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

Chelation Confidential Health Questionnaire

Name:		Date:	
Email:		Health Care #:	
Street Address:			
City:		Province:		Postal Code:	
Cell Phone:		Home Phone:	
Work Phone:		Occupation:	
Age:		Birth Date(m/d /y):	
Gender:		Marital Status:	
No. of Children:			

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

1.		2.		3.	
Phone:		Phone:		Phone:	

How did you find out about our clinic? (ex. Print Ads, Facebook, Google)			
Who referred you? (ex. newspaper, internet, health food store, friend, another health care practitioner)			
Have you been treated by a Naturopathic Doctor before, Yes or No?			
If 'yes', by whom?		When?	
For what reason(s)?			

In Case of Emergency Contact:

Full Name:		Relation:		Phone:	

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)	☐	Hepatitis A	☐	Flu shot	☐
Haemophilus influenza B	☐	Hepatitis B	☐	Polio	☐
MMR (measles, mumps, rubella)	☐	Hepatitis C	☐	Smallpox	☐
Chicken pox	☐	Other: ________________			

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*

Check those that apply. Main stressor:

	Financial		Job related		Interpersonal		Marriage
	Health		Family members		Spiritual		Unfulfilled expectations
Other:							

Do you have regular sleeping habits?			How many hours?	
Which if any apply to you?		*Early riser*		*Difficulty falling asleep*
		Wake in middle of night		*Nightmares?*
Do you exercise regularly?			How often?	

For the following, **enter "Yes" "No" or "Past" where indicated.**

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

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 in understanding your health?

CONSENT FORM

We would like to take this opportunity to welcome you to the Optimum Wellness Naturopathic 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

_______ Initials — 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 yourself 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 naturopath 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 your credit card will be charged for the full visit fee if the appointment is missed or cancelled with less than 48 hours' notice. This fee is due at the time of the missed visit and must be paid before the patient's next appointment.

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

Patient Name: (Please Print) ______________________________ Date: ________________

Signature: ____