Date: _____

Naturopathic Essentials Health Centre

Confidential Adult History Form

NAME: First: _____ Last: _____ Middle: _____

SEX (✓): male___ female___ **BIRTHDATE (Month/Day/Year):** _____ **AGE:** _____

STATUS (✓): Single/Widowed ___ Married/Partnered ___ Divorced/Separated ___

HOME ADDRESS: _____

OCCUPATION: _____ **COMPANY:** _____

Phone work: _____ Phone home: _____

Email: _____ Cellphone: _____

Emergency Contact:_____ Phone: _____

How did you hear about us? _____

*If you were referred to us by a friend or family member, please give us their name so we may send them a letter of appreciation. _____

**We send newsletters on health issues and other information mailings to all our patients. If you do NOT want to be part of the mailing list, please check here: "No thank you" __

OTHER HEALTH PROVIDER(S) INFORMATION

Family Physician: _____ Phone: ( )_____

Other Health Care Provider(s): _____ Phone: ( )_____

_____ Phone: ( )_____

Do you have extended medical coverage? _____

YOUR CURRENT HEALTH CONCERNS

What are your main reasons for visiting the clinic in order of importance to you?

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

ALLERGY INFORMATION

Do you have any allergies to any drugs, supplements, herbs, foods, animals or other?

_____

_____

CONTEXT OF CARE OVERVIEW

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.

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

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)

_____

_____

FAMILY HISTORY
Please list relatives who have the following conditions.

Condition	**Family Members** (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, veil, 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** _____

Alcohol (# glasses): _____ How often: _____ What type: _____

Cigarettes/Cigars (per day): ___ Other Recreational Drugs? _____

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)?

_____

_____

_____

_____

Is there anything that you think is important that has not been covered yet?

_____

_____

_____

Thank you for taking the time to complete this form.