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

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	☐	☐	☐	☐	☐	☐

Review of Systems

General

Weight?		lbs	Weight 1 year ago?		lbs
Maximum weight		lbs	Height?		
↳When?					

Skin – Indicate Y = Yes currently N = None P = in the Past

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

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

Head

Headaches?		Head Injury?	
Migraines?		Jaw/TMJ problems?	

Eyes

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

Nose and Sinuses

Frequent Colds?		Nose bleeds?	
Stuffiness/Sinus problems?		Loss of smell?	

Ears

Impaired hearing?		Ringing?	
Earaches?		Dizziness?	
Discharge?		Infections?	

Mouth and Throat

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

Neck

Lumps?		Swollen glands?	
Goiter?		Pain or stiffness?	

Respiratory

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

Cardiovascular

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

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

Gastrointestinal

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

Urinary

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

Musculoskeletal

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

Blood/Peripheral Vascular

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

Neurologic

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

Endocrine and Immune

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

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

Mental/Emotional

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

Male Reproduction

Hernias?		Premature ejaculation?	
Are you sexually active?		Testicular masses/pain?	
Sexually transmitted infections?		Prostate enlargement or disease?	
↳Type?		Discharge or sores?	
Impotence?			

Do you use birth control?	
↳What type?	

Sexual preference:	*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?				Average number of days?					
Length of cycle?		Last menstrual period?				Age of cessation of menses?					
Blood flow during the menses is:											
Not at all:	☐	*Spotting*	☐	*Moderate*	☐	*Heavy*	☐	*Heavy and Clots*	☐		
Do you have bleeding between periods?				Any pain during intercourse?							
Pain with 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 tensions/anxiety	
Dizziness or faintness		Mood swings	
Fatigue		Weight gain	

Are you now on or have you ever taken birth control pills?		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]?			
↳If yes, please list the type, dosage and frequency.			

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

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

Number of pregnancies?		*Deliveries*?		*Miscarriages*?		*Abortions*?	
Were there any complications associated with the above?							
Menopausal symptoms?							