



1. Why did you choose to come to this clinic?

What do you know about our approach?

2. What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

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

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1   2   3   4   5   6   7   8   9   10

4. a) What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviours or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits? (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

7. What do you LOVE to do?

**PAST MEDICAL HISTORY**

Please indicate which of the following conditions you have had.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Acne   | <input type="checkbox"/> Fatigue / Exhaustion / Mononucleosis      | <input type="checkbox"/> Nausea /Gas / Irritable bowel   |
| <input type="checkbox"/> Allergies /Hay fever                           | <input type="checkbox"/> Fractures / Fall / Accident               | <input type="checkbox"/> Numbness / Tingling / Tremors   |
| <input type="checkbox"/> Anemia / Blood Disorder                        | <input type="checkbox"/> Gall stones                               | <input type="checkbox"/> Osteoporosis / Disc Damage  |
| <input type="checkbox"/> Arthritis / Rheumatism                         | <input type="checkbox"/> Gastric reflux / Heartburn / Acidity      | <input type="checkbox"/> Psoriasis/Fungal Infections   |
| <input type="checkbox"/> Asthma / Emphysema                             | <input type="checkbox"/> Gum & Periodontal disease / Gingivitis    | <input type="checkbox"/> PMS / Painful Period  |
| <input type="checkbox"/> Autoimmune disease / Lupus                     | <input type="checkbox"/> Gout                                      | <input type="checkbox"/> Female concerns   |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Headaches /Migraines                      | <input type="checkbox"/> Male Prostate / Erectile  |
| <input type="checkbox"/> Candida Thrush /Yeast infections               | <input type="checkbox"/> Hearing Loss /Ringing noise/Dizziness     | <input type="checkbox"/> Sexually Transmitted Infections                                       |
| <input type="checkbox"/> Constipation/Haemorrhoids/Fissure              | <input type="checkbox"/> Heart Disease / Stroke                    | <input type="checkbox"/> Sinus/Ear Infections  |
| <input type="checkbox"/> Depression / Mental illness                    | <input type="checkbox"/> Hepatitis                                 | <input type="checkbox"/> Sore throat / Tonsillitis   |
| <input type="checkbox"/> Anxiety Attacks / Nervousness                  | <input type="checkbox"/> High Blood Pressure /High Cholesterol     | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Loneliness/ Grief                              | <input type="checkbox"/> Incontinence (frequent urination)         | <input type="checkbox"/> Frequent Pneumonia/Bronchitis   |
| <input type="checkbox"/> Diabetes                                       | <input type="checkbox"/> Insomnia / Poor sleep                     | <input type="checkbox"/> Frequent Influenza /Head Colds  |
| <input type="checkbox"/> Diarrhea / Giardia /Parasites                  | <input type="checkbox"/> Kidney Disorders / Bladder Infections     | <input type="checkbox"/> Addictions- Smoking/alcohol, etc                                      |
| <input type="checkbox"/> Epilepsy                                       | <input type="checkbox"/> Liver / Gall Bladder Disorders            | <input type="checkbox"/> Abuse (sexual, verbal, physical)                                      |
| <input type="checkbox"/> Eczema / Dermatitis                            | <input type="checkbox"/> Thyroid Problems                          | <input type="checkbox"/> Trauma / Shock / Shame  |
| <input type="checkbox"/> Edema/ /Swollen Ankles                         | <input type="checkbox"/> Miscarriage / Pregnancy Issues            | <input type="checkbox"/> Virus; Herpes, Shingles Warts,<br>HIV, HPV, Cold sores,<br>Other_____ |
| <input type="checkbox"/> Poor Circulation /Varicose Veins /<br>Bruising | <input type="checkbox"/> Jaw / Back / Neck /Hip / Knee<br>Problems |  |

**Others (Please List):** \_\_\_\_\_

**Tell us about your worst period of health. Why?** \_\_\_\_\_

**Please indicate if you have had any hospitalizations, surgeries &/or serious injuries:**  
 \_\_\_\_\_  
 \_\_\_\_\_

**CURRENT MEDICATION**

Please list all the medications, supplements, herbs and over-counter drugs you are taking.

Medication/supplements/herbs	Dosage	Since	Reason

**LIST ALL PREVIOUS MEDICINES:** (include how many courses of antibiotics)

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**FAMILY HISTORY**

Please list relatives who have the following conditions.

<b>Condition</b>	<b>Family Members</b> (ie. mom, dad, grandparents, etc)
Addictions (Please specify)	
Alzheimers / Parkinsons	
Allergies/ Hayfever	
Asthma	
Eczema / Hives	
Anemia	
Arthritis	
Cancer	
Diabetes	
Epilepsy	
Heart Disease / Stroke	
High Blood Pressure	
High Cholesterol	
Mental Illness / Depression / Anxiety	
Osteoporosis	
Thyroid Disorder	
Chronic Fatigue / Fibromyalgia	
Autoimmune Condition	
Other	

**DIET**

Do you have any dietary restrictions? (specify) \_\_\_\_\_

List food cravings? \_\_\_\_\_

Please describe your most regular foods OR yesterday's diet:

BREAKFAST: \_\_\_\_\_

LUNCH: \_\_\_\_\_

DINNER: \_\_\_\_\_

SNACKS: \_\_\_\_\_

**Fruits** (eaten daily):

**Servings of Vegetables per day** (1 cup = 1 serving) : 0 \_\_ 1 \_\_ 2 \_\_ 3 \_\_ 4 \_\_ 5+ \_\_

**Red Meat** (beef, veal, lamb, goat, pork, sausages, bacon, ham) per week: 0\_\_ 1-2 \_\_ 3-4 \_\_ 5+\_\_

**Refined white foods** (white bread, white rice, sweet breakfast cereals, pasta, noodles, cookies, pastries, cakes).

Servings per day: 0\_\_ 1-2\_\_ 3-4 \_\_ 5+\_\_

**Sugar/candies/chocolate** servings per day: 0\_\_ 1-2 \_\_ 3-4 \_\_ 5+\_\_

**Water** (# cups): \_\_ **Coffee**\_\_ **Tea** \_\_ **Soft Drinks** \_\_\_\_\_

**BOWEL MOVEMENTS** per week: \_\_\_\_\_

**SLEEP**

Avg. # of hours per night slept: \_\_\_\_\_

# of times you usually wake at night: 0 \_\_ 1\_\_ 2\_\_ 3+\_\_

Do you snore regularly? Yes\_\_ No \_\_

Do you have trouble falling or staying asleep? Yes\_\_ No \_\_ If Yes, why? \_\_\_\_\_

Do you feel you are well rested when you get up? Yes\_\_ No \_\_ If No, why? \_\_\_\_\_

On a scale of 1 to 10 (10 as the best), how do you rate your quality of sleep? 0 1 2 3 4 5 6 7 8 9 10

**ENERGY**

On a scale of 1 to 10 (10 as the best), how do you rate your energy? 0 1 2 3 4 5 6 7 8 9 10

Are your daily tasks affected by you being tired? Yes\_\_ No \_\_ Do you nap during the day? Yes\_\_ No \_\_

**WORK:** # Hours per week: \_\_\_\_\_ Do you enjoy your work? \_\_\_\_\_

**EXERCISE:** # times per week: \_\_\_\_\_ Length of time (minutes): \_\_\_\_\_ What type /sport? \_\_\_\_\_

**MEDITATION:** Yes\_\_ No\_\_ **Do you have time to relax daily:** Yes\_\_ No\_\_

**ENJOYING LIFE?** (✓) Definitely \_\_ Mostly Yes \_\_ Not Sure \_\_ Mostly Not \_\_

**What STRESSFUL factors** (including difficult relationships, moves, deaths, births, marriages, work, finances, past trauma, etc) have you been experiencing over the last year(s)?

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

**Describe your general mood.**\_\_\_\_\_

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

**SEXUAL HISTORY:**

Sexual preference (circle):      Heterosexual                  Homosexual                  Bisexual

Are you sexually active? Yes / No      If yes, please continue.

Do you use birth control /protection? Yes / No      If so, what kinds? \_\_\_\_\_

Have you ever been tested for STIs/STDs? Results? \_\_\_\_\_

Do you have any questions or concerns about sex, pregnancy, sexually transmitted infections (STIs), contraception or homosexuality and bisexuality? Please specify. \_\_\_\_\_  
\_\_\_\_\_

Do you have any dermatological concerns? Please specify. \_\_\_\_\_  
\_\_\_\_\_

Do you have a close friend or confidant to talk to about your problems? Who? \_\_\_\_\_

Any problems at school? Home? \_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Recreational drugs? Alcohol? (specify) \_\_\_\_\_  
\_\_\_\_\_

Do you have any questions/concerns about your body? \_\_\_\_\_  
\_\_\_\_\_

**FEMALES:**

What age did you start menstruating? \_\_\_\_\_ Regular or irregular cycle: \_\_\_\_\_

Menstrual cycle length: \_\_\_\_\_ Duration of flow: \_\_\_\_\_ Any Clots? \_\_\_\_\_

How many pads or tampons do you use on your heavy days? \_\_\_\_\_ Lightest days? \_\_\_\_\_

List any symptoms that occur with your menses like cramping/pain, bloating, breasts tenderness, fatigue, mood changes, etc.? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are there any other concerns/questions that you would like to address?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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