MANITOU WATERS NATUROPATHIC CLINIC

CONFIDENTIAL HEALTH QUESTIONNAIRE

Dear Patient: Please complete this questionnaire with care. Your answers will help me to determine the most effective health care for you. This is a confidential record of your medical history. It will not be released without your prior authorization.

Name: _____ Date of visit: _____

Age: _____ Birth date: _____

Address: _____
street city province postal code

Phone: (home) [ ] _____ (work) [ ] _____ Cell [ ] _____

Circle best place to call

E-mail:_____ Would you like to receive clinic updates / or upcoming events? (Your email will be held in strict confidence) Yes No

Occupation: _____

How did you hear of this office? _____ Referred by _____

Have you received Naturopathic care before? Yes _____ No _____ If yes, when? _____

Name of Practitioner(s) _____ For what reason(s)? _____

Name of Medical doctor (MD): _____ Phone: _____

Last Physician seen and when? _____

HEALTH HISTORY

What do you consider your most important health problem(s)? _____

_____

How long has it been occurring? _____

Have you had similar problems before? _____ Explain: _____

_____

Do you have any relatives with similar problems? _____

What do you feel is causing any health problems you may have? _____

_____

When did you last feel well? _____

Have you had any X-rays taken in the last five years? _____ Please list areas: _____

What surgery have you had? _____

Height _____ Blood type _____

Weight currently? _____ Maximum weight? _____ Minimum weight? _____

Are you satisfied with your present weight? _____ Have you ever had a weight problem? _____

Describe what diseases are predominant on both sides of your family

_____

_____

_____

What vaccinations have you had? DPTP MMR Tetanus Smallpox Flu shot

Did you experience any adverse reactions from them? _____

_____

Describe your family / work relationships:

_____

Do you meditate or use any relaxation exercise? _____

What are the things, which you find stressful? _____

What level of personal stress are you experiencing right now? Minimal Average Considerable Unbearable

Circle those that apply. Main stressor: Financial; Job related; Interpersonal; Marriage; Health; Spiritual; Family members; Unfulfilled expectations or other _____

_____

List any known allergies (food, drugs, environmental, etc.): _____

_____

Are / were you a smoker ? Y or N How long? _____ If you quit, when? _____

Does anyone else smoke in your household? _____ Does anyone smoke in your work place? _____

Do you have regular sleeping habits? Y or N How many hours? _____ Do you wake up rested? Y or N

Circle if any apply: Early riser; Difficulty falling asleep; Wake in middle of night; Snoring; Nightmares.

Do you exercise regularly? _____ If yes, include type, frequency and duration: _____

_____

Do you have difficulty perspiring? Y or N; Do you perspire at other times other than when exercising? Y or N

If yes, when: _____

How often do you have a full and complete bowel movement? _____

Do you experience gas or bloating after eating? Y or N Any heartburn? Y or N How often? _____

Do you or have you ever eaten large or regular amounts of chocolate? _____

Do you have amalgam dental fillings? Y or N How many? _____ Have you had any removed? Y or N

Root canals? Y or N When? _____ Dental implants? Y or N Periodontal disease? Y or N

Do you colour your hair? Y or N If your hair has turned grey, at what age were you? _____

How old is your home? _____ Has there been any kind of renovations / construction in your home recently [dry wall, paint, new carpets]? _____

Do you use a micro-wave oven? Y or N Electric blanket? Y or N Water bed? Y or N

What do you use for drinking water? Bottled Filtered Tap Water

How many cups/bottles/glasses do you drink on the 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	

List any vitamins, minerals, herbs and supplements that you are presently taking.

Supplement / Vitamin	Dose

Do you take any medication prescribed by your doctor? Y or N

Medication	Date started [m/yr]	Dosage

What other treatments are you currently following? (example, chiropractic, dietitian, physiotherapy, etc.)

_____

_____

What organ would you class as the weakest in your body and why? _____

Indicate which of the following you have or may have had:

	Abscess		Epilepsy		Malaria		Sinusitis
	Abortion		Frequent colds		Measles		Skin disease
	Alcoholism		Gall stones		Mono		Strep throat
	Anemia		Gout		Mumps		Stroke
	Anxiety		Hay fever		Parasites/worms		Sun stroke
	Asthma		Headaches		Peritonitis		Tonsillitis
	Cancer		Heart disease		Pleurisy		Tuberculosis
	Chicken pox		HIV		Pneumonia		Venereal disease
	Cold sores		Hypertension		Prostatitis		Warts
	Depression		Influenza/flu		Rheumatic fever		Whooping cough
	Diabetes		Kidney disease		Rubella		Tuberculosis
	Eczema		Leukemia		Scarlet fever		Venereal disease

Any other diseases, please list: _____

For the above conditions, are there any in which you have never fully recovered?

_____

What major injuries have you had?

Injury	When	Long term effects

What, if any, operations or surgeries have you had?

Operation	When	Complications

FOR MEN

Do you have difficulty with maintaining or achieving an erection? Y or N

Last prostate exam _____ PSA (blood test) Y or N

FOR WOMEN

Age of first menses _____ Are your menses regular? Y or N Age of cessation of menses _____

The blood flow during the menses is: Not at all; Spotting; Moderate; Heavy; Heavy and clots.

Pain with the menses: Not at all; Slight; Moderate; Severe; Incapacitating.

Are you now on or have you ever taken birth control pills? Y or N How long? _____

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.

_____

_____

Have you ever experienced fibrocystic disease of the breast? Y or N

Have you ever had uterine fibroids? Y or N

Do you have recurring vaginal infections? Circle which applies. Never Rarely Frequently More than 3x yr

Do you self-exam your breasts for lumps regularly? Y or N Last Pap Smear? _____

Single: Y or N Partnered/Married _____ years.

Number of children _____ Ages: _____

Number of pregnancies _____ Deliveries _____ Miscarriages _____ Abortions _____

Were there any complications associated with the above?

_____

_____

_____

Name:		# WEEKLY DIET DIARY				Date:	
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
am							
noon							
pm							
COMMENTS, FEELINGS, HOW IS YOUR BODY? (ENERGY LEVEL, DIGESTION)							