**

Average 6-8hrs sleep per night?	Y N	Do you have a religious or spiritual practice? ↳If yes, what?	Y N
Do you awake rested?	Y N		
Have a supportive relationship?	Y N		
Have a history of abuse?	Y N	Do you drink alcohol? ↳ What type? ↳How many drinks/day?	Y N P
Do you use recreational drugs?	Y N P		
Do you eat out often?	Y N		
Do you drink coffee/black tea/cola?	Y N P	Do you smoke tobacco? ↳How many packs/day? ↳How many years?	Y N P
Do you eat refined sugar?	Y N		
Do you enjoy your work?	Y N		
Do you take vacations?	Y N	Exposed to significant tobacco smoke (i.e., 2nd hand smoke)?	Y N P
Do you spend time outdoors?	Y N		

Diet

Describe a typical day's diet.

Breakfast_____

Lunch_____

Supper_____

Snacks_____

How many cups/bottles/glasses do you drink on average per day?

Beverage	Amount	Beverage	Amount	Beverage	Amount
Water		Fruit juice		Coffee	
Tea		Vegetable juice		Beer	
Soft drinks regular		Herbal Tea		Wine	
Soft drinks diet		Milk		Liquor	

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

Family History

	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)						
Health (G=Good; P=Poor)						
Age at death (if deceased)						
Check (√) those applicable						
Allergies/Hay fever						
Arthritis						
Asthma						
Cancer						
Depression						
Diabetes						
Drug abuse/alcoholism						
Epilepsy						
Gonorrhea						
Gout						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Paralysis						
Pneumonia						
Skin Disease						
Syphilis						
Tuberculosis						
Other						
Cause of Death						

Toxin Exposure

Did you grow up near a refinery, battery or metal factory, crematorium, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

What has been your main type of employment?

Have you had any jobs where you were exposed to metal dust (lead, mercury, iron etc.), industrial poisons, chemicals, pesticides, solvents, fumes or other toxic materials? If "yes", please describe and give dates.

Have you ever had health problems after you put in new carpeting, new cabinets, painted, or did other refurbishing in your home? In your workplace?

Do you use pesticides, herbicides or other chemicals around your home?

Are you particularly sensitive to perfumes, gasoline or other vapours?

Thank you for taking the time to assist us in understanding your health!

CONSENT FORM

We would like to take this opportunity to welcome you to the Optimum Wellness Integrated Clinic. This clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body, mind and spirit in its own inherent healing power. We seek to improve your quality of life and health through natural means.

Naturopathic Doctors assess the whole person, taking into consideration the physical, mental, emotional and spiritual aspects of an individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. At the Optimum Wellness Integrated Clinic a thorough case history will be taken, a complaint oriented physical exam may be performed, and recent blood work and medical tests may be reviewed.

There are some slight health risks to naturopathic medical treatment. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements, herbs and/or homeopathic remedies
- Pain, bruising or injury from intra-muscular injections or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa

You understand that a record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others unless so directed by you or unless law requires it. You understand that information from your medical record may be analyzed for research purposes and that your identity will be protected and kept confidential.

_____
Initials

You understand that your naturopathic doctor will answer any questions that you have to the best of their ability. You understand that treatment results are not guaranteed. You do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, you voluntarily consent to diagnostic and therapeutic procedures, except for (please list any exceptions):_____.

_____
Initials

You intend this consent form to cover the entire course of treatment for your chief health concerns. You confirm that you have the ability to accept or reject this care of your own free will and choice. You also acknowledge that you are not representing an agency (private, governmental or otherwise) attempting to gather information without so stating.

_____
Initials

You understand that charges are to be paid at the time of the visit unless specific arrangements have been made prior to your scheduled appointment.

_____
Initials

You understand that you will be charged for any appointment that is missed or cancelled with less than 48 hours notice. The missed appointment fee that will be charged will depend on circumstances, with a minimum fee of $50.

_____
Initials

You will refrain from wearing scents/perfume due to the sensitivity of other patients.

_____
Initials

Patient Name: (Please Print) _____ Date: _____

Signature: _____