Successful healthcare and preventive medicine require a healthy relationship between the patient and practitioners. Your responses to the following questions will significantly contribute to my understanding of you and your health history. Please complete in as much detail as you feel is relevant and to the degree that you are comfortable. Thank you!

PERSONAL INFORMATION:

Name_____ Date of Birth _____ Age _____

What is your current gender identity? (Check ALL that apply)

☐ Male
☐ Female
☐ Transgender Male/Transman/FTM
☐ Transgender Female/Transwoman/MTF
☐ Gender Queer
☐ Additional category (please specify): _____
☐ Decline to answer

What sex were you assigned at birth? (Check one)

☐ Male
☐ Female
☐ Other
☐ Decline to answer

Address_____
City _____ Province _____ Postal Code_____
Phone # (home) _____ (mobile) _____
Okay to leave a message re: appointments? _____
Email _____
Occupation _____ Hours per week _____ Employer _____
Emergency contact _____ Relation? _____ Phone: _____
MSP Care Card #_____ Extended Coverage _____
How did you hear about our clinic?

_____

Has any other family member been a patient at the clinic? _____
If yes, who?_____

What is your main reason for seeking naturopathic care? If you have a specific health condition, please describe it in detail, i.e. when was the first time you noticed your condition and describe any factors that you suspect may have played a role in its onset and continuation.

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_____

_____

Please list any other health concerns (physical, emotional or mental) in order of importance:

_____

_____

_____

_____

Name of current general practitioner (MD):_____ Phone _____
List other health professionals you are seeing and include their area of practice (Eg. Massage):

_____ (Ph)_____

_____ (Ph)_____

_____ (Ph)_____

How do you rate your overall health? POOR FAIR AVERAGE GOOD EXCELLENT
How do you rate your overall energy? POOR FAIR AVERAGE GOOD EXCELLENT
Current Weight _____ Height _____ Wt. 1 yr ago _____ Max. adult Wt. ___ Min. adult weight _____

MEDICATIONS:
Please list all current medications (prescription and over-the counter):

Medication	Dose/day	How long?
1.		
2.		
3.		
4.		

Approximately how many times have you taken antibiotics? _____

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Have you had an adverse reaction to a medication? NO/YES List the Medication: _____

ALLERGIES:

List all (to medications, pollens, foods, animals etc.):

_____

_____

NATUROPATHIC REMEDIES:

List all naturopathic remedies (herbal, vitamin/mineral, nutritional, homeopathic etc.) you are taking:

1.	5.
2.	6.
3.	7.
4.	8.

CHILDHOOD MEDICAL HISTORY:

Please CIRCLE if you have had any of the following childhood illnesses:

Asthma	Measles	Rheumatic fever
Chicken pox	Mumps	Diptheria
Scarlet fever	Mono (how long? _____)	Tuberculosis
Eczema	Polio	Whooping cough
Frequent ear infections/colds	Rubella (German measles)	Other: _____

IMMUNIZATIONS:

Please CIRCLE all that you have had:

DPT	HAEMOPHILUS	INFLUENZA B	HEPATITIS A	HEPATITIS B
MMR	TETANUS	CHICKEN POX	SMALLPOX	
POLIO	FLU SHOT	OTHER: _____		

Any adverse reactions to a vaccination? Briefly describe if applicable:_____

_____

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Please list (with approximate dates) any serious illnesses, injuries, surgeries or hospitalizations.

_____

_____

_____

FAMILY HISTORY:

Please indicate whether any of your family members have, or have had, the following:

Condition	Relative	Condition	Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's Disease		Heart conditions	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (what type?)		Cancer (what type?)	
Depression		Stroke	
Other mental illness		Suicide	
Bleeding disorders		Infertility	
Glaucoma		Thyroid conditions	

LIFESTYLE FACTORS:

Any current dietary restrictions? (vegan, vegetarian, etc.)

_____

_____

How much water do you drink in a day? _____

On average, how many hours of sleep do you get each night?_____ Good Quality? Y / N

Do you exercise? Y / N

What type(s) of exercise and what frequency? _____

What do you enjoy for recreation and relaxation?_____

Do you have a religious or spiritual practice you would like me to know about?

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_____

_____

Do you currently consume any of the following? (Indicate how often, how much and for how long)

Alcohol _____ Tobacco _____
Coffee _____ Soft drinks _____
Black tea _____ Marijuana _____
Laxatives _____ Other _____

Are you frequently exposed to animals? Y / N
Exposed to toxins or hazards? Y / N, If so, list: _____
Please list the five most significant, stressful events in your life, from the most recent to the most distant.
Are any of these situations continuing to impact your life? (If so place a star next to the event):

1)_____Date_____

2)_____Date_____

3)_____Date_____

4)_____Date_____

5)_____Date_____

Relationship status: _____ Number of children + ages: _____
What is the emotional climate of your home?

_____

_____

_____

Rate your current stress level (CIRCLE): LOW AVERAGE HIGH UNBEARABLE
Which factors most contribute to your stress? (CIRCLE)

HEALTH WORK MONEY FAMILY RELATIONSHIP
OTHER:_____

MALE REPRODUCTION:
Do you have regular annual health screening tests? (blood work, prostate examination) Y / N

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Date of last prostate examination? (month/yr) ____ / ____
Are you sexually active? Y / N Have you been sexually active in the past? Y / N
Current forms of contraception?_____
Any difficulty with urination? Y / N How often do you urinate at night? _____
Have you had any of the following? (CIRCLE):

TESTICULAR PAIN HERNIA STIs DISCHARGE SKIN LESIONS

Do you have any sexual concerns? Y / N If yes, please explain:
_____

FEMALE REPRODUCTION:
Are you currently pregnant? Y / N
Do you get regular PAP smears Y / N Date of last PAP? (month/year) _____ / _____
Have you ever had an abnormal PAP? Y / N What was the outcome? _____
Age of first period? _____ Is your period regular Y / N
Length of monthly cycle (eg 28,32)? _____ Average # days of period or flow? (3,5,7) _____
Do you have spotting/bleeding between periods? Y / N
Do you experience PMS? Y / N
Please circle relevant PMS symptoms:
BLOATING BREAST TENDERNESS IRRITABILITY DEPRESSION
HEADACHES MOOD SWINGS FOOD CRAVINGS OTHER: _____

Are you menopausal? Y / N If yes, age of last period _____
Are you sexually active? Y / N Have you been sexually active in the past? Y / N
Current forms of contraception: _____
Have you ever had a sexually transmitted infection? Y / N
Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____
Have you ever had any of the following concerning your breasts? (CIRCLE)

PAIN LUMPS INFECTIONS CYSTS NIPPLE DISCHARGE

Do you experience vaginal infections? NEVER RARELY FREQUENTLY
Do you experience bladder infections? NEVER RARELY FREQUENTLY
Do you have any sexual problems or concerns? Y / N please explain: _____

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

_____

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What expectations do you have from this first visit to our clinic?

_____

_____

REVIEW OF SYSTEMS:
Please CIRCLE if you are currently experiencing any of the following symptoms OR if you have experienced any of these symptoms before write a "P" for Past.

GENERAL SYMPTOMS	EARS/EYES/NOSE/THROAT	CARDIOVASCULAR
Headache	Dental decay	Low blood pressure
Head injury	Gum disease	High blood pressure
Fever	Enlarged thyroid	Stroke
Chills	Tonsillitis	Hardening arteries
Sweats	Sore throat	Swelling of ankles
Dizziness	Hoarseness	Poor circulation
Fainting	Enlarged glands	Paralytic stroke
Loss of sleep	Glaucoma	Irregular heart beat
Fatigue	Vision problems	Shortness of breath
Nervousness/anxiety	Cataracts	Chest pain
Weight loss	Eye pain	
Numbness/pain in extremities	Ear discharge	GASTROINTESTINAL
Allergies	Deafness	Bloating
Convulsions	Hay Fever	Excessive thirst
Depression	Mercury dental fillings	Excessive hunger
	Earache	Acid reflux
SKIN	Nasal discharge	Eating disorders
Changes in moles	Sinus infections	Belching

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Hives/ allergic reactions	Nose bleeds	Gas
Acne/skin eruptions		Nausea
Itching (ears, skin, rectum)	MUSCLE & JOINTS	Vomiting
Bruising easily	Fracture/dislocations	Vomiting of blood
Dryness	Stiff neck	Abdominal cramps
Boils		Constipation

Thank you for taking the time to fill this out completely.

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