

NATUROPATHIC HEALTH EVALUATION FORM – ADULT

Please take the time (allow 30 mins) to thoroughly and thoughtfully complete your naturopathic health evaluation form and submit it back to the clinic 24 hours prior to your 1st appointment. This information will be kept strictly confidential.

GENERAL INFORMATION

| | | |
|------------------------|---|--------------|
| First Name: | Middle Name: | Last Name: |
| Date of Birth (d/m/y): | Age: | Gender: M/F |
| Home Address: | | Suite/Apt: |
| City: | Province: | Postal Code: |
| Home Phone #: | Work #: | Cell #: |
| Email: | Circle your preferred method of contact | |

Emergency Contact

| | | | |
|------------------|-----------|---------------|----------|
| Name: | Relation: | Home Phone #: | Work #: |
| Family Physician | Name: | | Phone #: |

How did you hear about our Clinic (e.g. website, word of mouth, walking by)?

Were you referred by anyone? Y/N – If yes, by whom?

Have you ever seen a naturopathic doctor before? Y/N – If yes, whom?

How long ago?

HEALTH CONCERNS

What are your current primary health concerns? Please list in order of importance to you and complete the following.

| | |
|-----------------|--|
| Health Concern | e.g. Headaches |
| Onset? | e.g. 2 years ago |
| Makes Better? | e.g. lying down, heat, physical pressure |
| Makes Worse? | e.g. bright light, caffeine |
| Triggers? | e.g. too long between meals, low pressure before a storm |
| Treatment Goal? | e.g. reduce frequency |

| | |
|-----------------|--|
| Health Concern | |
| Onset? | |
| Makes Better? | |
| Makes Worse? | |
| Triggers? | |
| Treatment Goal? | |

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|-----------------|--|
| Health Concern | |
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| | |
|-----------------|--|
| Health Concern | |
| Onset? | |
| Makes Better? | |
| Makes Worse? | |
| Triggers? | |
| Treatment Goal? | |

HEALTH HISTORY

Please circle those **health conditions** you are currently experiencing. Please mark with a P those health conditions you have only experienced in the past. For current health conditions, please note month/year of onset/diagnosis.

| | | |
|---|---------------------------------|--|
| METABOLIC & HORMONAL (excluding reproductive) | Environmental Allergy | Celiac Disease |
| Type 1 Diabetes | Specify: | Lactose Intolerance |
| Type 2 Diabetes | Food Allergy | Irritable Bowel Syndrome |
| Metabolic Syndrome | Specify: | Crohn's Disease |
| Obesity | Drug Allergy | Ulcerative Colitis |
| Hypothyroidism | Specify: | Diverticulitis |
| Hashimoto's Thyroiditis | Other: | Colon Polyps |
| Hyperthyroidism | RESPIRATORY | Hemorrhoids |
| Hyperparathyroidism | Chronic Sinusitis | Anal Fissures |
| Cushing's Syndrome | Chronic Rhinitis | Appendicitis |
| Addison's Disease | Nasal Polyps | Hiatal/Inguinal Hernia |
| Inherited Metabolic Disorder | Sleep Apnea | Pancreatitis |
| Other: | Asthma | Hepatitis |
| CIRCULATORY, BLOOD & LYMPH | Chronic Bronchitis | Liver Cirrhosis |
| High Cholesterol | Emphysema | Liver Failure |
| High Blood Pressure | Pneumonia | Gallbladder Stones |
| Angina | Tuberculosis | Other: |
| Heart Attack | Other: | URINARY |
| Stroke | EARS & EYES | Bladder Infections (recurrent) |
| Congestive Heart Failure | Otitis Externa (recurrent) | Interstitial Cystitis |
| Transient Ischemic Attacks | Otitis Media (recurrent) | Nephritic Syndrome |
| Heart Infection | Labyrinthitis | Nephrotic Syndrome |
| Arrhythmia | Meniere's Disease | Kidney Failure |
| Heart Valve Diseases | Tinnitus | Kidney Stones |
| Peripheral Venous Insufficiency | Ruptured Ear Drum | Kidney Infection |
| Varicose Veins | Glaucoma | Other: |
| Deep Vein Thrombosis | Cataracts | MUSCULOSKELETAL & CONNECTIVE TISSUE |
| Intermittent Claudication | Conjunctivitis (recurrent) | Osteoarthritis |
| Raynaud's Syndrome | Macular Degeneration | Osteoporosis |
| Iron Deficient Anemia | Retinal Detachment | Sciatica |
| B12/Folate Anemia | Other: | Fibromyalgia |
| Thalassemia | SKIN, HAIR & NAILS | Rheumatoid Arthritis |
| Sickle-Cell Disorder | Eczema/Atopic Dermatitis | Systemic Lupus Erythematosus |
| Aplastic Anemia | Psoriasis | Sjorgen's/Sicca Syndrome |
| Diss. Intravascular Coagulation | Rosacea | Other: |
| Haemophilia | Shingles | NEUROLOGICAL |
| Other: | Vitiligo | Chronic Fatigue Syndrome |
| IMMUNE (GENERAL/OTHER) | Onychomycosis (nail fung infxn) | Migraine |
| Common Variable Immunodef'y | Other: | Dementia |
| Multiple Chemical Sensitivities | GASTROINTESTINAL | Alzheimer's Disease |
| Sarcoidosis | Gingivitis | Parkinson's Disease |
| Anaphylatic Allergy Reaction | Periodontitis | Huntington's Disease |
| Specify: | Chronic Gastritis | Multiple Sclerosis |
| | Gastric or Duodenal Ulcer | ALS |
| | GastroEsophageal Reflux Dz | |

| | | |
|---------------------------|--|--|
| Epilepsy | CANCER | FEMALE GENITAL/REPRO |
| Cerebral Palsy | Lung Cancer | PMS |
| Trigeminal Neuralgia | Breast Cancer | Dysmenorrhea (painful periods) |
| Bell's Palsy | Colon Cancer | Amenorrhea (absent periods) |
| Other: | Prostate Cancer | Polycystic Ovarian Syndrome |
| MENTAL & BEHAVIOURAL | Melanoma | Infertility |
| Addiction/substance abuse | Other: | Candida/Yeast Infxn (recurrent) |
| Specify: | MALE GENITAL/REPRO | Sexually Transmitted Disease (e.g.HIV, chlamydia, gonorrhea) |
| Depression | Benign Prostatic Hyperplasia | Specify: |
| Anxiety | Prostatitis/Infection | Endometriosis |
| Phobias | Infertility | Fibroids |
| Specify: | Erectile Dysfunction | Fibrocystic Breasts |
| Insomnia | Sexually Transmitted Disease (e.g.HIV, chlamydia, gonorrhea) | Mastitis |
| Bipolar Disorder | Specify: | Other: |
| Schizophrenia | Hydrocele | Gestational Diabetes |
| Suicide Attempts | Torsion of Testes | Preeclampsia/Eclampsia |
| Bulimia | Testicular Mass | Post-Partum Depression |
| Anorexia | Orchitis | Other: |
| Personality Disorder | Other: | Other: |
| ADD/ADHD | Other: | Other: |
| Autism | Other: | Other: |
| Other: | Other: | Other: |

Type of birth control?

Are you currently sexually active? Y/N

Sexual preference?

Women Only:

| | |
|---|------------|
| Age menses began? | |
| Average number of days bleeding? | |
| Average length of cycle (e.g. 28 days)? – Date last menses began? | |
| Are you currently pregnant? | Y/N |
| Are you trying to become pregnant? | Y/N |
| Number of pregnancies? | |
| Number of live births? | |
| Number of vaginal births? | |
| Number of caesarean sections? | |
| Number of miscarriages? | |
| Number of abortions? | |
| Are you currently breastfeeding? | Y/N |
| Are you peri-menopausal? | Y/N/Unsure |
| If yes, please list your symptoms? | |
| Are you menopausal/post-menopausal? | Y/N/Unsure |
| If yes, at what age did you become menopausal? | |
| What were/are your symptoms? | |

Please check if you had any of the following **illnesses during childhood** and mark them with an asterisk (*) if they were severe/involved complications.

| | | | | | |
|-----|-------------|-----|-----------------|-----|--------|
| Yes | | Yes | | Yes | |
| | Chicken Pox | | Meningitis | | Polio |
| | Diphtheria | | Mumps | | Other: |
| | Measles | | Rheumatic Fever | | Other: |

Please circle if you have experienced and provide year of injury, surgery and hospitalization.

| | | |
|-------------------------|---|------------------------|
| INJURY | Appendectomy | Pacemaker |
| Back | Cholecystectomy (gall bladder) | Tonsillectomy |
| Neck | Coronary Artery Bypass | Tympanostomy/Ear tubes |
| Head | Dental (e.g. root canal) | Tubal Ligation |
| Broken/Fractured Bones | Specify: | Vasectomy |
| Specify: | Hernia | Other: |
| Strains/Sprains | Hysterectomy – full (ovaries removed) or partial? | HOSPITALIZATION |
| Specify: | Joint Replacement | Specify Reason: |
| Other: | Specify: | Specify Reason: |
| SURGERY | Mastectomy | Specify Reason: |
| Angioplasty or Stenting | | Specify Reason: |

Please circle if you have had, provide last test/exam date and note any abnormal/significant findings.

| Year | Diagnostic Test/Exam | Findings? | Year | Diagnostic Test/Exam | Findings? |
|------|-----------------------|-----------|------|-------------------------|-----------|
| | Full Physical | | | Liver Panel | |
| | Complete Blood Count | | | Hepatitis B or C | |
| | Lipid Panel | | | Breast Exam | |
| | Cardiac Stress Test | | | Mammogram | |
| | ECG/EKG | | | Bone Density | |
| | Fasting Blood Glucose | | | Digital Rectal/Prostate | |
| | Colonoscopy | | | PSA | |
| | Fecal Occult Blood | | | PAP Smear | |
| | Upper Endoscopy | | | HIV | |
| | Upper GI Series | | | Syphilis | |
| | Lower GI Series | | | Other: | |

HEALTH CARE

Medications

| | Yes | No |
|---|-----|----|
| Have you had prolonged or regular use of NSAIDs (e.g. Aspirin, Advil, Motrin)? | | |
| Have you had prolonged or regular use of Tylenol? | | |
| Have you had prolonged or regular use of Steroids (e.g. Prednisone)? | | |
| Have you had prolonged or regular use of Acid Blocking Drugs (e.g. Zantac, Prilosec)? | | |
| Have you had prolonged or regular use of Laxatives (e.g. Metamucil, Dulcolax)? | | |
| Have you had prolonged or regular use of Antibiotics? | | |
| Have you had prolonged use of the Oral Contraceptive Pill? | | |
| Have you had prolonged use of Hormone Replacement Therapy? | | |

Please list all current medications (e.g. prescription, over-the-counter):

| Medication | Dose | For What Condition? | Since When? |
|------------|------|---------------------|-------------|
| | | | |
| | | | |
| | | | |

Please list major medications used in the past 10 years:

| Medication | Dose | For What Condition? | When? |
|------------|------|---------------------|-------|
| | | | |
| | | | |
| | | | |

Vaccinations

Please check whether you have or have not had the following vaccinations.

| Yes | No | Unsure | | Yes | No | Unsure | |
|-----|----|--------|--------------------------------------|-----|----|--------|-----------------------------|
| | | | MMR (measles, mumps, rubella) | | | | Varicella (chicken pox) |
| | | | DPT (diphtheria, pertussis, tetanus) | | | | Influenza (flu) |
| | | | Tetanus booster | | | | Meningitis |
| | | | IPV (inactivated polio virus) | | | | HPV (human papilloma virus) |
| | | | Hepatitis A | | | | Other (e.g. HINI flu) |
| | | | Hepatitis B | | | | Specify: |

Natural Health Products

Please list all current natural health products (herbs, vitamins, supplements, homeopathics):

| Product & Brand | Dose | For What Condition? | Since When? |
|-----------------|------|---------------------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Health Care Treatment

Please list all current health care treatments (e.g. chiropractic, physiotherapy, counselling):

| Treatment & Practitioner Name | Frequency | For What Condition? | Since When? |
|-------------------------------|-----------|---------------------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |

Please describe any significant side effects caused by your medications, vaccinations, natural health products or other health care treatment:

DIET

Please list any **food sensitivities or intolerances** (e.g. dairy, soy, wheat, gluten, corn, eggs, yeast, shellfish, fatty/greasy foods, caffeine, alcohol, monosodium glutamate, aspartame).

Please list any **dietary restrictions** (e.g. religious, vegetarian, vegan, low carbohydrate, low sodium, diabetic).

Please identify any **particular diet** (e.g. Atkins, Zone, Weight Watcher's) you currently follow.

Do you typically eat three meals a day? Y/N

Please describe a typical day's diet.

Breakfast:

Lunch:

Dinner:

Snacks:

Water (amount):

Other non-alcoholic beverages (kind and amount):

How often do you eat junk/fast food (e.g. candy bars, fries) each week?

How often do you eat sugary snacks/dessert each week?

How often do you eat processed/packaged food each week?

Do you eat/drink things sweetened artificially (e.g. with aspartame)? Y/N – If so, what?

Height:

Current weight:

Weight 1yr ago:

Usual weight:

Maximum weight:

Minimum weight:

Desired weight:

Do you have regular weight fluctuations of >10lbs? Y/N

Have you ever had a nutritional consultation? Y/N – Was it helpful? Y/N

What changes have you made to your diet or eating habits to improve your health?

LIFESTYLE

Exercise:

Please describe your current exercise program.

| Type | Activity | Frequency (per wk) | Duration (mins) |
|----------------|----------|--------------------|-----------------|
| Cardiovascular | | | |
| Strength | | | |
| Flexibility | | | |
| Other | | | |

Interests/Hobbies/Leisure Activities:

What are your main interests, hobbies, leisure activities (e.g. film, gardening, hiking)?

Stress/Relaxation:

| | |
|---|--|
| Scale: 0=no stress, 10=extraordinary stress | |
| How would you rate the current level of stress in your life? | |
| What is your greatest current source of stress (e.g. work, family, finances)? | |
| How would you rate the level of stress in your life in the past year? | |
| How well do you generally deal with stress? | |
| What do you do to relax (e.g. go for a walk, meditate, have a drink)? | |

Sleep:

| | |
|---|-----|
| When do you typically go to bed and rise from bed? | |
| In that time, how many hours of sleep do you think you are getting? | |
| Do you have difficulty falling asleep? | Y/N |
| Do you have difficulty staying asleep? | Y/N |
| Do you toss and turn throughout the night? | Y/N |
| Do you have difficulty waking? | Y/N |
| Do you do shift work? | Y/N |
| Do you fly or travel a lot? | Y/N |

Energy:

| | |
|---|-----|
| Scale: 0=absolutely no energy, 10=boundless energy | |
| How would you rate your average energy level throughout the day? | |
| When during the day do you have the least energy? | |
| How would you rate your energy at that time? | |
| When during the day do you have the most energy? | |
| How would you rate your energy at that time? | |
| Do you have enough energy to complete your daily tasks (e.g. work, make meals, watch kids)? | Y/N |
| Do you have enough energy to do more than your daily tasks (e.g. exercise, socialize)? | Y/N |

Substance Use:

| | |
|---|-----|
| <u>Caffeine:</u> | |
| How many cups (250ml) of caffeinated tea do you drink a day? | |
| How many cups of caffeinated coffee do you drink a day? | |
| How much caffeinated pop do you drink per day? | |
| <u>Alcohol:</u> | |
| How many alcoholic drinks do you have per week? (1 drink=5oz wine, 12oz beer, 1.5oz liquor) | |
| How long have you been drinking this amount of alcohol? | |
| Have you used alcohol in the past? | Y/N |
| If so, at what frequency? | |
| <u>Tobacco:</u> | |
| Do you use tobacco products? | Y/N |
| What kinds? | |
| If you do not or have not used tobacco, please skip the following questions. | |
| How many cigarettes do you smoke per day? | |
| How many years have you been smoking? | |
| If you successfully quit smoking, how long ago did you do so? | |
| If you have not successfully quit smoking, how many times have you attempted? | |
| <u>Recreational Drugs:</u> | |
| Do you use recreational drugs? | Y/N |
| If you do not or have not used drugs, please skip the following questions. | |
| What kinds? | |
| At what frequency? | |
| Have you used recreational drugs in the past? | Y/N |
| If so, at what frequency? | |

Environmental Exposures

| | |
|---|-----|
| Are you frequently exposed to animals? | Y/N |
| Are you (or have you been) exposed to damp or moldy conditions? | Y/N |
| Are you (or have you been) regularly exposed to second hand smoke? | Y/N |
| Have you had regular or significant exposures to: | |
| Herbicides/pesticides? | Y/N |
| Organic solvents? | Y/N |
| Heavy metals? | Y/N |
| UV? | Y/N |
| Radiation? | Y/N |
| Other? - please specify: | |
| Do you regularly drink from plastic bottles or warm food in plastic containers? | Y/N |
| Do you regularly dry clean your clothing? | Y/N |
| Do you live in a new or old home? | |
| Do you consider your home a healthy physical environment? | Y/N |
| If not, why not? | |
| Do you consider your workplace a healthy physical environment? | Y/N |
| If not, why not? | |
| What is your primary source of drinking water? | |

If you have noticed a negative impact of specific environmental exposures on your health, please describe here:

| | |
|--|-----|
| Have you traveled outside of Canada in the last 5 years? | Y/N |
| If so, where? | |
| Did you suffer any sickness during your travels? | Y/N |
| If so, what? | |
| Have you camped in the past 5 years? | |

SOCIAL HISTORY

| | |
|---|-----|
| Do you have a significant other in your life (e.g. husband, partner)? | Y/N |
| If yes, what is their name? | |
| How long have you been together? | Y/N |
| How would you describe your relationship? | |
| Have you every been divorced? | Y/N |
| Have you been widowed? | Y/N |
| Do you have children? | Y/N |

If you do have children, please provide the following information:

| | | | |
|-------|-------|-------|-------|
| Name: | Name: | Name: | Name: |
| Age: | Age: | Age: | Age: |

| | |
|--|-----|
| Who lives in your household? | |
| How would you describe the emotional climate of your home? | |
| Who/what are your sources of social support (e.g. family, church)? | |
| Who/what is your primary source of social support (e.g. sister)? | |
| Do you feel you have adequate social support in your life? | Y/N |
| Are you currently working? | Y/N |
| If so, please specify: | |
| Do you generally enjoy your work? | Y/N |
| If you are not working, is this by choice? | Y/N |
| Do you do volunteer work? | Y/N |
| If yes, please specify: | |
| Are you involved in any community groups, clubs, etc? | Y/N |
| If yes, please specify: | |

FAMILY HEALTH HISTORY

Please list the **health conditions your family members have experienced**, note their age at diagnosis in brackets () beside their condition, and if deceased, their age at death.

| Relation | Health Conditions (please use the previous table listing possible health conditions as a reference) | If Deceased, Age at Death |
|----------------------|---|---------------------------|
| Mother | e.g. type 2 diabetes (55yoa), heart disease (60yoa) | 70yoa |
| Mother | | |
| Father | | |
| Brother | | |
| Sister | | |
| Maternal Grandmother | | |
| Maternal Grandfather | | |
| Paternal Grandmother | | |
| Paternal Grandfather | | |
| Maternal Aunt | | |
| Maternal Uncle | | |
| Paternal Aunt | | |
| Paternal Uncle | | |
| Child | | |
| Child | | |

If you have any concerns (e.g. time commitment, significant financial restrictions) please note them here:

THANK YOU for investing your time in completing this health care evaluation. Please submit your form back to **Norfolk Wellness 24 hours before your initial consultation**. We sincerely look forward to meeting and working with you to achieve better health and well-being.