

# West Vancouver Clinic of Naturopathic Medicine

## Health History Questionnaire

Please help us provide you with a complete evaluation by carefully filling out this questionnaire. All of your answers will be held *absolutely confidential*. If you have questions, please ask. Thank you.

Name \_\_\_\_\_ Age \_\_\_\_\_ M  F  Today's Date (Mo/Day/Year) \_\_\_\_\_

Your Care Card Number \_\_\_\_\_ Birth Date (Mo/Day/Year) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Children (Name/Age) \_\_\_\_\_

If the above is a child: Father's Name \_\_\_\_\_ Names of Other Healthcare Providers:

Mother's Name \_\_\_\_\_ Naturopathic Physician \_\_\_\_\_

Massage Therapist \_\_\_\_\_

Who referred you to our clinic? \_\_\_\_\_ Medical Doctor \_\_\_\_\_

Chiropractor \_\_\_\_\_

Number of visits to another Naturopathic Physician this year \_\_\_\_\_ Specialist \_\_\_\_\_

## YOUR MAIN HEALTH CONCERN

Please state your reasons for attending our clinic:

---

---

---

When did your problem(s) begin (be specific)? \_\_\_\_\_

Have you been given any diagnosis? If so, what? \_\_\_\_\_

What measures have you taken to improve your problem(s)? \_\_\_\_\_

## YOUR PAST MEDICAL HISTORY (please circle and include date)

Significant Illnesses:      Cancer      Diabetes      Hepatitis      High Blood Pressure      Heart

Disease

Rheumatic      Fever      Seizures      Thyroid Disease      Venereal      Disease

Other

Surgeries: \_\_\_\_\_

Significant Trauma (auto accidents, falls, etc.) \_\_\_\_\_

Your Birth (prolonged labour, forceps delivery, etc.) \_\_\_\_\_

Allergies (drugs, chemicals, foods) \_\_\_\_\_

**FAMILY MEDICAL HISTORY** ← \_\_\_\_\_

Please indicate family member and mother's side (M) or father's side (F)

Allergies

Asthma

Cancer

Diabetes

Heart Disease

High Blood Pressure

Seizures

Stroke

**OCCUPATIONAL STRESS** (chemical, physical, psychological) ← \_\_\_\_\_

**DESCRIBE YOUR WEEKLY EXERCISE** ← \_\_\_\_\_

**CURRENT MEDICINES** (prescriptions, over-the-counter drugs, vitamins, herbs,) ← \_\_\_\_\_  
Please describe any use of drugs for non-medical purposes.

**DIET** ← \_\_\_\_\_

Are you or have you ever been on a restricted diet? What kind?

Please describe your average daily diet:

Morning

Afternoon

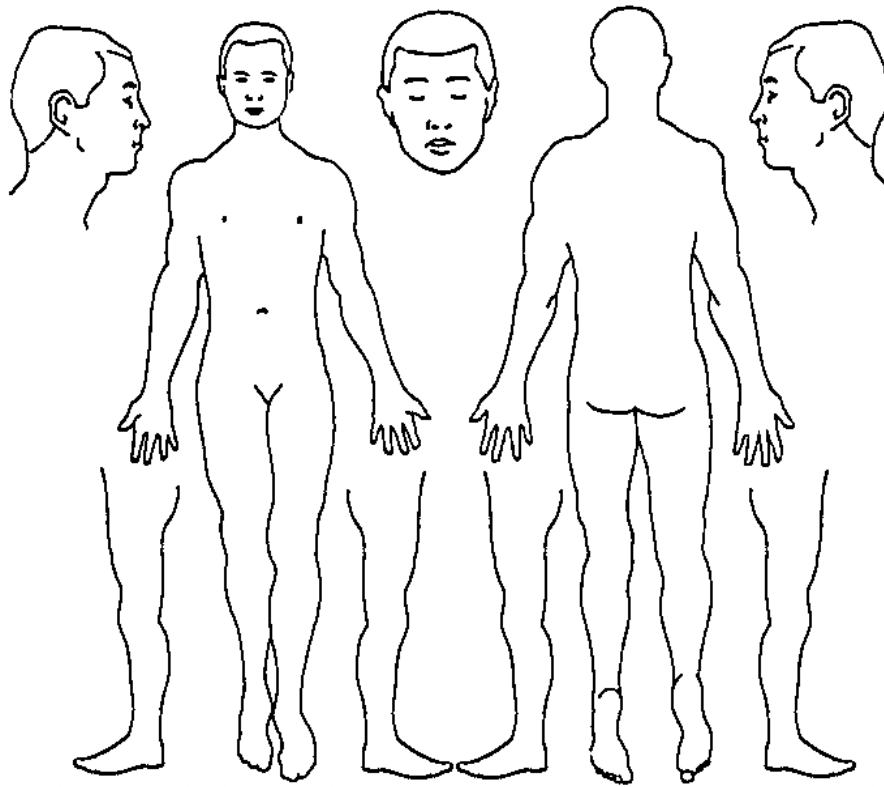
Evening

How many packs of cigarettes do you smoke a day?

How much coffee, tea or cola do you drink per week?

How much alcohol do you drink per week?

**INDICATE PAINFUL OR DISTRESSED AREAS** ← \_\_\_\_\_



Please check if the following symptoms are currently a problem or are a recurring problem:

**GENERAL** ←

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Poor appetite                          | <input type="checkbox"/> Poor sleep                         | <input type="checkbox"/> Fatigue            |
| <input type="checkbox"/> Fevers                                 | <input type="checkbox"/> Chills                             | <input type="checkbox"/> Night sweats       |
| <input type="checkbox"/> Sweat easily                           | <input type="checkbox"/> Tremors                            | <input type="checkbox"/> Cravings           |
| <input type="checkbox"/> Localized weakness                     | <input type="checkbox"/> Poor balance                       | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed or bruise easily                 | <input type="checkbox"/> Weight loss                        | <input type="checkbox"/> Weight gain        |
| <input type="checkbox"/> Peculiar tastes or smells              | <input type="checkbox"/> Strong thirst (cold or hot drinks) |   |
| <input type="checkbox"/> Sudden energy drop (what time of day)? |   |   |

**SKIN AND HAIR** ←

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Rashes                         | <input type="checkbox"/> Ulcerations                      | <input type="checkbox"/> Hives        |
| <input type="checkbox"/> Itching                        | <input type="checkbox"/> Eczema                           | <input type="checkbox"/> Pimples      |
| <input type="checkbox"/> Dandruff                       | <input type="checkbox"/> Loss of hair                     | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Any other hair or skin problems? |                                       |

**HEAD, EYES, EARS, NOSE AND THROAT** ←

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Concussions     | <input type="checkbox"/> Migraines              |
| <input type="checkbox"/> Glasses         | <input type="checkbox"/> Eye strain      | <input type="checkbox"/> Eye pain               |
| <input type="checkbox"/> Poor vision     | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Colour blindness       |
| <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Blurry vision   | <input type="checkbox"/> Earaches               |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing    | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Sinus problems  | <input type="checkbox"/> Nosebleeds      | <input type="checkbox"/> Recurrent sore throats |

Grinding teeth

tongue

Teeth problems

Headaches (where and when)?

Any other head or neck problems?

Facial pain

Jaw clicks

Sores on lips or

---

## CARDIOVASCULAR ←

High blood pressure

Irregular heartbeat

Cold hands or feet

Blood clots

Any other heart or blood vessel problems?

Low blood pressure

Dizziness

Swelling of hands

Phlebitis

Chest pain

Fainting

Swelling of feet

Difficulty in breathing

---

## RESPIRATORY ←

Cough

Bronchitis

breath

Difficulty in breathing when lying down

Any other lung problems?

Coughing blood

Pneumonia

Production of phlegm (what colour)?

Asthma

Pain with a deep

---

## GASTROINTESTINAL ←

Nausea

Vomiting

Constipation

Diarrhea

Abdominal pain or cramps

Any other problems with your stomach or intestines?

Indigestion

Belching

Gas

Bad breath

Chronic laxative use

Black stools

Blood in stools

Rectal pain

Hemorrhoids

---

## GENITO-URINARY ←

Pain on urination

Urgency to urinate

Decrease inflow

Do you wake to urinate (how often)?

Any other problems with your genital or urinary system?

Frequent urination

Unable to hold urine

Impotency

Any particular colour to your urine?

Blood in urine

Kidney stones

Sores on genitals

---

## PREGNANCY AND GYNECOLOGY ←

\_ Age at first menses

\_ First date of last menses

pregnancies

\_ Days between menses

Unusual menses 0 Heavy

\_ Number of births

\_ Abortions

\_ Duration of menses

Light

\_ Premature births

\_ Number of

\_ Miscarriages

Clots

- Painful periods
- Irregular periods
- Last PAP
- Vaginal discharge
- Vaginal sores
- Breast lumps
- Changes in body / psyche prior to menstruation
- Do you practice birth control? What type and for how long?

**MUSCULOSKELETAL** ←

---

- Neck pain
- Muscle pain
- Knee pain
- Back pain
- Muscle weakness
- Foot/ ankle pain
- Hand/ wrist pain
- Shoulder pain
- Mp pain
- Any other joint or bone problems?

**NEUROPSYCHOLOGICAL** ←

---

- Seizures
- Dizziness
- Loss of balance
- Areas of numbness
- Lack of coordination
- Poor memory
- Concussion
- Depression
- Anxiety
- Quick temper / irritable
- Easily susceptible to stress
- Have you ever been treated for emotional problems?
- Have you ever considered or attempted suicide?
- Any other neurological or psychological problems?

**COMMENTS** ←

---

Please indicate any other problems you would like to discuss.