

Patient Information Form (Adult)

A detailed history is vital to the practice of Naturopathic Medicine. It is a team effort between you and I to investigate the nature and root cause of your disease and suffering. Therefore it is helpful to pay attention to what you experience and how you react to it. This includes all areas of your life. Your uniqueness and individuality will help to determine a holistic treatment plan specifically for you. Your participation and commitment is necessary for the success of this treatment plan. It is important that you become aware of the connection between your body, mind and stress and their impact on your health and wellness.

Full name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: _____ Sex: _____

Home address: _____ City: _____

Postal Code: _____ Home phone:(____)_____ Work Phone:(____)_____

Email _____

Would it be okay to contact you via email regarding appointments or clinic news? Y N

Live with(circle): Spouse Partner Parents Friends Children Pets Alone

Children (name and age):

Occupation: _____ Employer: _____

Referred by: _____

Emergency Contact Name: _____ Relationship: _____

Tel: (____)_____

Family Medical Doctor: _____ Tel: (____)_____

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

Complaint

Since

Causes

What medication (include prescription drugs and over the counter drugs) are you currently taking?

Medication

Dose

Since

Any adverse effects?

What other types of treatment are you currently following?

Treatment

Since

Results

What surgery or major injuries/illnesses have you had?

Surgery/Illness/Injury

When

Complications?

Do you have any allergies or food sensitivities? Please list:

Have any screening tests done?

Where have you travelled and when? Did you suffer any illness as a result?

What vaccinations have you received, when and what/if adverse side effects have you experienced?

<u>Vaccination</u>	<u>Date</u>	<u>Adverse Side Effect</u>
Tetanus	_____	_____
Pertussis	_____	_____
Diphtheria	_____	_____
Polio	_____	_____
Measles	_____	_____
Rubella	_____	_____
Mumps	_____	_____
Influenza	_____	_____
Hepatitis B	_____	_____
Hemophilus influenza	_____	_____
Tuberculosis	_____	_____
Coronavirus (please note type(s))	_____	_____

What is your:

Weight now _____ Weight 1 year ago _____ Max weight _____

Ideal weight _____ Height _____ Any loss of height? _____

Do you diet often? Yes _____ No _____

What exercise do you do and how much? _____

CIRCLE any of the following you may have had:

abscesses depression heart disease mononucleosis rheumatic fever syphilis alcoholism diabetes

hepatitis mumps rubella tonsillitis allergies emphysema herpes parasites scarlet fever

tuberculosis anemia epilepsy influenza pelvic inflamm.dis. sexual abuse typhoid fever arthritis

gall stones kidney stones peritonitis skin disease venereal warts asthma goiter leukemia pleurisy

strep throat warts cancer gonorrhea malaria pneumonia sinusitis whooping cough chicken pox

gout measles PMS sunstroke worms cold sores hayfever miscarriage prostatitis stroke yellow fever

Family History:

Have any of the above listed conditions affected your relatives?

<u>Relative</u>	<u>Age if alive</u>	<u>Age at death</u>	<u>Ailments</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mother (if living give details of health and illness)

Father (if living give details of health and illness)

Siblings and their status of health:

Spouse/partner and their health status:

Children and health status:

How much of the following substances are you using?

Tobacco: _____ Alcohol: _____

Coffee: _____ Recreational drugs: _____

Circle the environmental hazards you have been exposed to (past and present):

Chemicals tobacco smokes Radiation Heavy Chemicals other: _____

In general:

Is there a pattern to your symptoms (e.g. cyclic, repetitive, timely)?

Do you feel any of the present troubles are due to or connected to:

- The use or abuse of alcohol, drugs, coffee, cola beverages
- Excess mental or physical stress
- Sexual practices

Anger, anxiety, bitterness, excitement, fear, worry, injury, loss of sleep, travel, major changes Comments

Does the weather or geographical location affect your symptoms?

Why did you choose to come to this clinic?

What behaviours or lifestyle habits do you currently engage in regularly that you believe **support** your health?
Please list:

What behaviours or lifestyle habits do you currently engage in regularly that you believe are **self- destructive** lifestyle habits? Please list:

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?

The following is a review of systems form. It helps to jog your memory about symptoms that you may have forgotten about, but are relevant to your case.

Circle the number, which applies, to you. 1 means not so much/poor and 5 means yes/excellent.

I general feel relaxed	1	2	3	4	5
I sleep well and regularly	1	2	3	4	5
I wake rested and refreshed	1	2	3	4	5
I feel physically fit and healthy	1	2	3	4	5
I feel youthful and flexible	1	2	3	4	5
My energy level is good	1	2	3	4	5
I exercise 3 or more times weekly	1	2	3	4	5
I walk regularly	1	2	3	4	5
I eat healthy food	1	2	3	4	5
I take time for leisure activities	1	2	3	4	5
I enjoy my work	1	2	3	4	5
My relationship with coworkers is open and harmonious	1	2	3	4	5
I feel loved and supported by friends and/or family	1	2	3	4	5
I see challenges as opportunities	1	2	3	4	5
I feel in control of my life and work	1	2	3	4	5
I am generally free from pain	1	2	3	4	5
I have few health problems	1	2	3	4	5
I am committed to personal growth	1	2	3	4	5
I allow time for the spiritual dimension of life	1	2	3	4	5

For the following sections check the box beside the current or recurring symptoms. If it is a symptom that you have experienced in the past underline it.

GENERAL

- | | | |
|--|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed/bruise easily | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Peculiar tastes/smell | <input type="checkbox"/> Strong thirst (hot/cold drinks) | <input type="checkbox"/> Sudden energy drop |

SKIN & HAIR

- | | | |
|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent mole |
| <input type="checkbox"/> Change in mole | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Nail Changes | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Lumps |
| <input type="checkbox"/> Other _____ | | |

HEAD, EYES, EARS & THROAT

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glasses/contacts | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Colour blindness |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blind spot |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Red eyes | <input type="checkbox"/> Itchy eyes |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Frequent colds/flu | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Excess saliva | <input type="checkbox"/> Face pain |
| <input type="checkbox"/> Sore lips or tongue | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks |
| <input type="checkbox"/> Headaches: where and when _____ | | |
| <input type="checkbox"/> Other _____ | | |

CARDIOVASCULAR

- | | | |
|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Swelling hands or feet |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Murmurs | <input type="checkbox"/> Deep leg pain |
| <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Thrombophlebitis | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Have you had an ECG? _____ | <input type="checkbox"/> Other heart tests? _____ | |

RESPIRATORY

- | | | |
|--|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Shortness of breath (SOB) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> SOB at night | <input type="checkbox"/> Pain with a deep breath | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Production of phlegm? Y/N | <input type="checkbox"/> Colour of phlegm _____ | <input type="checkbox"/> Last chest x-ray? _____ |
| <input type="checkbox"/> Other: _____ | | |

GASTROINTESTINAL

- | | | |
|--|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Indigestions | <input type="checkbox"/> Black stools |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Belching | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Food allergies | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Bowel movements → | <input type="checkbox"/> How often? _____ | <input type="checkbox"/> Is this a change? _____ |
| <input type="checkbox"/> Other: _____ | | |

URINARY

- | | | |
|--|---|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Decrease to flow | <input type="checkbox"/> Frequent infection → | If so how often? _____ |
| <input type="checkbox"/> Wake at night to urinate? → | If so how often? _____ | |
| <input type="checkbox"/> Odour to urine? Describe: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

FEMALE/MALE/INTERSEX

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Heavy menses | <input type="checkbox"/> Vaginal itching | <input type="checkbox"/> Discharge or sores | <input type="checkbox"/> Light menses |
| <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Pain with intercourse | <input type="checkbox"/> Clots |
| <input type="checkbox"/> Do self breast exams | <input type="checkbox"/> Painful menses | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Bleeding between menses | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Irregular menses | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Abnormal pap | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Difficulty conceiving | <input type="checkbox"/> Testicular masses | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Hysterectomy: partial/complete | <input type="checkbox"/> STI's _____ | <input type="checkbox"/> Last pap _____ | |
| Sexual preference _____ | <input type="checkbox"/> Birth control _____ | | |
| <input type="checkbox"/> Menopausal symptoms _____ | | | |
- Age of first menses ____ Length of cycle ____ Duration of menses ____ Date of last menses ____ Number of: Pregnancies ____ Births ____ Miscarriages ____ Abortions ____ Adopted children ____

ENDOCRINE

- | | | |
|---|--|--|
| <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Excessive urination |
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Hormone therapy | <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Rapid weight gain |
| <input type="checkbox"/> Rapid weight loss | <input type="checkbox"/> Loss of height | |
| <input type="checkbox"/> Other: _____ | | |

MUSCULOSKELETAL

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Other: _____ | | |

NEUROLOGICAL

- | | | |
|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Area of numbness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety/nervous |
| <input type="checkbox"/> Quick temper/irritable | <input type="checkbox"/> Very susceptible to stress | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Involuntary movement | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Insomnia |