Comprehensive Patient Questionnaire

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your naturopath will take a thorough case history, do a screening physical examination that may include a breast exam, blood and urine samples.

Part A: General Information & History

Date:
Last Name
First Name
Initials
Age
Street Address
D.O.B. //
dd / mm / yy
City
Province
Postal Code
H:( )
W:( )
C:( )
Marital Status: Single Married Separated Divorced Common-law
First Name of Partner/Significant Other:
Email:
Children: Y N
Ages & Sex:
Occupation:
Place of Employment:
Emergency Contact:
Phone:
Referral: Self Physician Other (please specify)
Physician:
T:
Dentist:
T:
PHN#:
List all health professionals you are currently seeing
Reason
Name:
Practice:
Name:
Practice:
Name:
Practice:
Name:
Practice:

Part A continued: History Current health conditions you desire improvement in **and** length of time they have been a concern to you, placed in order
of importance:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

To what extent do these areas interfere with your daily activities (work, sleep, etc.)?
_____
_____
_____

Have you been given a diagnosis for this problem -- if so, what?
_____
_____
_____

Family History
MGM: maternal grand mother PGM: paternal grand mother
MGF: maternal grand father PGF: paternal grand father
F: father M: mother B: brothers S: sisters Sp: spouse C: children DC: deceased

Check the box if there is a family history for the following health problems. If the health condition resulted in a family members death, please mark the middle column with DC

Allergies/Hay fever
Alcoholism
Anemia
Arthritis
Asthma
Cancer
Diabetes
Digestive Illness
Epilepsy
Glaucoma
Headaches
Heart Disease
High Cholesterol
High Blood Pressure
Kidney Disease
Mental Illness
Obesity
Stroke
Syphilis
Thyroid Condition
Tuberculosis
Other
1

Past Medical
Hospitalizations (year, reason):
_____

_____
__
Surgeries (year, type):
_____
_____
__
Serious illnesses/injuries/accidents (year, cause/injury):
_____
_____
__

Childhood illnesses:
Health as a child (1 (poor) to 10 (excellent)) _____ If less than 8, explain
_____ Rheumatic fever _____ German measles _____ Polio _____
Allergies _____ Chicken pox _____ Frequent colds/flu's _____ Mumps _____ Ear infections
_____ Skin conditions (eczema, psoriasis) _____

Vaccinations
type, year, adverse reactions:
_____
_____
__
Allergies: (list all known)
Allergy Items
Pets:
What kind
Medications: (prescription & over-the-counter)
Medication Dose
How many
Reaction
For What?
Drugs
Foods
Other
How long?

Supplements: (non-prescription, herbal, nutritional, any over-the-counter items)
Supplement Dose How long?
Have you ever had general anesthetic? Y N If yes,
when?_____
Antibiotic use? Y N If yes,
when?_____

Dental
To the best of your knowledge please list all dental work/treatments you have undergone. Include fillings (specify type), pulled teeth, root canals, bridges, crowns, dentures, braces, retainer/splints, accidents/injuries or any other type of dental/jaw surgery.
Date
Treatment
Describe any current dental concerns or symptoms:
_____
_____
__ Are you aware of any grinding of your teeth or clenching your jaw? Y N If yes, when? day night both

Chemicals
Please list any current or past exposures to solvents, chemicals, cleaning agents, insecticides, herbicides, pesticides, chemical/metal vapors, dry cleaning agents
Item

Work or Home

Travel (list backcountry & third world trips)
Where Illness or Trauma
When
How Long
When

Lifestyle
Physical Fitness
Hobbies
Exercise regularly? Y N Describe your program: _____
_____
__
Please list your hobbies or recreational interests.
_____
_____
__
Enjoy work? Y N If no, why?
_____
What have been your previous occupations?
_____
Please indicate on the line below where you feel your current balance between work and play is:
All Work 0 -----1------2------3------4------5------6------7------8------9------10 All Play

Support, Stressors & Personal Growth
Do you get along with your family?
_____
Please list the stressors that affect you the most:
1.
2.
3.
Please list the people/areas that support you the most:
1.
2.
3.
Do you currently follow a (religious/spiritual) belief system?
_____
Do you feel supported and comfortable with this belief system?
_____
Do you (circle)... meditate pray use visualization use relaxation techniques use other techniques?
Describe _____
_____
__
How might you finish this statement in regards to suggestions/programs for your health...I: ␣
can following plans/programs ␣ start programs then let things slide ␣
prefer choosing from options ␣ am easily overwhelmed

How will you know when you are feeling better?
_____
_____
__
_____
__
How might things look for you when your life is very good?
_____
_____
__

_____
__
Do you have any concerns or reservations in pursuing complementary & alternative therapies?
_____
_____
__

Smoking

	How Often	How Long
Quit – When		
Cigarettes		
Cigars		
Pipe		
Marijuana		

Drinking

	How often	How long
Quit – When		
Liquor		
Beer		
Wine		
Coffee		
Soft Drinks		

Diet: (for each "yes" list type, serving size & frequency)

Vegetarian? if yes, what kind	lacto	ovo	lacto-ovo	pesco	vegan
meat			Y	N	
fish			Y	N	
fowl			Y	N	
dairy			Y	N	
eggs			Y	N	
beans/legumes			Y	N	
fruits			Y	N	
vegetables			Y	N	
grains/bread/pasta/cereal			Y	N	

Meal **Food/Drink**	**Time**
Breakfast	
Lunch	
Dinner	
Snacks / Dessert	
Drinks	
Cravings	n/a
Aversions	n/a

What kind of water do you drink and how much?

_____

Please mention any foods or drinks that aggravate your symptoms or that you find hard to digest:

_____

_____

_____