Health History Questionnaire

By completely filling out this form you will help us to help you. All answers will be *absolutely confidential*. If you have any questions please ask. Thank you.

Name_____ Age _____ M ☐ F ☐ Today's Date _____
Your Care Card Number_____ Birthdate (M/D/Y)_____
Home Address _____
_____ Postal Code _____
Occupation _____
Home Phone _____ Cell Phone _____
Spouse's Name_____ Children (Name/Age)_____
_____
E-mail Address _____
I give permission to be emailed occasionally of specials or new treatments: Yes or No (circle)

Names Of Other Healthcare Providers:
Medical Doctors _____ Naturopathic Physician_____
Chiropractor_____ Others _____

Who referred you to our clinic?
_____

Your Main Health Concern

Why are you coming to our clinic today?

When did your problem(s) begin (be specific)?

Changes in medication(s)?

Your Past Medical History (Please check and date)

☐ Cancer	☐ Diabetes	☐ Venereal Disease
☐ High Blood Pressure	☐ Seizures	☐ Surgeries
☐ Heart Disease	☐ Hepatitis/Kidney Disease	☐ Anemia (All types)
☐ High Cholesterol	☐ Thyroid Disease	☐ Osteoporosis/Osteopenia
☐ Rheumatic Fever	☐ Asthma	☐ Other Major Illness
☐ Significant Trauma (auto accidents, falls, other)		(Specify) _____
☐ Allergies (drugs, chemicals, foods) (Specify) _____		_____

Family Medical History

Please indicate family member, and if on father's (F) or mother's (M) side of the family.

☐ Cancer	☐ High Blood Pressure	☐ Asthma
☐ Diabetes	☐ Heart Disease	☐ Allergies
☐ Seizures	☐ Stroke	☐ Osteoporosis
☐ Thyroid Disease	☐ High Cholesterol	

☐ Other (Please Specify)_____

Occupational Stress (chemical, physical, psychological)

☐ How many packs of cigarettes do you smoke a day?
☐ How much coffee, tea, cola, or alcohol do you drink per week?

Describe Your Weekly Exercise

Current Medicines

List all prescriptions, over-the-counter drugs, vitamins, herbs, and any non-medical drugs.

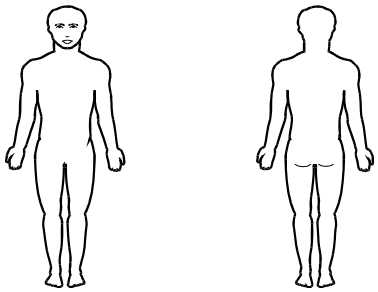
Diet

Are you or have you ever been on a restricted diet? If so, what kind?

Please describe your average daily diet:

☐ Morning	☐ Afternoon	☐ Evening

Indicate Painful or Distressed Areas



Please check if the following symptoms are a current or recurring problem.

General

- ☐ Poor appetite
- ☐ Poor sleep
- ☐ Fatigue
- ☐ Chills
- ☐ Fevers
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Change in appetite
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Sudden energy drop (time?)
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Change in hair or skin texture
- ☐ Loss of hair
- ☐ Dandruff
- ☐ Recent moles
- ☐ Ulcerations
- ☐ Other hair or skin problems?

Head, Eyes, Ears, Nose, And Throat

- ☐ Headaches
- ☐ Neck pain
- ☐ Concussions
- ☐ Eye pain
- ☐ Eye strain
- ☐ Blurry vision
- ☐ Using glasses
- ☐ Night blindness
- ☐ Colour blindness
- ☐ Cataracts
- ☐ Earaches
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Facial pain
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Jaw clicks or pain
- ☐ Tooth pain
- ☐ Mercury tooth fillings
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue

Heart and Circulation

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heartbeat
- ☐ Dizziness
- ☐ Fainting
- ☐ Chest pain
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet

Lungs and Breathing

- ☐ Difficulty breathing
- ☐ Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Pain with a deep breath
- ☐ Production of phlegm, (colour)?
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Other problems

Digestion and Elimination

- ☐ Indigestion
- ☐ Gas
- ☐ Bloating
- ☐ Constipation
- ☐ Bad Breath
- ☐ Abdominal pain or cramps
- ☐ Nausea
- ☐ Vomiting
- ☐ Chronic laxative use
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Diarrhea

Genito-Urinary

☐ Frequent urination	☐ Unable to hold urine	☐ Kidney stones
☐ Urgency to urinate	☐ Decrease in flow	☐ Impotency
☐ Pain on urination	☐ Distinctive or odd colour	☐ Sores on genitals
☐ Do you wake to urinate?	☐ Blood in urine	☐ Other problems

Women

____Age of first menses	☐ Unusual menses	☐ Irregular periods
____Duration of menses	☐ Heavy	☐ Painful periods
____Days between menses	☐ Light	☐ Vaginal discharge
____Date of start of last menses	☐ Clots	☐ Vaginal sores
____Date of last PAP exam		☐ Breast lumps

☐ Do you perform a monthly self - breast exam? _____
☐ Changes in body or emotions prior to menstruation?
☐ Do you practice birth control? ☐ What type and for how long?
Number of pregnancies_____ Number of births_____ Miscarriages_____ Abortions_____

Muscles, Joints, and Bones

☐ Neck pain	☐ Knee pain	☐ Muscle pain
☐ Back pain	☐ Foot / ankle pain	☐ Muscle weakness
☐ Hand / wrist pain	☐ Hip pain	
☐ Shoulder pains	☐ Other joint or bone problems?	

Brain, Nerves, and Emotions

☐ Loss of balance	☐ Depression	☐ Concussion
☐ Quick temper / irritable	☐ Susceptible to stress	☐ Seizures
☐ Poor memory	☐ Dizziness	☐ Areas of numbness
☐ Anxiety	☐ Lack of coordination	

☐ Have you ever been treated for emotional problems?
☐ Have you ever considered or attempted suicide?
☐ Any other neurological or psychological problems?

Comments

☐ Please describe any other problems you would like to discuss.

If you like what we do, tell everyone. If you have concerns, tell us.
To health and happiness! Congratulations on your new journey.

The Village Clinic

Consent Form for Naturopathic Medicine

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic physicians assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent capacity to heal itself. Your Naturopathic Physician will take a thorough case history, may perform a pertinent physical exam and may suggest lab work or request copies of lab work previously completed by your family physician or specialist.

Please inform your Naturopathic Physician of any disease process you are suffering from and any medications, over the counter drugs and supplements you are taking. Please advise your Naturopathic Physician if you are nursing, pregnant or become pregnant throughout the course of your treatment.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, costs, benefits, risks, side effects and, in each case, the consequences of not having the diagnosis and/or treatment acted upon.

As with any form of medical intervention, there can be risks associated with treatment by naturopathic medicine. These include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, bruising or injury from injections
- fainting or puncturing of an organ with acupuncture needles

All visits are confidential. We are committed to preserving and safeguarding your right to privacy. A record will be kept of the health services provided to you. The record will be kept confidential and will not be released to others unless so directed by you or if the law requires it.

If required, the Naturopathic Physician may discuss your case with other healthcare providers. I give permission to the physicians and practitioners at The Village Clinic to collaborate on my case. _____
Initial

_____

I understand that results are not guaranteed. I do not expect naturopathic physicians to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to naturopathic and collaborative care from The Village Clinic. I intend this consent form to cover the entire course of my treatment at The Village Clinic. I understand that I am free to withdraw my consent at any time.

Patient name: (please print) _____

Signature of patient or guardian: _____

Signature of Dr. Maria Fabbro ND: _____