Comprehensive Patient Profile for Naturopathic Visits

Name: _____ Age: _____ Date of birth: _____ Sex: ____
(m / d / y)

Address: _____ City: _____ Postal code: _____

Phone numbers: (H)_____(W)_____ Occupation: _____

Who referred you to us? _____ Alberta Health Care No. _____
(for file tracking purposes)

Family doctor _____ Chiropractor _____

Other practitioners in your health care team: _____

Email address (for policy, course info and health info updates) _____

A note to clients seeking naturopathic care: Holistic, naturopathic and preventative health care are only possible when the doctor has a complete picture of the client physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionaire. Consider copying it for your own future records.

PRIMARY HEALTH CONCERNS:
In your opinion, what are your most important health concerns (chief complaints)?

Condition/complaint Diagnosed By: Since:

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

Which of the above problems are of most immediate concern to you? _____

_____

How did these conditions develop? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify as having caused or clearly aggravated your health problems? If you prefer, feel free to list these in chronological flow chart form on a separate page.

_____

_____

_____

PRIOR TREATMENTS AND RESPONSE:

Please list all of the former treatments you have used, both conventional and alternative and the degree of effectiveness of each treatment. Please be specific about the benefits you received (if any) from each treatment. This greatly aids us in developing an optimal treatment plan for you.

_____

_____

_____

_____

_____

MEDICAL HISTORY -- In the lists below, please circle all major illnesses you are experiencing now or have experienced in the past:

Measles (Rubeola)
German measles (rubella)
Chicken pox
Mononucleosis
Mumps
Scarlet fever
Whooping cough
Polio
Reye's syndrome
Typhoid
Cholera
Malaria
Food poisoning
Worms/parasites
Diarrhea
Dysentery

Acne
Carbuncles, Boils
Scabies
Poison ivy
Keloids
Impetigo
Ringworm
Eczema
Psoriasis
Warts
Ulcers on any body part
Skin cancer
Urticaria
Herpes
Shingles

Cancer (specify)

Colitis
Irritable bowel syndrome
Crohn's disease
Diverticulitis
Hiatal hernia
Constipation
Hemorrhoids
Stomach/duodenal ulcers
Appendicitis

Osteoarthritis
Rheumatism
Back pain/sciatica
Fibromyalgia
Gout
Rheumatoid arthritis

Strep throat
Scarlet fever
Tonsilitis
Sinusitis
Allergies (environmental)
Pneumonia
Asthma
Pleurisy
Tuberculosis
Bronchitis
Hay fever

Myasthenia gravis
Lupus
Raynaud's disease
Multiple sclerosis

Chronic fatigue syndrome
Environmental illness
Candida (yeast syndrome)

Spleen disease
Gall bladder disease
Jaundice
Pancreatic disease
Hepatitis
Other liver disease

Prostate problems
Kidney problems
Bladder problems
Diabetes
Hypoglycemia

Eye problems

Heart problems
Circulatory problems
High blood pressure
Low blood pressure
Fainting
Anemia
Varicose veins
Stroke
Platelet disorders

Migraine headaches
Dizziness/vertigo
Numbness
Palpitations
Cramps
Epilepsy
Meningitis

Schizophrenia
Bipolar disorder
Clinical depression
Eating disorder

Gonorrhea
Chlamydia
Syphilis
HIV
Genital herpes
Human papillovirusHPV
Genital warts
PMS
Fibrocystic breasts
Uterine fibroids
Endometriosis
Ovarian cysts
Vaginitis (recurrent)
Painful periods
Infertility

Malnutrition
Rickets
Osteoporosis
Hemochromatosis
Wilson's disease

Cushing's disease
Addison's disease
Hypothyroid
Hyperthroid (thyroiditis)

Other:

Immunizations:

Type	Smallpox	Polio	Meningitis	MMR	DTPP	BCG	Typhoid	Tetanus	Hepatitis	Flu	Hib	Cholera
How many times												

PRIOR DOCTOR-PATIENT RELATIONSHIPS

Please take a moment to reflect on your past relationships with your care providers and note how the relationships with future care providers could improve to optimize your health care. What do you need from your doctor that you have not received? How can you become more effective in your role with your doctor?

_____

_____

_____

_____

MEDICATIONS - List all your present medications including drugs, vitamins, minerals, homeopathics, herbs:

Drug/Nutrient: Purpose: Dose: Taken since:

_____

_____

_____

_____

_____

_____

_____

_____

Are you allergic to any medicines or other substance? If yes, please list:

_____

What happens when you have an allergy attack? _____

_____

What prior types of allergy testing have you had?

❍ Intradermal ❍ Scratch ❍ Blood IgG food ❍ Blood IgE inhalant/food ❍ Cytotoxic

❍ Electroacupuncture (VEGA, MORA) ❍ Kinesiology ❍ Food intolerance testing ❍ None

SURGERIES: Tonsils, Adenoids, Abdomen, Heart, Appendix, Hernia, Hemorroids, Joint replacement, Kidney stones, Gallstones, Uterus, Penis, Prostate, Hydrocele, Cataract

ACCIDENTS: Any major accident or injury to the body or head, any occasion of unconsciousness, any hemorrhage or major bleeding from any part of the body.

TRAUMA: Any serious shock, grief, major disappointments, severe fright, nervous breakdown, period of stress overload.

Please list all surgeries, accidents or traumatic events you have experienced:

Disease, Surgery, Accident, Trauma	Age	Duration	Recovered?	Treatment including meds

Type of Xray or diagnostic procedure:	Date	Hospital/Clinic
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY - Please put an "L" for living and a "D" for deceased. Age is at present or at time of death.

	L/D	Age	Conditions experienced or cause of death
Paternal grandfather	_____	_____	_____
Pateral grandmother	_____	_____	_____
Maternal grandfather	_____	_____	_____
Maternal grandmother	_____	_____	_____
Father	_____	_____	_____
Mother	_____	_____	_____
Paternal uncles	_____	_____	_____
Paternal aunts	_____	_____	_____
Maternal uncles	_____	_____	_____
Maternal aunts	_____	_____	_____
Brothers/sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

SOCIAL HISTORY

Does income meet monthly expenses? ❍ Yes ❍ No

Are you currently ❍ single ❍ married/common-law ❍ divorced No of children ____ Have you travelled outside of Canada in the past year? ❍ Yes ❍ No Where? _____

Military status: when did you serve? _____ where? _____

HEALTH HABITS

Do you use tobacco or have you in the past? ❍ Yes ❍ No Years since quitting: _____

How often do you use: cigarrettes ____ cigars ____ chewing tobacco ____ snuff ____

Do you now or have you in the past used marijuana or other drugs? ❍ Yes ❍ No

If yes, which drugs, how often and how long? _____

Have you ever been exposed to toxic chemicals, solvents or other possible toxins? ❍ Yes ❍ No

If yes, please explain: _____

Do you exercise? ❍ Yes ❍ No What form(s)? _____

How often? _____ How long for? _____

Do you make time for rest, relaxation or meditation during the day and/or before bed? ❍ Yes ❍ No

How often? _____ How do you relax? _____

What are your interests and hobbies? _____

Which of the following do you do on a regular basis: ❍Jog ❍Swim ❍Walk ❍Bicycle ❍Gardening ❍Yoga ❍Breathing exercises ❍Meditation ❍Weighlifting ❍Other

BEVERAGES

How many cups/bottles/glasses do you drink on the average of:

Coffee ____ Tea ____ Water ____ Milk ____ Fruit juice ____ Soft drinks ____ Vegetable juice ____

Herbal tea ____ Beer ____ Wine ____ Liquor ____

What is your drinking water source?

❍ Distilled water ❍ Filtered ❍ Spring/bottled ❍ Well ❍ Deionized ❍ Tap/city

DIET

How may meals do you generally eat each day? One __ Two __ Three __ More than three __

Where do you usually buy your food? _____

Who cooks the food you eat? _____

List your average breakfast: _____

List your average lunch: _____

List your average dinner: _____

List the foods you exclude from your diet: _____

_____

List any of the following (and relative amounts) eaten regularly by yourself. Coffee, caffeinated teas, highly seasoned foods, processed foods, refined foods, candy and any food you suspect might be harmful to your health.

_____

_____

List any foods you crave, regardless of their nutritional value (includes sweets, chocolate, salty, sour, bread, rich/fatty foods, etc.): _____

_____

_____

List any foods to which you have a bad reaction and what that reaction is:

_____

_____

What temperature liquid to you prefer to drink? __ Hot __ Cold __Room temp.

Are you satisfied with your diet the way it is now? Why or why not? _____

_____

_____

PERSONAL CARE - Which of the following do you do on a regular basis?

❍ Dry brush of skin ❍ Enemas ❍ Colon irrigation ❍ Hot/cold baths ❍ Sauna ❍ Shower

❍ Cosmetics ❍ Steam ❍ Mineral bath ❍ Bath oils ❍ Clay packs ❍ Flossing

❍ Toothbrushing (1/2/3) x per day ❍ Hair spray ❍ Deodorant ❍ Elec. hairdryer or blanket

What type of clothing do you wear? __ cotton __ wool __ synthetic __ dyed

Are you tolerant of tight fitting clothes or neckties? ❍ Yes ❍ No

SLEEP - Do you have trouble falling asleep? ❍ Yes ❍ No If yes, what keeps you up? _____

Do you sleep straight through the night? ❍ Yes ❍ No

Do you wake feeling refreshed? ❍ Yes ❍ No

Do you have recurring dreams? ❍ Yes ❍ No If yes, what is the theme? _____

_____

What position do you sleep in? _____

Is there a position you cannot sleep in? ❍ Yes ❍ No If yes, which one? _____

HOME ENVIRONMENT

Which of the following do you routinely use at home?

❍ Forced air	❍ Radiant heat	❍ Gas heat	❍ Oil heat	❍ Electric heat
❍ Wood stove	❍ Air conditioning	❍ Electric blanket	❍ T.V.	❍ Microwave
❍ Feather pillow	❍ Heated waterbed	❍ Computer screen	❍ Other _____	

OTHER ENVIRONMENTAL EXPOSURES

Are your home and work environments well ventilated? ❍ Yes ❍ No

Are your home or work environments excessively ❍ Moist ❍ Dry

Are there unusual or unpleasant smells in your work/living environment? ❍ Yes ❍ No

When were the ducts in your home last cleaned? _____

Which of the following are bothersome to you or are known allergies?

❍ Sunshine	❍ Dust	❍ Dampness	❍ Lack of sun	❍ Mold
❍ Dryness	❍ New moon	❍ Tobacco smoke	❍ Cold	❍ Full moon
❍ Perfume	❍ Heat	❍ Spring	❍ Car fumes	❍ Summer
❍ Winter	❍ Fall	❍ Dogs	❍ Cats	
❍ Seashore	❍ Grasses/weeds	❍ Mountains	❍ Tree pollens	

❍ Fluorescent lighting ❍ Foods (specify) _____

❍ Approach of storms ❍ Change of weather (specify) _____

❍ Poor air ventilation ❍ Chemicals (specify) _____

❍ Other _____

LIFESTYLE

How would you describe your present level of personal stress?
Minimal ____ Average ____ Considerable ____ Unbearable ____

What is the main stressor?

Financial ____ Job related ____ Interpersonal ____ Marriage ____ Health ____ Expectations ____
Family members ____ Spiritual ____ Unfulfilled expectation ___

How do you feel about your work? Do you enjoy it; are you satisfied and fulfilled by it; does it provide you with the necessities of life; is it just a job that you feel you must do in order to make a living? Are you overworked?

_____

_____

_____

How would you describe your relationships with co-workers? _____

_____

SYMPTOMS - Please mark (1)=mild, (2)=moderate, or (3)= severe next to the following symptoms which apply to you NOW or in the PAST.

Integument (Skin)

NOW	PAST	
____	____	Skin rough, dry, scaly, bumpy, itchy (circle if applicable).
____	____	Rashes, warts, moles, cysts (circle). Have any changed in size/color lately?
____	____	Light or dark patches of skin (circle if applicable).
____	____	Pimples. List location(s): _____
____	____	Color changes, ridges, pits, white spots on nails (circle if applicable).
____	____	Loss of hair. List location(s). _____
____	____	Hives. List what causes them:_____
____	____	Scars. List location(s): _____

Hematopoietic, Lymph, Immune

NOW	PAST	
____	____	Painful lymph nodes.
____	____	Difficulty stopping bleeding.
____	____	Bleeding from unusual places.
____	____	Bruising easily.
____	____	Wounds heal slowly.
____	____	Anemia
____	____	Swollen glands.
____	____	Fluid retention.
_____		Date of last BLOOD TESTS.

Head

____	____	Dizziness.
____	____	Severe headaches.
____	____	Seizures, convulsions.
____	____	Double vision.
____	____	Fainting spells.

Eyes

____	____	Poor eyesight (near or far).
____	____	Light hurts eyes.
_____		If older than 50, date of last glaucoma check.

Mouth

____	____	Sore mouth or tongue.
____	____	Speech difficulties.
____	____	Bleeding gums.
____	____	Loss of teeth.
____	____	Cold sores, blisters.
____	____	Amount of mercury amalgam.

Endocrine

NOW	PAST	
____	____	Unexplained weight loss/gain.
____	____	Prefers hot weather.
____	____	Prefers cold weather.
____	____	Can't stand cold.
____	____	Can't stand heat.
____	____	Cold hands and feet.
____	____	Fatigue, long term.
____	____	Weakness.
____	____	Increased thirst.
____	____	Increased hunger.

Ears

____	____	Discharge from ears.
____	____	Hearing problems.
____	____	Sensitivity to noise.
____	____	Pain in ears.
____	____	Ringing in ears.
_____		Date of last hearing check.

Nose

____	____	Nose bleeds.
____	____	Sinus congestion.
____	____	Loss of smell.
____	____	Nasal scabs/crusts.

Throat

____	____	Persistent hoarseness.
____	____	Difficulty swallowing.
____	____	Recurrent strep throat.
____	____	Loss of voice.
____	____	Chronic sore throat or pain.

SYMPTOMS - Please mark (1)=mild, (2)=moderate, or (3)= severe next to the following symptoms which apply to you NOW or in the PAST.

Respiratory

NOW	PAST		NOW	PAST	
____	____	Unexplained fever.	____	____	Dry sweats.
____	____	Chest pain when breathing.	____	____	Night sweats.
____	____	Wheezing.	____	____	Shortness of breath.
____	____	Difficulty breathing at night.	____	____	Daily cough.
____	____	Chest congestion.			

Have you ever been exposed to T.B. (tuberculosis)? ❍ Yes ❍ No

When was your last T.B. test? _____ Results? _____

When was your last chest X-ray? _____ Reason? _____ Results? _____

Have you ever blown into a chamber as a test for lung function/capacity? ❍ Yes ❍ No Date_____

How many pillows do you sleep on? _____

Cardiovascular

NOW	PAST		NOW	PAST	
____	____	Chest pain when walking.	____	____	Leg vein problems.
____	____	Chest pain when sitting/lying.	____	____	Leg pain when walking.
____	____	Ankle or abdominal swelling.	____	____	Numbness/tingling in arms/legs.
____	____	Heart palpitations - fibrillation	____	____	Heart murmur (type) _____
		flutter, skipping beat, beating	_____		Date of last exercise stress test
		fast, beating slow (circle if yes)	_____		Date of last EKG.
_____		Date of any blood vessel studies.	_____		Date of last echocardiogram.

Have you had rheumatic fever or syphilis? ❍ Yes ❍ No If yes, when _____

How far can you walk? _____ How many stairs can you climb before having to stop? _____

What makes you stop? _____

Urinary

NOW	PAST		NOW	PAST	
____	____	Frequent urination	____	____	Painful urination.
____	____	Night urination.	____	____	Difficult starting urine.
____	____	Difficulty holding urine.	____	____	Blood in urine.
_____		Dates of cystoscopy, IVP, KUB, X-rays.			

FOR MEN ONLY Male Reproductive

NOW	PAST		NOW	PAST	
____	____	Prostate problems.	____	____	Painful erection.
____	____	Swelling, lumps, pain in testicles.	____	____	Difficulty achiev/maint. erection.
____	____	Discharge from penis.	____	____	Difficulty /premature ejaculation.
____	____	Infertility.	_____		Date of last prostate exam.

Are you currently sexually active? ❍ Yes ❍ No

What type of contraceptive do you use? _____

SYMPTOMS - Please mark (1)=mild, (2)=moderate, or (3)= severe next to the following symptoms which apply to you NOW or in the PAST.

Gastrointestinal

NOW	PAST		NOW	PAST	
____	____	Constipation.	____	____	Indigestion immediately after eating a meal.
____	____	Diarrhea.	____	____	Indigestion 2-3 h after meals with bloating/pain.
____	____	Alternating constipation/diarr.	____	____	Stomach pain 5-6 h after eating, usually at night,
____	____	Change in bowel movements.			relieved by eating or drinking.
____	____	Strain at stool.	____	____	Above symptoms worse with worry/stress.
____	____	Hemorrhoids.	____	____	Heavy, full after eating.
____	____	Black stools.	____	____	Nervous, shaky with headache, better sweets.
____	____	Blood in stools.	____	____	Sudden, strong cravings with sweets or alcohol.
____	____	Stools - yellow, grey, green	____	____	Irritable if late for a meal, miss meal or on waking.
		foul odored, black, undigested	____	____	Appetite change - increase or decrease (circle).
		matter (circle).	____	____	Loss of appetite.
_____		Number of bowel movements.	____	____	Insatiable appetite.
_____		Date of last HEMOCCULT	____	____	Weight change - increase or decrease (circle).
		test (hidden blood in stool).	____	____	Diet but fail to lose weight.
____	____	Vomiting blood.	____	____	Eat but fail to gain weight.
____	____	Frequent or severe nausea.	____	____	Overweight.
____	____	Heartburn.	____	____	Underweight.
____	____	Trouble swallowing.	____	____	Compulsive eating.
____	____	Excessive belching.	____	____	Addictive eating.
____	____	Excessive lower bowel gas.	____	____	Anorexia.
____	____	Difficulty belching, stomach	____	____	Bulimia.
		cramps, colic.	____	____	Stomach/abdominal pain.
____	____	Abdominal bloat/distension.	____	____	Yellow jaundice.
____	____	Distress from fat/greasy food.	____	____	Bad taste in mouth.
____	____	Bad breath.	____	____	Intestinal parasites suspected.
____	____	Body odor (incl. feet).	_____		Date of last sigmoidoscopy.

FOR WOMEN ONLY -- Female Reproductive

NOW	PAST		NOW	PAST	
____	____	Lumps in breast(s).	____	____	Painful sex.
____	____	Nipple discharge.	____	____	Lack of sexual desire.
____	____	Breast pain.	____	____	Difficulty feeling sexual arousal.
____	____	Pelvic pain.	____	____	Never/seldom have orgasms.
____	____	Discharge from vagina.	____	____	Menstruation excessive.
____	____	Vaginal itching/burning.	____	____	Menstruation absent.
____	____	Genital eruptions (specify)	____	____	Bleed/spot between periods.
		_____	_____		Date of last mammogram.

Have you ever used birth control pills? ❍ Yes ❍ No If yes, how long _____

Side effects? _____

Have you ever used an IUD? ❍ Yes ❍ No How long? _____ What kind? _____

Side effects? _____

FOR WOMEN ONLY -- Female Reproductive

Cont'd Are you currently sexually active? _____

Current form of contraception

_____ Age of first menstruation

_____ Did you have a normal puberty? ❍Yes ❍No

Periods occur every _____ days. Regular? ❍Yes ❍No Periods usually last _____ days on average.

Date of last period _____.

Please mark B if before, D if during or A after menstruation.

PMT-A	PMT-D	PMT-C	PMT-H
____ Nervous tension	____ Depression	____ Headache	____ Weight gain
____ Irritability	____ Forgetful	____ Craving for sweets	____ Abdominal bloating
____ Mood changes	____ Crying	____ Increased appetite	
____ Swelling of extremities		____ Anxiety	____ Confusion
____ Heart pounding	____ Breast tenderness	____ Insomnia	
____ Dizziness or faint	____ Fatigue		

Date of last PAP smear _____. Was it normal? ❍Yes ❍No

Have you had in the past, or do you currently have problems with infertility? _____

_____

____ # of pregnancies ____ # of births ____ # of miscarriages _____ # of abortions

Any complications of pregnancy? ❍Yes ❍No If yes, please explain: _____

_____

SYMPTOMS - Please mark (1)=mild, (2)=moderate, or (3)= severe next to the following symptoms which apply to you NOW or in the PAST.

Pituitary

NOW	PAST		NOW	PAST	
____	____	Failing memory.	____	____	Low blood pressure.
____	____	Increased sexual desire.	____	____	Decreased sexual desire.
____	____	Splitting headaches.	____	____	Menstrual disorders.
____	____	High/low sugar tolerance.	____	____	Intestinal bloating.
____	____	Abnormal thirst.	____	____	Chunky hips or waist.
____	____	Ulcers, colitis.			

Thyroid

NOW	PAST		NOW	PAST	
____	____	Overweight.	____	____	Decreased appetite.
____	____	Difficulty losing weight.	____	____	Nervousness.
____	____	Constipation.	____	____	Heart palpitations.
____	____	Tired upon rising.	____	____	Irritable/restless.
____	____	Easily fatigued.	____	____	Increased appetite.
____	____	Dry or scaly skin.	____	____	Underweight.
____	____	Chilly/sensitive to cold.	____	____	Flush/get hot easily
____	____	Mental slowness.	____	____	Insomnia.
_____		Date of last thyroid test.			

SYMPTOMS - Please mark (1)=mild, (2)=moderate, or (3)= severe next to the following symptoms which apply to you NOW or in the PAST.

Adrenals

NOW	PAST		NOW	PAST	
____	____	Easily stressed.	____	____	Nails weak, ridged.
____	____	Easily/chronically fatigued.	____	____	Tendency to get hives.
____	____	Dizziness.	____	____	Rheumatism/arthritis.
____	____	Headaches.	____	____	Poor circulation.
____	____	Hot flashes.	____	____	Increased blood pressure.
____	____	Bronzing of the skin.	____	____	Weak after getting a cold.
____	____	Craves salt.	____	____	Facial hair (women).

Sympathetic Nervous System

NOW	PAST		NOW	PAST	
____	____	Upset from acid foods.	____	____	Cold extremities.
____	____	Dry eyes, nose, mouth.	____	____	Light sensitive.
____	____	Nervousness.	____	____	Decreased urine output.
____	____	Wounds that heal slowly.	____	____	Heart pounds when lying.
____	____	Gag easily.	____	____	Reduced appetite.
____	____	Very quick mentally.	____	____	Frequent cold sweats.

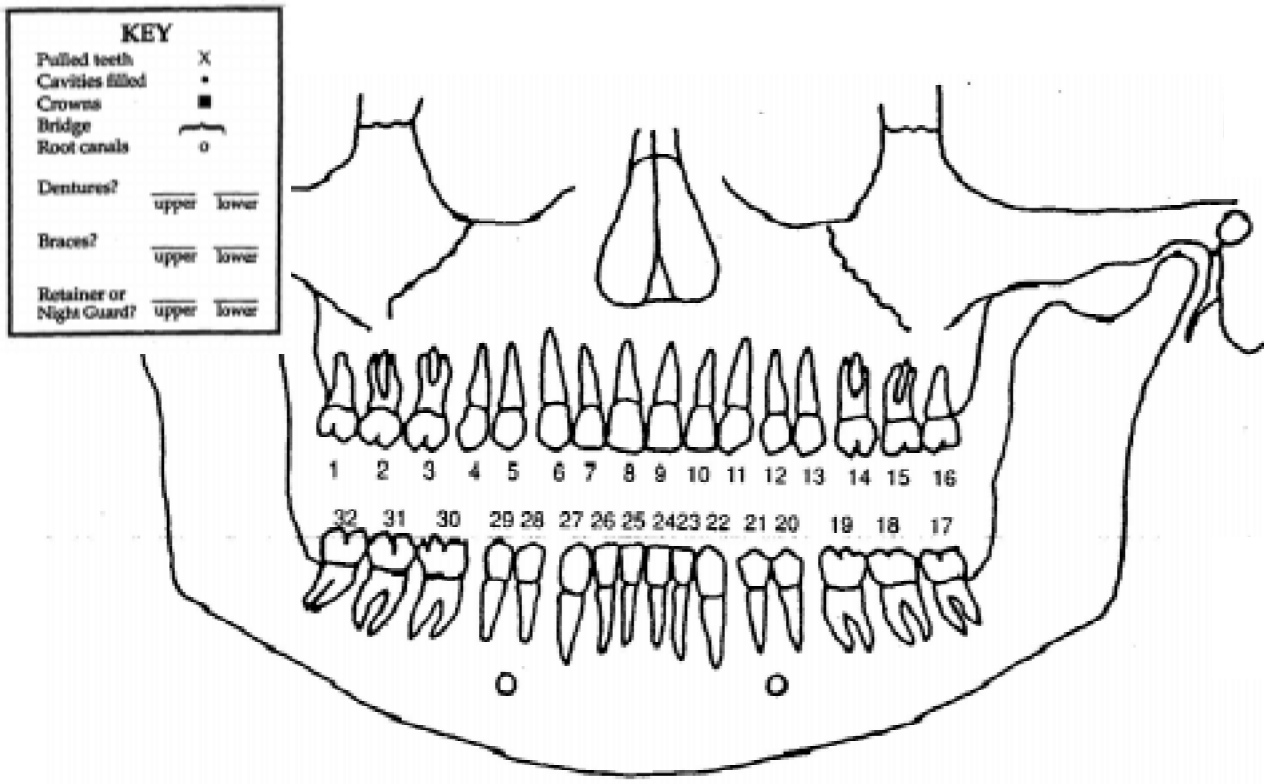
Parasympathetic Nervous System

NOW	PAST		NOW	PAST	
____	____	Joint stiffness on rising.	____	____	Frequent vomiting.
____	____	Muscle/leg/toe cramps	____	____	Alternating constipation/diarrhea
____	____	Butterflies in stomach	____	____	Pulse slow/regular.
____	____	Digestion rapid	____	____	Breathing irregular
____	____	Indigestion after eating.	____	____	Poor circulation.
____	____	Perspiration scant/absent.	____	____	Eyelids swollen/puffy.
____	____	Perspire easily/profusely.			

Central and Peripheral Nervous System

NOW	PAST		NOW	PAST	
____	____	Loss of balance/fainting.	____	____	Paralysis.
____	____	Dizziness regularly.	____	____	Numbness/tingling (circle).
____	____	Convulsions (seizures).	____	____	Temporary loss of sensation.
____	____	Tremor (shaking, trembling)	____	____	Lack of strength.
____	____	Blurred/double vision.	____	____	Continual headache.

DENTAL HISTORY



Name of your current dentist: _____

Were there problems with your baby teeth?_____

Have you had your wisdom teeth removed? _____

How many silver fillings_____ gold fillings _____ composite fillings _____ porcelain fillings _____

Do you have any veneers or tooth reconstructions? Please detail. _____
_____

Have you ever injured or fractured a tooth? Please detail. _____
_____

Do you suffer from chronic sinusitis? _____

Are your teeth hot/cold sensitive? _____

Are your teeth sensitive to certain tastes? _____

Have you been told that you are an easy plaque former? _____

When was your last dental visit? _____

When was your last cleaning? _____

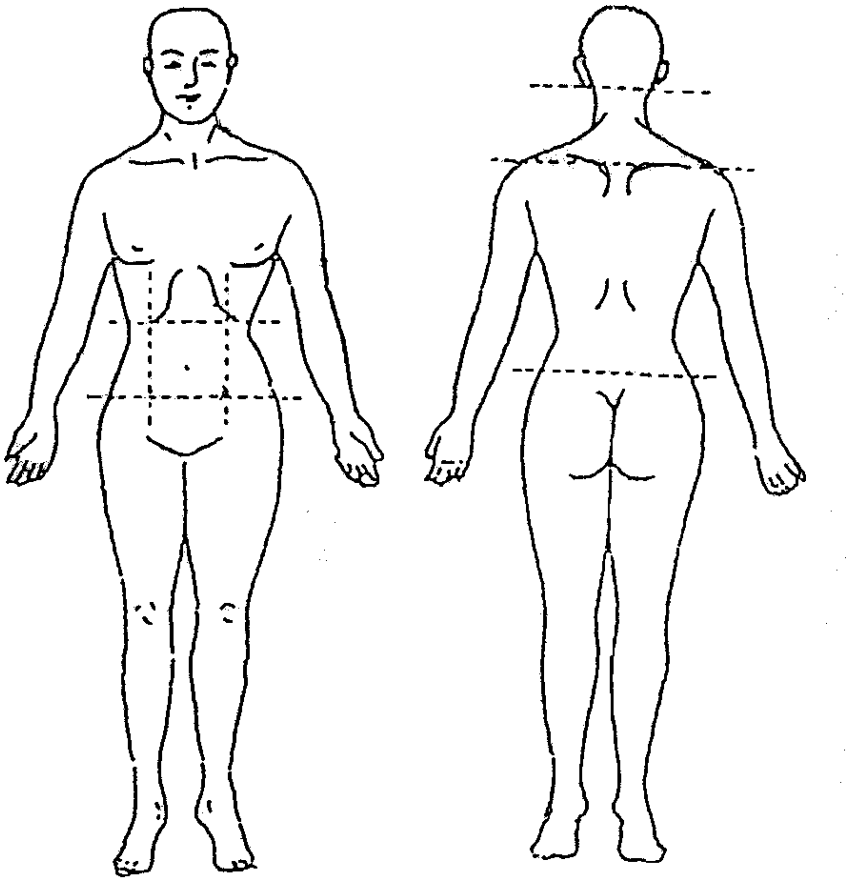
Have you had orthodontic work such as braces? _____

SYMPTOMS - Please mark (1)=mild, (2)=moderate, or (3)= severe next to the following symptoms which apply to you NOW or in the PAST.

Spine and Extremities

NOW	PAST		NOW	PAST	
____	____	One arm or leg shorter.	____	____	Muscle cramps.
____	____	Joint pain/stiffness/ swelling (mark).	____	____	Unusual redness of palms. ____
____	Backaches (mark location).		____	____	Coughing, sneezing or straining
____	____	Burning on soles of feet.			at stools intensifies back pain.
____	____	Date of last spinal X-rays.			

Please mark any problem or painful areas as exactly as possible with an X on the diagram below.



GENERAL STATUS

Listed below are factors which may or may not influence your state of being. Please mark the appro-priate box signifying their influence on your condition or yourself in general if applicable.

BETTER	WORSE		BETTER	WORSE	
❍	❍	Winter.	❍	❍	Spring.
❍	❍	Summer.	❍	❍	Autumn.
❍	❍	Cold.	❍	❍	Heat.
❍	❍	Dampness.	❍	❍	Storms.
❍	❍	Sun.	❍	❍	Wind.
❍	❍	Open air.	❍	❍	Confined (stuffy) air.
❍	❍	Change of weather.	❍	❍	Moonlight.
❍	❍	Ocean seashore.	❍	❍	Mountains.
❍	❍	Physical exertion.	❍	❍	Upon rising.
❍	❍	Morning.	❍	❍	Afternoon.
❍	❍	Evening.	❍	❍	Night.
❍	❍	Bath.	❍	❍	Cold applications.
❍	❍	Warm applications.	❍	❍	Travelling.
❍	❍	Before menstruation.	❍	❍	During menstruation.
❍	❍	After menstruation.	_____		Other.

SYMPTOMS - Please mark (1)=mild, (2)=moderate, or (3)= severe next to the following symptoms which apply to you NOW or in the PAST.

Mental Status

NOW	PAST		NOW	PAST	
____	____	Anxiety.	____	____	Memory difficulty, forgetting.
____	____	Restlessness.	____	____	Mental confusion.
____	____	Excessive worry.	____	____	Decr. concentration, comprehension.
____	____	Depression.	____	____	Make many mistakes.
____	____	Despair/discontent.	____	____	Shy, timid.
____	____	Suicidal thoughts.	____	____	Critical of self.
____	____	Suicidal attempts.	____	____	Critical of others.
____	____	Loneliness/feel alone.	____	____	Lack of self-confidence.
____	____	Mood swings.	____	____	Suspiciousness/jealous.
____	____	Prefer to be with	____	____	Sensitive to noises.
		company.	____	____	Organized, neat/clean.
____	____	Prefer to be left alone	____	____	Affectionate.
		don't seek out company.	____	____	Assertive, powerful.
____	____	Afraid when left alone.	____	____	Confident, secure.
____	____	Would rather be alone	____	____	Intimate with others.
		when not feeling well.			

Self-Description

In 1-2 paragraphs, write a short description of yourself as you are currently. Include strengths, weaknesses, major personality characteristics.

Anger: What makes you angry?
_____ Do you get angry often/easily?
_____ Do you experience uncontrollable rage? _____ Do you have difficulty expressing anger? _____ How do you express anger? _____

Sadness: What makes you sad? _____
Do you cry when sad?
_____
Do you cry easily/often?
_____
Would you rather be left alone when sad?
_____
Does being consoled help?
_____

Grief: List major experiences of grief/loss in your life.

Fears: What fears do you have? Are any unmanageable?

Sex: Is your present sex life satisfactory? Are there any known episodes of physical or sexual abuse in your past?

How many children do you have? Please list name, sex and ages. Include any details of your relationship to them that you feel is important.

Who are the most important people in your life? What is the quality of major relationships in your life? How do you relate to most people?

Is there anything about your present behavior that you would like to change?

What are the 5 things that you hate doing?

What do you feel is your major mental and/or emotional limitation?

What do you do for enjoyment? When was your last vacation?

What are the things that drain your energy (eg. clutter, people, situations)?

Spiritual/Religious Background

Whether we are religious or not, believe in God/Higher power or not, our religious or spiritual roots often have profound influences on our lives. Recent studies have demonstrated how our faith and spiritual practices affect our health. However, I also recognize that faith, religion and spiritual practice are very personal in nature. Feel free to omit any question you do not wish to answer.

What are your religious roots?
Agnostic ____ Buddhist ____ Christian ____ (please circle: Orthodox/Protestant/Catholic)
Christian science ____ Jehovah's witness ____ Jewish ____ Hindu ____ Islam ____ Mormon ____
New age ____ Other: _____

Are you an active participant?

What disciplines do you practice regularly? Prayer ____ Meditation ____ Journalling ____
Study group ____ Fasting (for spiritual purposes) ____ Other: _____

Your present faith/spiritual practices are how important to your daily life?
Very important ____ Somewhat important ____ Not very important ____

What has been the most important spiritual influence on your life?

THANKS FOR YOUR CO-OPERATION, PATIENCE AND THOROUGHNESS!

INFORMED CONSENT for NATUROPATHIC SERVICES

Welcome to Resonance Wellness Inc. Resonance Wellness utilizes the principles and practice of Naturopathic Medicine to assist the body's own ability to heal and to improve the quality of life and health through natural interventions.

Your naturopathic doctor will conduct a thorough case history based on a review of your Initial Intake Form. Complaint specific physical exam, autonomic response testing (ART), laboratory testing of blood, saliva and/or urine may be used as part of the diagnostic work-up.

You will receive information about your diagnosis and/or treatment, including suggested courses of action, and expected benefits, risks and potential side-effects of treatments. Potential costs or additional requirements of such interventions will also be discussed. Treatment results are not guaranteed.

Treatments may include nutritional supplementation, dietary counseling, acupuncture, intravenous therapies, homeopathic medicines, and botanical medicines. Please be informed that it is your choice to purchase products directly from our dispensary or from another supplier. You may be referred for other evaluations or therapies as are applicable to your treatment plan. There are in-office paraprofessionals to whom you may be referred. Any practitioner at the clinic you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.
Payment is due at the time services are rendered. Payment can be made by cash, cheque, debit, Visa and or MasterCard. The current fee schedule for services is available online and at the front counter.

Cancellations less than 24 hours in advance may incur a fee.

Statement of Acknowledgement

I, _____ as a patient (or legal guardian of _____)
of Resonance Wellness Inc., have read the above information and understand that my care will reflect the Philosophy, Principles and Practice of Naturopathic Medicine.

As Resonance Wellness Inc. is an integrated health clinic, I recognize that all the practitioners working with me will have access to my record. My record will be kept confidential and will not be released without my consent.

I also recognize that even the gentlest therapies potentially have complications in certain physiological conditions such as pregnancy or lactation or in very young children or those on multiple medications. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture, acupuncture or neural therapy; muscle strains and sprains, disc injuries from spinal manipulations and small risk of stroke with neck manipulation.

The information I have provided to Resonance Wellness is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements.

I am aware that I am free to withdraw my consent and to discontinue treatment at any time.

_____ _____ _____

SIGNATUE DATE WITNESS

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