lakeview
naturopathic
clinic

Personal Information

Name _____ Age _____ Birth date _____

Address _____ City _____ Postal _____

Phone (home)_____ (work)_____
Okay to leave a message? Yes/No

Occupation_____Employer_____

Marital Status: Sgl Mar Div Sep CL Widowed Number of children_____

Emergency contact_____Relation_____

Phone_____ or phone _____

How did you find out about my
office?_____

Last physician or health practitioner seen?_____
when?_____

When was your last physical exam?_____

Blood tests done? Yes/No Blood Type_____

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Confidential Health History

What is your **main** reason for coming in today?

_____

_____

_____

List in order of importance other health problems that are troubling you:

1)_____ & length of time_____

2)_____ & length of time_____

3)_____ & length of time_____

4)_____ & length of time_____

What kind of medical treatment have you received?

_____

Have you ever seen a: Naturopathic doctor Chiropractor Acupuncturist Massage Therapist Osteopath Other Complementary health care practitioner?_____

What was the therapy and what were the results?_____

Your Health History

The general state of your health is: **excellent___ good___ avg___ fair___ poor___**
What is your current level of energy from 1 to 10 (where 10 is the best you have ever felt)?_____

What is your current approximate weight?_____ One year ago?_____ Ideal weight ?_____ Height?_____

Please list the 5 most significant, stressful events in your life:

1)_____ date_____

2)_____ date_____

3)_____ date_____

4)_____ date_____

5)_____ date_____

Are any of these situations continuing to impact your life? Yes/No (Please circle number)
Are you currently working with a professional counselor, psychologist, social worker, pastor, or other therapist?
___ Have you in the past_____ when?_____

Which of the following have you had and indicate now (n) or past (p):

	n	p		n	p		n	p		n	p
Allergies			Weight problems			Stroke			Venereal disease		
Asthma			Gallstones			Cancer			Syphilis		
Eczema			Gout			Epilepsy			Gonorrhea		
Psoriasis			Arthritis			Migraine			Miscarriage		
Ear infections			Thyroid problems			Pneumonia			Varicose veins		
Strep throat			Anemia			Diabetes			Broken bones		
Hay fever			High blood press.			Malaria			Numbness/tingling		
Measles			Rheumatic fever			Tuberculosis			Cold hands/feet		
Mumps			Fainting			Small pox			Visual problems		
Chicken pox			Poor memory			Polio			Warts		
Whooping cough			Balance problems			Yeast infections			Mono		
Diphtheria			Speech problems			Gas/bloating			Depression		
Scarlet fever			Ringing in ears			Hemorrhoids			Child abuse		
Sinusitis			Jaundice			Parasites			Physical abuse		
Canker sores			Hepatitis			Rectal bleeding			Sexual abuse		
Acne			Heart disease			Herpes			Emotional abuse		
Tonsillitis			Alcoholism			Headaches			Rape		

Other: _____

Are there any of these from which you feel you have never been well since? _____

Do you have any allergies to any drugs, herbs, foods, animals or other? Yes/No
Please specify: _____

Have you had any major injuries? If so, what happened and when?

_____

_____

Previous surgeries and hospitalizations (include dates)

_____

_____

_____

Were you vaccinated? Yes/No Did you have any adverse reactions (e.g.. fever)? Yes/No

Which of the following do you currently use? Please indicate how much, how often & how long

alcohol_____ tobacco_____
hormones_____ coffee_____
cortisone_____ laxatives_____
sedatives_____ antacids_____
recreational drugs (which ones) _____

Other medications (please give name, dose, and amount of time on the medication)

_____ / _____
_____ / _____
_____ / _____

Vitamins/herbs:

_____ / _____
_____ / _____
_____ / _____

Any other supplementation: _____

You currently live with? spouse____ partner____ parents____ friends____ children____ alone____
Are you currently in a happy supportive relationship? **Very Mostly Somewhat Not**

What is your weakest organ system and why? (example: digestive, immune etc.)
_____

Family History

	Age if Living	Age at Death	Cause of Death	Health Concerns
Mother				
Father				
Sister(s)				
Brother(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Any other blood relatives with notable health conditions (i.e. Cancer, heart disease, stroke etc.)				

Personal Habits

What do you enjoy most in your life?_____
What are your main interests or hobbies?_____
What do you worry about most in your life? _____
What nurtures you? _____
Do you exercise? Yes/No If yes, what and how often?_____
Do you have a religious or spiritual practice? Yes/No
On a scale of 1-10, how would you rate the quality of your sleep (10 being great) _____
Do you have a problem falling asleep?___ Staying asleep?____ How much do you sleep?_____hrs
How many hours of sleep do you think you need?_____ Do you wake refreshed?_____
Do you nap or rest horizontally throughout the day? Yes/No For how long? _____
How is your body temperature, compared to others? **Warmer Cooler Average**
Do you enjoy your work? Yes/No Do you take vacations? Yes/No
How often do you get colds, flu, sore throats in a year? _____
How do you learn? **I read I listen (lectures) Television Through stories Very visual Hands on**

Reproductive

Are you sexually active? Yes/No Is this more or less than one year ago? _____
Sexual preference: Heterosexual_____ Bisexual_____ Homosexual_____
Do you use birth control? Yes/No What type of birth control?_____

Female

Age of first menses _____ If periods have stopped, at what age did they stop? _____
Are your cycles regular? Yes/No Periods begin every_____days, and last _____days
Are your periods **Heavy medium light?** What colour is the blood? _____
Are there any clots? Yes/No Any cramps with your period? Yes/ No
Do you have any spotting or bleeding between your periods? Yes/No Every month? _____

Do you have any premenstrual symptoms? **Water retention breast tenderness irritability depression headaches anger mood swings crying bloating acne cravings Other:**

_____

Number of pregnancies_____ Number of abortions_____ Number of miscarriages_____
Number of live births_____ Any problems getting pregnant?_____
Do you get regular PAP smears? Yes/No Any abnormal PAP's Yes/No
Do you do regular breast self exam? Yes/No Have you noticed any breast lumps? Yes/No

Male

How often do you get up in the night to urinate? _____ Has this increased recently? Yes/No
Any problems with impotency? (getting or maintaining an erection) Yes/No
Do you have any sores on your penis? Yes/No _____
Do you have any abnormal discharge from the penis? Yes/No _____
Any venereal diseases?_____
Any prostate problems? Yes/No Have you had your prostate examined? Yes/No When? _____

Kidneys and Bladder

Have you had a bladder infection? Yes/No How often?_____ How was it treated? _____
Do you have any burning sensation during or after urination? **(Past Present Now)**
Is your urine **(dark yellow bright yellow cloudy pale or clear strong odour)**?
Do you have any difficulty starting or stopping when urinating? Yes/No _____

Perspiration

Do you have any difficulty perspiring? Yes/No Does your sweat have a strong odour? _____
Do you perspire when exercising? **(lightly moderately heavily*)***
Do you perspire at times other than when you exercise? Yes/No When?_____

Digestion and Elimination

Do you have any problems with gas, bloating, or fullness after eating? Yes/No
How often is this a problem? **often, sometimes, never** How severe? _____
How long have you had this problem? _____
How often do you have bowel movements? _____
Do you ever have any **blood mucous undigested food black stools**? Please circle
Any rectal itching? Yes/No Are your stools **formed or loose**? Any diarrhea? _____
Ever have alternating constipation and diarrhea? Yes/No How often? _____
Do you ever have yellow or light coloured stools? Yes/No
Do you ever have to strain to pass stool? Yes/No How often? _____
Do you pass gas (flatus) frequently? _____ Do you burp frequently? _____
Do your stools or gas have a strong disagreeable odour? Yes/No
Have you traveled outside of Canada in the last 5 yrs? Yes/No _____
Have you been camping in the last 5 yrs? Yes/No _____
Have you ever fasted? Yes/No (**juice or water)**_____

Occupational/household

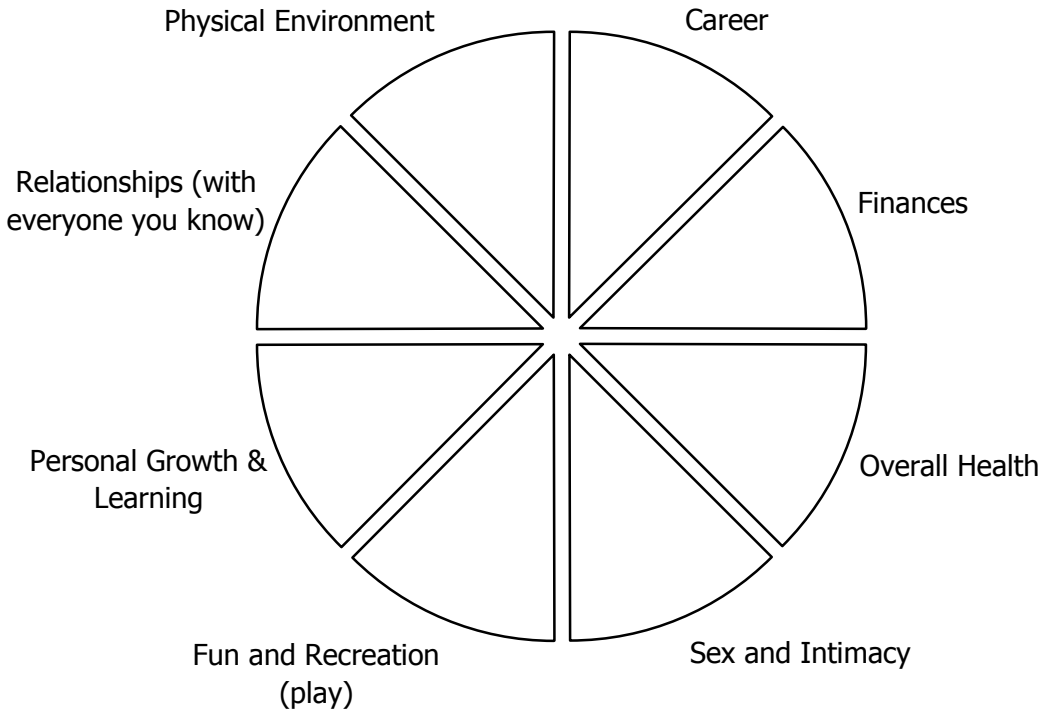
Is your home damp or moldy at all? Yes/No
Do you live in the city? Yes/No
Do you have a specialized air filtration at home? Yes/No
Do you work in an office building? Yes/No Do the windows open? Yes/No
Do you work in the presence of toxic fumes or chemicals? Yes/No
Do any of your hobbies involve toxic materials? Yes/No
Are you currently exposed to second hand smoke? Yes/No
What do you use for drinking water? **(tap water bottled water filtered water reverse osmosis)**

Is there anything else you feel I should know about you?

_____
_____
_____
_____

And now for the fun and *optional* portion. Please use whatever medium you like (pen, crayons, markers etc.) and fill in the following pieces of pie. Fill in the pie piece as full as this feels in your life. For example; if you feel you are at your absolute best health you would fill in the entire piece of pie but if you have never felt worse you would fill in only a very tiny portion of the pie. Start at the center and colour outwards towards the words.

Wellness Wheel



Thank you for taking the time to fill in this lengthy questionnaire. It will be a valuable resource in understanding your health