

**NATUROPATHIC HEALTH HISTORY - Adult**

Name \_\_\_\_\_ Today's date: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Place of birth (city/country) \_\_\_\_\_

MSP# \_\_\_\_\_

Current Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (cell/pager) \_\_\_\_\_

Please circle the best phone number for leaving messages.

E-mail address \_\_\_\_\_

Occupation/Place of work \_\_\_\_\_ full/part-time? \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

**EMERGENCY CONTACTS**

Name \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

**OTHER HEALTH CARE PROVIDERS (medical doctors, chiropractors, therapists, etc.)**

1. \_\_\_\_\_ Ph: \_\_\_\_\_

2. \_\_\_\_\_ Ph: \_\_\_\_\_

3. \_\_\_\_\_ Ph: \_\_\_\_\_

4. \_\_\_\_\_ Ph: \_\_\_\_\_

**What is your main health concern (your main reason for seeking naturopathic care)?**

**What are your other main health concerns, in order of importance to you:**

1. \_\_\_\_\_ For how long? \_\_\_\_\_

2. \_\_\_\_\_ For how long? \_\_\_\_\_

3. \_\_\_\_\_ For how long? \_\_\_\_\_

4. \_\_\_\_\_ For how long? \_\_\_\_\_

5. \_\_\_\_\_ For how long? \_\_\_\_\_

Have you ever received alternative health care for your health concerns? If yes, please indicate (naturopath, acupuncturist or Doctor of Chinese Medicine, homeopath, massage, etc.)

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What were the results of the above? \_\_\_\_\_

Are you still receiving this care? Y N

Have you received medical care for any of your health concerns (surgery, medication, etc.)?

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Are you still receiving this care? Y N

Please list all current medications (prescription or over-the-counter), supplements, herbal remedies, homeopathic remedies, etc. that you are taking:

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Please list all past medications, supplements, etc. that you are no longer taking, and indicate results and/or adverse effects:

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Have you had any recent laboratory tests (i.e. blood drawn, x-rays, others)? Please list below:

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**MEDICAL HISTORY**

How would you describe your general state of health? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_

Minimum adult weight \_\_\_\_\_ Maximum adult weight \_\_\_\_\_ (not including pregnancy)

On average, how would you describe your energy level (scale of 1-10, with 10 the highest) \_\_\_\_\_

Please list the five most significant stressful events or influences in your life, from the most recent. Are any of these events continuing to impact your life? (if yes, please place a star next to the event):

- 1. \_\_\_\_\_ Date \_\_\_\_\_
- 2. \_\_\_\_\_ Date \_\_\_\_\_
- 3. \_\_\_\_\_ Date \_\_\_\_\_
- 4. \_\_\_\_\_ Date \_\_\_\_\_
- 5. \_\_\_\_\_ Date \_\_\_\_\_

Do you currently work with a professional counselor, psychologist, social worker, priest, rabbi, psychiatrist, or other therapist? Y N Have you in the past? Y N

Please list all known allergies:

Foods: \_\_\_\_\_

Animals: \_\_\_\_\_

Medications: \_\_\_\_\_

Environmental/Seasonal: \_\_\_\_\_

Please indicate any previous injuries, serious illnesses, or hospitalizations. Include dates (approximate) if possible:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How many times have you been treated with antibiotics? \_\_\_\_\_

Most recent antibiotic use, and what for \_\_\_\_\_

Do you regularly use any of the following? (if yes, please indicate frequency)

Painkillers \_\_\_\_\_ Laxatives \_\_\_\_\_ Antacids \_\_\_\_\_

Diet pills \_\_\_\_\_ Birth control pills, implants, i.u.d., \_\_\_\_\_

Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_

Caffeine (tea, coffee, coke) \_\_\_\_\_

Antihistamines \_\_\_\_\_

Recreational drugs (which ones) \_\_\_\_\_

Have you had any of the following immunizations, either as a child or as an adult?

- |   |  |
|---|--|
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> Tetanus booster; most recent? _____ |
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella)        | <input type="checkbox"/> Haemophilus influenza B (HiB)       |
| <input type="checkbox"/> Flu shot                             | <input type="checkbox"/> Polio                               |
| <input type="checkbox"/> Hepatitis A                          | <input type="checkbox"/> Hepatitis B                         |
| <input type="checkbox"/> Other _____                          |  |

Did you have any adverse reactions to any of the above? (i.e. seizures, rashes, fever, etc.)

\_\_\_\_\_

I don't know my immunization history \_\_\_\_\_

Have you recently traveled to tropical areas? \_\_\_\_\_

Which of the following childhood conditions have you had?

- |                          |                 |                |
|--------------------------|-----------------|----------------|
| Rubella (German measles) | Measles         | Mumps          |
| Chicken pox              | Polio           | Scarlet Fever  |
| Pneumonia                | Bronchitis      | Roseola        |
| Colic                    | Ear infections  | Whooping cough |
| Asthma                   | Eczema          | Hay fever      |
| Impetigo                 | Tonsillitis     | Strep throat   |
| Mononucleosis            | Rheumatic fever | Other _____    |

Which of the following have you had as an adult?

- |                              |                     |                           |
|------------------------------|---------------------|---------------------------|
| Chronic infections           | High blood pressure | Low blood pressure        |
| Pneumonia                    | Bronchitis          | Psoriasis                 |
| Anemia                       | Hypoglycemia        | Diabetes, 1 or 2          |
| Heart disease                | Stroke              | High cholesterol          |
| Hepatitis                    | Cancer              | Kidney infections/disease |
| Asthma                       | Eczema              | Hay fever                 |
| Arthritis/chronic joint pain | Depression          | Anxiety                   |
| Mental Illness               | Mononucleosis       | Thyroid problems          |
| Seizures                     | STD's               | Cold sores                |
| Canker sores                 | Weight problems     | Alcoholism                |
| Drug Addictions              | HIV                 | Other _____               |

Do you get regular screening tests with your medical doctor (blood tests, PAP, mammograms, etc.) Y N

If yes, which? \_\_\_\_\_

### **FAMILY MEDICAL HISTORY**

Do any of the above conditions appear in your family history? Please indicate in the space below:

\_\_\_ I don't know my family medical history.

Please list approximate age, main health concern (if known), and, if deceased, cause of death, for the following members of your family (to the best of your knowledge).

	Age (if living)	Main health concern	Age at death	Cause
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Maternal:

Grandmother	_____	_____	_____	_____
Grandfather	_____	_____	_____	_____

Paternal:

Grandmother	_____	_____	_____	_____
Grandfather	_____	_____	_____	_____

What is your ethnicity? \_\_\_\_\_

Do you have any children? Y N      If yes, how many? \_\_\_\_\_

Do they have any health problems? \_\_\_\_\_

Have you ever in the past, or currently, been diagnosed with a mental illness? Y N

If yes, please indicate what \_\_\_\_\_

What would you say is your strongest area of health? \_\_\_\_\_

What would you say needs the most attention? \_\_\_\_\_

**DIETARY HISTORY**

Do you have any dietary restrictions, religious or ethical?

\_\_\_\_\_

Food cravings / Favourite foods: \_\_\_\_\_

Food aversions: \_\_\_\_\_

Have you ever noticed any questionable reactions to foods that have not been diagnosed as allergies?

\_\_\_\_\_

**LIFESTYLE**

What do you enjoy most in your life? \_\_\_\_\_

What are your interests/hobbies? \_\_\_\_\_

Are you (please circle)    Married    In relationship    Single    Separated/Divored    Widowed

What is your sexual orientation? \_\_\_\_\_

Do you exercise regularly?    Y    N

What do you do for exercise, how often, and at what intensity?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you enjoy your chosen form of exercise?    **Y**    **N**

What do you worry about most in your life? \_\_\_\_\_

Do you have a religious or spiritual practice, and what is it? \_\_\_\_\_

What is your occupation (employed, student, stay-at-home parent, etc.)? \_\_\_\_\_

Is this fulfilling for you?    **Y**    **N**

Do you take vacations?    **Y**    **N**

What is your level of education? \_\_\_\_\_ Are you happy with this?    **Y**    **N**

**HOME AND WORK ENVIRONMENT**

Are you regularly exposed to tobacco smoke?    **Y**    **N**

Are there animals at home or at work?    **Y**    **N**

How is your home heated? \_\_\_\_\_ Is your home damp? \_\_\_\_\_

Does your home or work expose you to known toxins or hazards? \_\_\_\_\_

Do any of your hobbies/interests expose you to toxins or hazards? \_\_\_\_\_

What are your current living arrangements? \_\_\_\_\_

How would you describe the emotional climate in your home? \_\_\_\_\_

How stressful is work/home life? \_\_\_\_\_

How much do you perceive this to impact on your health? \_\_\_\_\_

What do you do to deal with stress? \_\_\_\_\_

**FEMALE REPRODUCTION**

Age of first period \_\_\_\_\_ Age at menopause \_\_\_\_\_ Length of each period \_\_\_\_\_

Length of cycles \_\_\_\_\_ Regular/irregular? (circle one) Bleeding between periods? **Y N**

Please describe a typical period, in terms of flow, colour (dark or light), clotting, etc.

\_\_\_\_\_

Do you experience any of the following associated with PMS? (please circle)

Bloating Cramps Breast tenderness Irritability Depression Mood swings Headaches

Bowel changes Clumsiness Lethargy/Fatigue Change in appetite Brain fog Acne

Other: \_\_\_\_\_

Are you sexually active? **Y N** If you use birth control, which kind? \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ Abortions/Miscarriages \_\_\_\_\_

Difficulty conceiving \_\_\_\_\_

Date and result of last PAP smear \_\_\_\_\_

Date and result of last mammogram \_\_\_\_\_

Do you do self breast exams? **Y N**

Have you experienced menopause? \_\_\_\_\_ What age? \_\_\_\_\_ Difficulties? \_\_\_\_\_

Please briefly describe any symptoms you are experiencing, associated with menopause:

\_\_\_\_\_

**MALE REPRODUCTION**

Any difficulties with urinating? (please describe) \_\_\_\_\_

How often do you get up at night to urinate? \_\_\_\_\_ Since when? \_\_\_\_\_

Any difficulties with impotency (getting or maintaining an erection)? **Y N**

Any prostate problems that you know of? \_\_\_\_\_

Date and result of last prostate exam \_\_\_\_\_

Any STD's (Sexually Transmitted Diseases) that you know of? \_\_\_\_\_

Do you have any sores on your penis? **Y N** Any unusual discharge? **Y N**

Are you sexually active? **Y N** If you use birth control, what kind? \_\_\_\_\_

Do you have children? \_\_\_\_\_

Have you ever had any difficulty conceiving with a partner? \_\_\_\_\_

**AND FINALLY.....**

Please describe, in the space below, your health goals:

Is there anything else that you feel is important that has not been covered by the questions in this form?

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Thank you for taking the time to fully complete this form.

Your diligence is appreciated and important to the process of taking good care of your health.

**If you have any questions about any item on this form, please contact me at the number below.**

**All information on this form is confidential and will not be shared with any other individual or company without your explicit and signed consent.**



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