

Optimum Wellness Naturopathic Medical Clinic ®

Leader in Optimizing Wellness ®...

356 Saddleback Road, Edmonton, AB, T6J 4R7

Tel: 780 439-1200 Fax: 780 434-6800

CONTACT INFORMATION

Name: _____ Alberta Health Care #: _____

Address: _____ Date: _____

Street

City

Province

Postal code

Telephone: (home) [____] _____ (work) [____] _____ Best place to call *H or W*

E-mail: _____ Cell : [____] _____ Fax:[____] _____

Age: _____ Birth Date: M _____ D _____ Y _____ Occupation: _____

Sex: Male ___ Female ___ Marital Status: *S M D W Sep* Number of Children: _____

Who are your other Health Care Providers?

(ie: MD, Naturopathic doctor, Chiropractor, Massage Therapist, Physiotherapist, etc)

1) _____ 2) _____ 3) _____

Tel: _____ Tel: _____ Tel: _____

How did you find out about our clinic? Who referred you? *Newspaper, Internet, Health food store, Friend, Another health care practitioner* Name: _____

Have you been treated by a Naturopathic Doctor before? *Y or N*

If 'yes', by whom? _____ When? _____

For what reason(s)? _____

In Case of Emergency:

Contact: _____ [____] _____

Full name

Relation

Telephone

Signature: _____ Date: _____

List your health concerns and how long they have been occurring, in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

CONFIDENTIAL HEALTH QUESTIONNAIRE

Dear Patient: Please complete this questionnaire with care. Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. This is a confidential record of your medical history. It will not be released without your prior authorization.

Have you had similar health concerns before? _____ Explain: _____

Do you have any relatives with similar problems? _____

What do you feel is causing any health problems you may have? _____

When did you last feel well? _____

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

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

What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? Please list.

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive to your health? Please list.

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

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

What is your present level of commitment to address any underlying causes of your health concerns that relate to your lifestyle? Rate on a scale from 1 to 10, with 10 indicating 100% commitment.

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

Medications

Check (✓) any of the following that you currently take or use.

- | | | |
|--|--|--|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Appetite suppressants | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Thyroid medication | <input type="checkbox"/> Sleeping pills |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Diet pills | <input type="checkbox"/> Birth control pills |

How many times have you been treated with antibiotics? _____ When was the last time? _____

Please list all **“current”** prescription medications

Medication	Date started [m/y]	Dose	Effectiveness

Please list all **“past”** prescription medications

Medication	Date started [m/y]	Dose	Effectiveness

Please list all **“current”** vitamins, herbs, homeopathics, non-prescription, etc

Supplement / Vitamin (Brand Name)	Date started [m/y]	Dose	Effectiveness

Please list all **“past”** vitamins, herbs, homeopathics, non-prescription, etc

Supplement / Vitamin (Brand Name)	Date started [m/y]	Dose	Effectiveness

Health History

Do you have any known contagious diseases at this time? Y N

If yes, what? _____

How would you describe your current state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that you have had. Include approximate dates.

List any X-rays, CT scans, or other studies that you have had.

Immunizations

What immunizations have you had?

- | | | |
|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Flu shot |
| <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Polio |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Other: _____ | |

Please indicate any adverse reactions you have experienced from an immunization.

Illnesses

Which of the following conditions have you had?

<input type="checkbox"/> Abscesses	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Rubella	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Herpes genitalia	<input type="checkbox"/> Parasites	<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Amnesia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pelvic inflammatory disease	<input type="checkbox"/> Shingles	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gall stones	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Peritonitis	<input type="checkbox"/> Skin disease	<input type="checkbox"/> Venereal warts
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Strep throat	<input type="checkbox"/> Warts
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Malaria	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Gout	<input type="checkbox"/> Measles	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Sunstroke	<input type="checkbox"/> Worms
<input type="checkbox"/> Cold sores	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Stroke	<input type="checkbox"/> Yellow fever
<input type="checkbox"/> Depression					

Lifestyle

Do you meditate or use any relaxation exercises? _____

What level of personal stress are you experiencing right now? Minimal Average Considerable Unbearable

Circle those that apply. Main stressor: Financial; Job related; Interpersonal; Marriage; Health;

Family members; Spiritual; Unfulfilled expectations or other: _____

Are / were you a smoker? Y or N How long? _____ If you quit, when? _____

Does anyone else smoke in your household? _____ Does anyone smoke in your work place? _____

Do you have regular sleeping habits? Y or N How many hours? _____

Circle if any apply to you: Early riser; Difficulty falling asleep; Wake in middle of night; Nightmares.

Do you exercise regularly? Y or N How often? _____

Do you or have you ever eaten large or regular amounts of chocolate? _____

Do you have silver dental fillings? Y or N How many? _____ Have you had any removed? Y or N

Root canals? Y or N When? _____

Do you color your hair? Y or N If your hair has turned grey, at what age were you? _____

How old is your home? _____ Has there been any kind of renovations / construction in your

home recently [dry wall, paint, new carpets]? _____

Do you use a microwave oven? Y or N Electric blanket? Y or N Waterbed? Y or N

What are your main interests and hobbies? _____

For the following, circle “Y” for yes, “N” for no, or “P” for in the past

Average 6-8hrs sleep per night?	Y N	Do you have a religious or spiritual practice?	Y N
Do you awake rested?	Y N	↳ If yes, what?	
Have a supportive relationship?	Y N	Do you watch television?	Y N
Have a history of abuse?	Y N	↳ How many hours/day?	
Do you use recreational drugs?	Y N P	Do you read?	Y N
Treated for drug dependence?	Y N P	↳ How many hours/day?	
Do you eat three meals a day?	Y N	Do you drink alcohol?	Y N P
Do you eat out often?	Y N	↳ What type?	
Do you drink coffee?	Y N P	↳ How many drinks/day?	
Do you drink black tea?	Y N P	Treated for alcoholism?	Y N P
Do you drink cola/other sodas?	Y N P	Do you smoke tobacco?	Y N P
Do you eat refined sugar?	Y N P	↳ How many packs/day?	
Do you add salt to your food?	Y N P	↳ How many years?	
Do you enjoy your work?	Y N	Exposed to significant tobacco smoke (i.e., 2 nd hand smoke)?	Y N P
Do you take vacations?	Y N		
Do you spend time outdoors?	Y N		

Family History

	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)						
Health (G=Good; P=Poor)						
Age at death (if deceased)						
Check (√) those applicable						
Allergies/Hay fever						
Arthritis						
Asthma						
Cancer						
Depression						
Diabetes						
Drug abuse/alcoholism						
Epilepsy						
Gonorrhea						
Gout						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Paralysis						
Pneumonia						
Skin Disease						
Syphilis						
Tuberculosis						
Other						
Cause of Death						

Diet

Describe a typical day's diet.

Breakfast _____

Lunch _____

Supper _____

Snacks _____

How many cups/bottles/glasses do you drink on average per day?

Beverage	Amount	Beverage	Amount	Beverage	Amount
Water		Fruit juice		Coffee	
Tea		Vegetable juice		Beer	
Soft drinks regular		Herbal Tea		Wine	
Soft drinks diet		Milk		Liquor	

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

Allergies

Are you sensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental? _____

Any chemicals? _____

Any supplements? _____

Toxin Exposure

Did you grow up near a refinery, battery or metal factory, crematorium, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

What has been your main type of employment?

Have you had any jobs where you were exposed to metal dust (lead, mercury, iron etc.), industrial poisons, chemicals, pesticides, solvents, fumes or other toxic materials? If "yes", please describe and give dates.

Have you ever had health problems after you put in new carpeting, new cabinets, painted, or did other refurbishing in your home? In your workplace?

Do you use pesticides, herbicides or other chemicals around your home?

Are you particularly sensitive to perfumes, gasoline or other vapours?

Thank you for taking the time to assist us in understanding your health!