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

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						

Review of Systems

General

Comments?

Weight? ___________________ lbs Weight 1 year ago? ___________ lbs

Maximum weight? ___________ lbs Height? ___________________

↳When? ____________________

Skin

Y = Yes currently N = None P = in the Past

Rashes?	Y N P	Lumps?	Y N P
Eczema, hives?	Y N P	Hair loss?	Y N P
Acne, boils?	Y N P	Dryness?	Y N P
Itching?	Y N P	Night sweats?	Y N P
Colour change?	Y N P	Change in a mole?	Y N P
Temperature change?	Y N P	Skin cancer?	Y N P
Nail changes?	Y N P		

Comments?

Head

Headaches/Migraine?	Y N P	Head Injury?	Y N P
Hair loss?	Y N P	Jaw/TMJ problems?	Y N P

Eyes

Impaired vision?	Y N P
Blurred vision?	Y N P
Eye pain?	Y N P
Tearing or dryness?	Y N P
Discharge?	Y N P
Itching/redness?	Y N P

Nose and Sinuses

Frequent colds?	Y N P
Stuffiness/Sinus problems?	Y N P
Nose bleeds?	Y N P
Loss of smell?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P
Discharge?	Y N P	Infections?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Loss of taste?	Y N P
Teeth grinding?	Y N P	Sore tongue/mouth?	Y N P
Gum problems?	Y N P	Metallic taste?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Difficulty breathing?	Y N P
Spitting up blood?	Y N P	Pain on breathing?	Y N P
Asthma?	Y N P	Wheezing?	Y N P
Pneumonia?	Y N P	Bronchitis?	Y N P
Emphysema?	Y N P	Shortness of breath?	Y N P

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/low blood pressure?	Y N P	Fainting?	Y N P
Blood clots?	Y N P	Palpitations/fluttering?	Y N P
Swelling in ankles?	Y N P	Chest pain?	Y N P

Comments?

Gastrointestinal

Trouble swallowing?	Y N P	Change in thirst?	Y N P
Nausea?	Y N P	Change in appetite?	Y N P
Vomiting?	Y N P	Indigestion?	Y N P
Vomiting blood?	Y N P	Heartburn?	Y N P
Blood in stool?	Y N P	Constipation?	Y N P
Abdominal pain or cramps?	Y N P	Diarrhoea?	Y N P
Belching or passing gas?	Y N P	Gall bladder disease/gall stones?	Y N P
Black, tarry stools?	Y N P	Hemorrhoids/fissures?	Y N P
Jaundice (i.e., yellow skin)?	Y N P	Change in bowel movements?	Y N P
Liver disease?	Y N P	Bowel movements how often?	

Urinary

Pain on urination?	Y N P	Frequent infections?	Y N P
Increased frequency?	Y N P	Kidney stones?	Y N P
Urgency or hesitancy?	Y N P	Blood in urine?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Muscle weakness?	Y N P
Joint swelling?	Y N P	Sciatica?	Y N P
Muscle spasms or cramps?	Y N P	Backache?	Y N P
Arthritis?	Y N P		

Blood/Peripheral Vascular

Easy bleeding or bruising?	Y N P	Cold hands/feet?	Y N P
Deep leg pain?	Y N P	Extremity swelling?	Y N P
Varicose veins?	Y N P	Lymph node swelling?	Y N P
Anemia?	Y N P		

Neurologic

Seizures/convulsions?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Vertigo or dizziness?	Y N P	Speech problems?	Y N P
Fainting?	Y N P	Involuntary movement?	Y N P

Endocrine and Immune

Hypothyroid?	Y N P	Diabetes?	Y N P
Hyperthyroid?	Y N P	Heat or cold intolerance?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P
Excessive thirst?	Y N P	Hypoglycaemia?	Y N P
Excessive hunger?	Y N P	Excessive sweating?	Y N P
Excessive urination?	Y N P	Hormone therapy?	Y N P
Chronic fatigue syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

Comments?

Mental/Emotional

Treated for emotional problems?	Y N P	Memory problems?	Y N P
Mood swings?	Y N P	Anxiety or nervousness?	Y N P
Poor concentration?	Y N P	Depression?	Y N P
Tension and/or stress?	Y N P	Considered/attempted suicide?	Y N P
Phobias?	Y N P	Insomnia?	Y N P

Male Reproduction

Hernias?	Y N P	Premature ejaculation?	Y N P
Are you sexually active?	Y N P	Testicular masses/pain?	Y N P
Sexually transmitted infections?	Y N P	Prostate enlargement or disease?	Y N P
Type?		Discharge or sores?	Y N P
Impotence?	Y N P	Sexual preference:	
Do you use birth control? Type?	Y N P	*Heterosexual Bisexual Homosexual*	

Is there anything else that you would like to add or comment on?______________________________________

____

Thank-you for your time and effort.
I look forward to working with you on your journey to health and well-being.

"Those who do not find time every day for health
must sacrifice a lot of time one day for illness."
-Father Sebastian Kneipp

Women's Health

Are you pregnant, suspect you are pregnant, or breastfeeding? _________

Age of first menses?_____ Are your menses regular? *Y or N* Average number of days? ________

Length of cycle? ________ Last menstrual period? _______ Age of cessation of menses? _______

The blood flow during the menses is: *Not at all; Spotting; Moderate; Heavy; Heavy and clots* Do you have bleeding between periods? *Y N P* Any pain during intercourse? _____________________

Pain with the menses? *Not at all; Slight; Moderate; Severe; Incapacitating*

PMS Questionnaire

Rate each of the following symptoms of your last menstrual cycle only

SYMPTOMS	0, 1, 2, 3	SYMPTOMS	0, 1, 2, 3
Abdominal bloating		Forgetfulness	
Breast tenderness /lumps		Headache	
Craving for sweets		Increased appetite	
Crying		Insomnia	
Depression		Nervous tension/anxiety	
Dizziness or faintness		Mood swings	
Fatigue		Weight gain	

0 = not experienced
1 = mild [present but does not interfere with activities]
2 = moderate [present and interferes with activities but not disabling]
3 = severe [disabling; unable to function]

Are you now on or have you ever taken birth control pills? *Y N P* How long?______What type? ________

Are you now or have you ever used any hormone-modulating medications in the form of pills, patches, or creams [estrogen, progesterone, or birth control pills] *YNP* If yes, please list the type, dosage and frequency:

____

Y = Yes currently N = None P = in the Past

Fibrocystic breast disease?	Y N	Endometriosis?	Y N P
Do you do self-breast exams?	Y N	Uterine fibroids?	Y N P
Ovarian cysts?	Y N P	Cervical dysplasia?	Y N P
Vaginal discharge?	Y N P	Vaginal itching?	Y N P
Yeast infections?	Y N P	Difficulty conceiving?	Y N P
Sexually transmitted infections? Type?	Y N P	Sexual preference? *Heterosexual Bisexual Homosexual*	
Are you sexually active?	Y N		
Recurrent vaginal infections? *Never Rarely Frequently More than 3x/year*			
Any sexual difficulties?	Y N P	Last pap smear?	

Number of pregnancies?___________Deliveries?__________Miscarriages?________Abortions?________

Were there any complications associated with the above? _______________________________________

____

Menopausal symptoms? ____

____

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: ____