

Naturopathic Health History

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for treatments is confidential except as required or allowed by law to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____		Date of Birth: _____		Gender: _____	
Address: _____		_____		_____	
Number	Street	Suite	City	Province	Postal Code
Occupation: _____			E-mail: _____		
Tel (home): _____		Tel (work): _____		Cell: _____	
Physician's Name: _____			Tel: _____		
Physician's Address: _____		_____		_____	
Number	Street	Suite	City	Province	Postal Code
In Emergency Notify: _____		Relationship: _____		Tel: _____	
Date of last visit to physician or health practitioner: _____			How did you hear about us? _____		

What is your main reason for coming in today? _____

If you have a specific health condition, please describe it in detail. _____

When was the very first time you noticed your condition and how long has your main health problem been troubling you? _____

Please describe carefully any factors that you suspect may have played a role in its onset and its continuation. _____

Is your current health problem getting better, worse, or the same? _____

Describe the treatment that you have received for this problem and from whom. _____

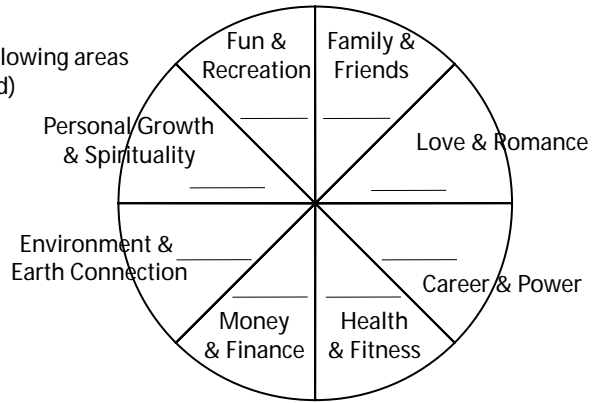
Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current problem or for any other problem? No Yes

What was the therapy and the result? _____

Please list other health problems, and their duration, in order of importance:

- 1) _____
- 2) _____
- 3) _____

Please indicate on the pie chart your level of personal satisfaction in the following areas of your life by assigning a number from 0-10 in each area (10 = very satisfied)



What is the general state of your health?

- Excellent
- Good
- Average
- Fair
- Poor

Describe, on average, your energy level on a scale from 1-10 (with 10 being the highest) _____

During the day, when is your energy level the best / the worst? _____

Do you exercise? No Yes If so, what type and how often? _____

Please list the 5 most significant and stressful events in your life (from the most recent)	date
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Are any of these situations continuing to impact your life? No Yes

Are you currently working with a professional counsellor, psychologist, social worker or other therapist? Please specify:

Have you in the past? No Yes If so, when? _____

Are you currently working with a Doctor of conventional medicine? Please explain:

Which of the following conditions have you experienced?

- | | | | | |
|---------------------------------------|-------------------------------------|---|---|---|
| <input type="checkbox"/> measles | <input type="checkbox"/> mumps | <input type="checkbox"/> chicken pox | <input type="checkbox"/> small pox | <input type="checkbox"/> whooping cough |
| <input type="checkbox"/> polio | <input type="checkbox"/> diphtheria | <input type="checkbox"/> typhoid fever | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> scarlet fever |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> herpes | <input type="checkbox"/> ear infections | <input type="checkbox"/> pneumonia | <input type="checkbox"/> tonsillitis |
| <input type="checkbox"/> canker sores | <input type="checkbox"/> epilepsy | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> chronic infections | <input type="checkbox"/> gonorrhoea |
| <input type="checkbox"/> syphilis | <input type="checkbox"/> insomnia | <input type="checkbox"/> hepatitis | <input type="checkbox"/> weight problem | |

Review of Systems

Please circle if you are currently experiencing ("C") or have experienced in the past ("P") any of the following:

General

- P C Headaches
- P C Migraines
- P C Fatigue
- P C Fever
- P C Sweats
- P C Heat or cold intolerance
- P C Dizziness
- P C Fainting
- P C Poor/disturbed sleep
- P C Recent weight change
- P C Numbness/Tingling
in arms/hands/legs
- P C Allergies
- P C Seizures

Gastrointestinal

- P C Constipation
- P C Diarrhea
- P C Abdominal bloating
- P C Abdominal pain
- P C Gas
- P C Heartburn
- P C Undigested food in stool
- P C Blood in stool
- P C Belching
- P C Change in appetite
- P C Nausea/Vomiting
- P C Colitis
- P C Crohn's
- P C IBS
- P C Hemorrhoids
- P C Hernia

Respiratory

- P C Asthma
- P C Emphysema
- P C Persistent cough
- P C Chronic bronchitis
- P C Shortness of breath
- P C Excessive phlegm production
- P C Spitting up blood
- P C Smoker

Eyes, Ears, Nose, Throat, Mouth

- P C Ear infections
- P C Ringing in ears
- P C Deafness
- P C Vertigo
- P C Ear discharge
- P C Eye pain
- P C Eye infections
- P C Failing vision
- P C Glaucoma
- P C Cataracts
- P C Mercury tooth fillings
- P C Gum disease
- P C Frequent colds/flu
- P C Recurrent Strep throat
- P C Sinus infection
- P C Sore throat
- P C Hoarseness
- P C Cold sores
- P C History of head injury

Skin

- P C Hives/allergy
- P C Acne
- P C Eczema
- P C Psoriasis
- P C Itching
- P C Bruises easily
- P C Varicose veins
- P C Warts
- P C Change of mole
- P C Skin dryness
- P C Fungal infections

Musculoskeletal

- P C Muscle pain
- P C Muscle weakness
- P C Muscles spasms/cramps
- P C Jaw pain
- P C Spinal curvature
- P C Arthritis
- P C Osteoporosis
- P C Bursitis
- P C Tendonitis
- P C Gout
- P C Joint pain, If so, which joint(s)? _____

Cardiovascular

- P C Palpitations
- P C Murmurs
- P C Elevated cholesterol
- P C High or Low blood pressure
- P C Previous Heart attack
- P C Heart disease
- P C Varicose veins
- P C Ankle swelling
- P C Poor circulation
- P C Cold hands and/or feet
- P C Shortness of breath
- P C Chest pain/Angina
- P C Anemia

Kidneys and Reproductive

- P C Inability to control urine
- P C Frequent urination
- P C Urination during the night
- P C Urinary tract infection
- P C Painful urination
- P C Blood in urine
- P C Kidney infection
- P C Kidney stones
- P C Sores in genitals
- P C PMS
- P C Menopause
- P C Endometriosis
- P C Hysterectomy
- P C STDs
- P C Pregnancy

Emotional

- P C Depression
- P C Anxiety
- P C Mood swings
- P C Anger
- P C Eating disorder
- P C Phobias
- P C Psychiatric issues
- P C Drug abuse
- P C Thoughts of suicide
- P C Psychological counseling

Have you had any illnesses not listed? If yes, please specify: _____

Have you had any hospitalizations, surgeries, or injuries? If yes, please specify: _____

Do you have allergies to any drugs, herbs, foods, animals, or other? No Yes If yes, please list:

Which of the following do you currently use? Please indicate amount (how much, how often, and how long):

alcohol _____ hormones _____

coffee _____ sedatives _____

tobacco _____ laxatives _____

antacids _____ cortisone _____

Other medications (please give the full name, dosage, and how long you have been taking the medication):

drug, vitamin or herb name	dosage	duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How many times have you been treated with antibiotics? _____

For what condition(s)? _____

Family History

Please list ages, health problems and, if deceased, cause of death:

	living age	health problems	cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____

Vaccinations

Please indicate your vaccination history, including age and any adverse reactions:

	date	reaction
DPT (diphtheria, pertussis, tetanus)	_____	_____
MMR (measles, mumps, rubella)	_____	_____
Flu	_____	_____
Polio	_____	_____
Hepatitis B	_____	_____
Others	_____	_____

Diet

Please describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (type and quantity) _____

Do you have any food cravings? _____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? _____

Is there any additional information that you would like to add?

Signature _____ Date _____

Thank you for taking the time to fill out this form. All information is confidential and will not be released for legal or medical purposes without your consent.



Consent Information

We would like your consent. We want you to understand the services we hope to provide to you, the cost involved and what we do with personal information we obtain from you. If you have any questions on any of the following information, please do not hesitate to ask.

Consent for Treatment

I have read and understood all of the associated forms, answered them truthfully and to the best of my knowledge and fully consent to treatment at Balance Integrated Healthcare. I understand that there is a 12-hour cancellation policy and if I fail to notify the clinic, then I may be charged for my session.

Consent for the Cost of our Services

I understand the costs of the services that I am being provided at Balance Integrated Healthcare.

Consent for Personal Information

I understand that in order to provide me with the services I am seeking, Balance Integrated Healthcare will collect some personal information about me (e.g. home telephone number, address, emergency contacts).

I have reviewed Balance Integrated Healthcare's privacy policy about the collection, use and disclosure of personal information, the steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given the chance to ask any questions I have about the privacy policy and they have been answered to my satisfaction.

I understand that, as explained in Balance Integrated Healthcare's Privacy Policy, there are some rare exceptions to these commitments.

I understand that if I do not check off the following boxes I will receive the following:

- Please **DO NOT** send me the monthly Balance Integrated Healthcare *Healthy Insights* newsletter (find out about a new health topic every month) written by one of the practitioners at Balance Integrated Healthcare. (email required).
- I would **NOT** like to receive email/mail notices of promotions and special offers from Balance Integrated Healthcare (helps you stay on top of all the events at Balance Integrated Healthcare including upcoming seminars/workshops and newly acquired services!)

I hereby agree to Balance Integrated Healthcare collecting, using and disclosing personal information about me only with my expressed written authorization.

Signature

Name (please print)

Date

Notes (office use only)
