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: ____

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 heath 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.____

6.____

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 behaviors 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.

- ☐ Laxatives
- ☐ Cortisone
- ☐ Tranquilizers
- ☐ Aspirin
- ☐ Pain relievers
- ☐ Appetite suppressants
- ☐ Thyroid medication
- ☐ Diet pills
- ☐ Antacids
- ☐ Antibiotics
- ☐ Sleeping pills
- ☐ 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.

____

____

____

Allergies

Are you sensitive or allergic to…
Any drugs?____________________________________
Any foods?____________________________________
Any environmentals?________________________________
Any chemicals?__________________________________
Any supplements?_________________________________

Immunizations

What immunizations have you had?

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Haemophilus influenza B
- ☐ MMR (measles, mumps, rubella)
- ☐ Chicken pox
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other: ____________________
- ☐ Flu shot
- ☐ Polio
- ☐ Smallpox

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

____

____

Illnesses

Which of the following conditions have you had?

	Abscesses		Diabetes		Heart disease		Mononucleosis		Rubella		Syphilis
	Alcoholism		Eating Disorder		Hepatitis		Mumps		Scarlet fever		Tonsillitis
	Allergies		Emphysema		Herpes genitalia		Parasites		Sexual abuse		Tuberculosis
	Amnesia		Epilepsy		Influenza		Pelvic inflammatory disease		Shingles		Typhoid fever
	Arthritis		Gall stones		Kidney disease		Peritonitis		Skin disease		Venereal warts
	Asthma		Goiter		Leukemia		Pleurisy		Strep throat		Warts
	Cancer		Gonorrhea		Malaria		Pneumonia		Sinusitis		Whooping cough
	Chicken pox		Gout		Measles		Prostatitis		Sunstroke		Worms
	Cold sores		Hay fever		Miscarriage		Rheumatic fever		Stroke		Yellow fever
	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? ↳If yes, what?	Y N
Do you awake rested?	Y N		
Have a supportive relationship?	Y N		
Have a history of abuse?	Y N	Do you watch television? ↳How many hours/day?	Y N
Do you use recreational drugs?	Y N P		
Treated for drug dependence?	Y N P	Do you read? ↳How many hours/day?	Y N
Do you eat three meals a day?	Y N		
Do you eat out often?	Y N	Do you drink alcohol? ↳What type? ↳How many drinks/day?	Y N P
Do you drink coffee?	Y N P		
Do you drink black tea?	Y N P		
Do you drink cola/other sodas?	Y N P	Treated for alcoholism?	Y N P
Do you eat refined sugar?	Y N P	Do you smoke tobacco? ↳How many packs/day? ↳How many years?	Y N P
Do you add salt to your food?	Y N P		
Do you enjoy your work?	Y N		
Do you take vacations?	Y N	Exposed to significant tobacco smoke (i.e., 2nd hand smoke)?	Y N P
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.)?______________________________

____

Review of Systems

General

Comments?

Weight? ________________ lbs

Weight 1 year ago? __________ lbs

Maximum weight? __________ lbs

Time of day when your energy is:

↳When? __________________

↳Best?________ ↳Worst?____________

Blood type? ________________

Height? ________________

Skin

Rashes?	Y N P	Lumps?	Y N P
Eczema, hives?	Y N P	Hair loss?	Y N P
Acne, boils?	Y N P	Dryness?	Y N P
Itching?	Y N P	Night sweats?	Y N P
Colour change?	Y N P	Change in a mole?	Y N P
Temperature change?	Y N P	Skin cancer?	Y N P
Nail changes?	Y N P		

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems?	Y N P

Eyes

Impaired vision?	Y N P	Double vision?	Y N P
Glasses/contacts?	Y N P	Spots in vision?	Y N P
Eye pain?	Y N P	Blurred vision?	Y N P
Tearing or dryness?	Y N P	Colour blindness?	Y N P
Glaucoma?	Y N P	Cataracts?	Y N P
Sensitive to the sun?	Y N P	Discharge?	Y N P
Itching/redness?	Y N P	Blind spot?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P
Discharge?	Y N P	Infections?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose bleeds?	Y N P
Stuffiness?	Y N P	Hay fever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Loss of taste?	Y N P
Teeth grinding?	Y N P	Sore tongue/mouth?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Comments?

Cough?	Y N P	Difficulty breathing?	Y N P
Spitting up blood?	Y N P	Pain on breathing?	Y N P
Asthma?	Y N P	Sputum?	Y N P
Pneumonia?	Y N P	Wheezing?	Y N P
Emphysema?	Y N P	Bronchitis?	Y N P
Shortness of breath?	Y N P	Pleurisy?	Y N P
Shortness of breath lying down?	Y N P	Tuberculosis?	Y N P
Shortness of breath at night?	Y N P	Last chest x-ray?	

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/low blood pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/fluttering?	Y N P
Rheumatic fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P	Past ECG (Echocardiogram)?	Y N P

Gastrointestinal

Trouble swallowing?	Y N P	Change in thirst?	Y N P
Nausea?	Y N P	Change in appetite?	Y N P
Vomiting?	Y N P	Indigestion?	Y N P
Vomiting blood?	Y N P	Heartburn?	Y N P
Blood in stool?	Y N P	Constipation?	Y N P
Abdominal pain or cramps?	Y N P	Diarrhoea?	Y N P
Belching or passing gas?	Y N P	Gall bladder disease/gall stones?	Y N P
Black, tarry stools?	Y N P	Ulcer?	Y N P
Jaundice (i.e., yellow skin)?	Y N P	Hemorrhoids/fissures?	Y N P
Liver disease?	Y N P	Hernia?	Y N P
Bowel movements – how often?		Change in bowel movements?	Y N P

Urinary

Pain on urination?	Y N P	Frequent infections?	Y N P
Increased frequency?	Y N P	Inability to hold urine?	Y N P
Frequency at night?	Y N P	Kidney stones?	Y N P
Urgency or hesitancy?	Y N P	Blood in urine?	Y N P

Male Reproduction

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate enlargement or disease?	Y N P
Venereal disease?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N P	Chlamydia?	Y N P
Impotence?	Y N P	Gonorrhoea?	Y N P
Premature ejaculation?	Y N P	Condyloma (i.e., genital warts)?	Y N P
Do you use birth control?	Y N P	Herpes?	Y N P
↳What type?		Syphilis?	Y N P
Sexual preference: *Heterosexual* *Bisexual* *Homosexual*			

Musculoskeletal

Comments?

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P
Joint swelling?	Y N P	Backache?	Y N P

Blood/Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P
Extremity numbness?	Y N P	Extremity swelling?	Y N P
Extremity coldness?	Y N P	Extremity ulcers?	Y N P
Past transfusion?	Y N P	Lymph node swelling?	Y N P

Neurologic

Seizures/convulsions?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Speech problems?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P
Fainting?	Y N P	Involuntary movement?	Y N P

Endocrine

Hypothyroid?	Y N P	Diabetes?	Y N P
Hyperthyroid?	Y N P	Heat or cold intolerance?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P
Excessive thirst?	Y N P	Hypoglycaemia?	Y N P
Excessive hunger?	Y N P	Excessive sweating?	Y N P
Excessive urination?	Y N P	Hormone therapy?	Y N P

Immune

Chronic fatigue syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

Mental/Emotional

Treated for emotional problems?	Y N P	Memory problems?	Y N P
Mood swings?	Y N P	Anxiety or nervousness?	Y N P
Poor concentration?	Y N P	Depression?	Y N P
Tension and/or stress?	Y N P	Considered/attempted suicide?	Y N P
Phobias?	Y N P	Insomnia?	Y N P

Is there anything else that you would like to add or comment on?____________________________________

____

Thank-you for your time and effort.
I look forward to working with you on your journey to health and well-being.

"Those who do not find time every day for health
must sacrifice a lot of time one day for illness."
-Father Sebastian Kneipp

For Women – Please circle all that apply

Age of first menses? ____ Are your menses regular? *Y or N* Average number of days? ________

Length of cycle? _______ Last menstrual period? ______ Age of cessation of menses? ______

The blood flow during the menses is: *Not at all; Spotting; Moderate; Heavy; Heavy and clots*

Do you have bleeding between periods? *Y N P_* Any pain during intercourse? ____________________

Pain with the menses? *Not at all; Slight; Moderate; Severe; Incapacitating*

PMS Questionnaire

Rate each of the following symptoms of your last menstrual cycle only

0 if not experienced
1 if mild [present but does not interfere with activities]
2 if moderate [present and interferes with activities but not disabling]
3 if severe [disabling; unable to function]

SYMPTOMS	0, 1, 2, 3	SYMPTOMS	0, 1, 2, 3	SYMPTOMS	0, 1, 2, 3
Abdominal bloating		Anxiety		Breast lumps	
Breast tenderness		Confusion		Craving for sweets	
Crying		Depression		Dizziness or faintness	
Fatigue		Forgetfulness		Headache	
Heart palpitations		Increased appetite		Insomnia	
Irritability		Mood swings		Nervous tension	
Nipple discharge		Swelling of extremities		Weight gain	

Are you now on or have you ever taken birth control pills? *Y N P* How long? _____ What type? _______

Are you now or have you ever used any hormone-modulating medications in the form of pills, patches, or creams [estrogen, progesterone, or birth control pills]? *Y N P* If yes, please list the type, dosage and frequency: ____

Have you experienced fibrocystic disease of the breast? *Y N P* Endometriosis? *Y N P*

Have you had uterine fibroids? *Y N P* Do you have cervical dysplasia? *Y or N* Ovarian cysts? *Y or N*

Have you ever had a venereal disease? *Y N P* What type? _____________

Do you have recurring vaginal infections? *Never; Rarely; Frequently; More than 3x/yr*

Do you have vaginal discharge? *Y N P* Do you have vaginal itching? *Y N P* Yeast infections? *Y N P*

Do you self-exam your breasts for lumps regularly? *Y or N* Last Pap Smear? ______________________

Are you sexually active? *Y or N* Any sexual difficulties? _______________ Difficulty conceiving? *Y or N*

Sexual preference? *Heterosexual; Bisexual; Homosexual*

Number of pregnancies?___________ Deliveries?__________ Miscarriages?________ Abortions?________

Were there any complications associated with the above? ____

____

Menopausal symptoms? ____

____

CONSENT FORM

We would like to take this opportunity to welcome you to the Optimum Wellness Naturopathic Clinic. This clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body, mind and spirit in its own inherent healing power. We seek to improve your quality of life and health through natural means.

Naturopathic Doctors assess the whole person, taking into consideration the physical, mental, emotional and spiritual aspects of an individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. At the Optimum Wellness Naturopathic Clinic a thorough case history will be taken and a complaint oriented physical exam will be performed. We would also like to obtain recent blood tests (taken within the last 2 months). More specific examinations such as breast, rectal, prostate or genital exams may also be required.

It is very important that you inform us immediately of any health concerns that you have, if you are taking any medication (either prescription or over the counter drugs, supplements, herbs and/or homeopathic remedies). If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise us immediately.

There are some slight health risks to naturopathic medical treatment. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements, herbs and/or homeopathic remedies
- Pain, bruising or injury from intra-muscular injections or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa

______ Initials — You understand that a record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others unless so directed by you or unless law requires it. You understand that you may look at your medical record at anytime and can request a copy of it by paying the document fee of $25. You understand that information from your medical record may be analyzed for research purposes and that your identity will be protected and kept confidential.

______ Initials — You understand that your naturopath will answer any questions that you have to the best of their ability. You understand that treatment results are not guaranteed. You do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, you voluntarily consent to diagnostic and therapeutic procedures, except for (please list any exceptions): ______________________________.

______ Initials — You intend this consent form to cover the entire course of treatment for your chief health concerns. You also confirm that you have the ability to accept or reject this care of your own free will and choice. You also acknowledge that you are not representing an agency (private, governmental or otherwise) attempting to gather information without so stating.

______ Initials — You understand that charges are to be paid at the time of the visit unless specific arrangements have been made prior to my schedules appointment. Payment for all dispensary items is due at the time of the visit.

______ Initials — You understand that you will be charged for the first appointment if it is missed or if you cancel with less than 24 hours notice. For follow-up visits a missed appointment fee of $50 will be charged for any appointments that are missed or late cancellations (less than 24 hours).

Patient Name: (Please Print) ________________________ Date: ________________

Signature: ____