Patient Information Form (Adult)

A detailed history is viral 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 Therefor it is helpful to pay attention to what you experience and how you react to it. This includes al 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 to 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: _____

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 and what adverse side effects have you experienced?

Vaccination	Date	Adverse Side Effect
Tetanus		
Pertussis		
Diphtheria		
Polio		
Measles		
Rubella		
Mumps		
Influenza		
Hepatitis B		
Hemophilus influenza		
Tuberculosis		

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?

Relative Age if alive Age at death Ailments

_____

_____

_____

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 three expectations do you have from this visit to our clinic?
1.
2.
3.
What long-term expectations do you have from working with our clinic?

_____

_____

What expectations do you have of me personally as your physician?

_____

_____

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

What behaviors 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 <u>past underline it.</u>

GENERAL

- ☐ Poor appetite
- ☐ Fevers
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed/bruise easily
- ☐ Peculiar tastes/smell
- ☐ Sudden energy drop
- ☐ Poor sleep
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Weight loss
- ☐ Strong thirst (hot/cold drinks?)
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight gain

SKIN & HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in mole
- ☐ Nail Changes
- ☐ Other_____
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Skin cancer
- ☐ Night sweats
- ☐ Hives
- ☐ Acne
- ☐ Recent moles
- ☐ Dryness
- ☐ Lumps

HEAD, EYES, EARS & THROAT

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

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Rheumatic fever
- ☐ Anemia
- ☐ Easy bleeding
- ☐ Other: _____
- ☐ Have you had an ECG? _____
- ☐ Low blood pressure
- ☐ Palpitations
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Difficulty breathing
- ☐ Deep leg pain
- ☐ Easy bruising
- ☐ Other heart tests?_____
- ☐ Chest pain
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Murmurs
- ☐ Varicose veins
- ☐ Thrombophlebitis

RESPIRATORY

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

GASTROINTESTINAL

☐ Nausea ☐ Indigestions ☐ Black stools
☐ Vomiting ☐ Belching ☐ Blood in stools
☐ Constipation ☐ Gas ☐ Rectal pain
☐ Diarrhea ☐ Bad breath ☐ Hemorrhoids
☐ Ulcer ☐ Liver disease ☐ Gallbladder disease
☐ Abdominal pain ☐ Chronic laxative use ☐ Jaundice
☐ Food allergies ☐ Vomiting blood ☐ Rectal bleeding
☐ Bowel movements → ☐ How often? _____→ ☐ Is this a change?_____
☐ Other:_____

URINARY

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine
☐ Urgency to urinate ☐ Unable to hold urine ☐ Kidney stones
☐ Decrease to flow ☐ Frequent infections → If so how often?_____
☐ Wake at night to urinate? → If so how often? _____
☐ Odor to urine? Describe:
☐ Other:_____

MALE

☐ Hernia ☐ Testicular pain ☐ Herpes
☐ Impotency ☐ Prostate disease ☐ Testicular masses
☐ Discharge or sores ☐ STI's _____ ☐ Other:_____
Sexual preference: Heterosexual Bisexual Homosexual Other: _____

FEMALE

☐ Heavy menses ☐ Light menses ☐ Clots
☐ Painful periods ☐ Bleeding between periods ☐ Irregular periods
☐ Abnormal pap ☐ Vaginal discharge ☐ Vaginal sores
☐ STI ☐ Vaginal itching ☐ Ovarian cysts
☐ Sexual difficulties ☐ Pain on intercourse ☐ Endometriosis
☐ Breast lumps ☐ Nipple discharge ☐ PMS
☐ Difficulty conceiving ☐ Hysterectomy: partial/ complete ☐ Menopausal symptoms____
☐ Other_____ _____
☐ Do you do self breast exams?
Age of first menses:_____ Length of cycle_____ Duration of menses_____
Number of: pregnancies____ Births_____ Miscarriages _____ Abortions___Adopted children__
Date of last menses___ Last pap?_____ Birth control? What type? _____
Sexual preference: Heterosexual Bisexual Homosexual Other: _____

ENDOCRINE

- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Thyroid problem
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive urination
- ☐ Excessive sweating
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hormone therapy
- ☐ Excessive fatigue
- ☐ Rapid weight gain
- ☐ Rapid weight loss
- ☐ Loss of height
- ☐ Other: _____

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Muscle pain
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pain
- ☐ Hand/wrist pain
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Arthritis
- ☐ Sciatica
- ☐ Broken bones
- ☐ Other:_____

NEUROLOGICAL

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Area of numbness
- ☐ Lack of coordination
- ☐ Poor memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety/nervous
- ☐ Quick temper/irritable
- ☐ Very susceptible to stress
- ☐ Numbness/tingling
- ☐ Fainting
- ☐ Involuntary movement
- ☐ Speech problems
- ☐ Phobias
- ☐ Mood swings
- ☐ Insomnia