

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

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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:

