

# Health History Questionnaire

By completely filling out this form you will help us to help you. All answers will be *absolutely confidential*. If you have any questions please ask. Thank you.

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  They

Your Care Card Number \_\_\_\_\_ Birthdate (M/D/Y) \_\_\_\_\_

Home Address \_\_\_\_\_

Postal Code \_\_\_\_\_

Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

E-mail Address \_\_\_\_\_

I give permission to be emailed occasionally of specials or new treatments: Yes or No (circle)

Names of Other Healthcare Providers:

Medical Doctors \_\_\_\_\_ Naturopathic Physician \_\_\_\_\_

Chiropractor \_\_\_\_\_ Others \_\_\_\_\_

Who referred you to our clinic?

## **Your Main Health Concern**

Why are you coming to our clinic today?

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

Changes in medication(s)?

## **Your Past Medical History**

(Please check and date)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Venereal Disease        |
| <input type="checkbox"/> High Blood Pressure                               | <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Surgeries               |
| <input type="checkbox"/> Heart Disease                                     | <input type="checkbox"/> Hepatitis/Kidney Disease | <input type="checkbox"/> Anemia (All types)      |
| <input type="checkbox"/> High Cholesterol                                  | <input type="checkbox"/> Thyroid Disease          | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Rheumatic Fever                                   | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Other Major Illness     |
| <input type="checkbox"/> Significant Trauma (auto accidents, falls, other) |   | (Specify) _____                                  |
| <input type="checkbox"/> Allergies (drugs, chemicals, foods)               |   | _____  |
| (Specify) _____  |   |  |

**Family Medical History**

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Please indicate family member, and if on father's (F) or mother's (M) side of the family.

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma       |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Allergies    |
| <input type="checkbox"/> Seizures                     | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Thyroid Disease              | <input type="checkbox"/> High Cholesterol    |                                       |
| <input type="checkbox"/> Other (Please Specify) _____ |  |                                       |

**Occupational Stress** (chemical, physical, psychological)

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- How many packs of cigarettes do you smoke a day?
- How much coffee, tea, cola, or alcohol do you drink per week?

**Describe Your Weekly Exercise**

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**Current Medicines**

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List all prescriptions, over-the-counter drugs, vitamins, herbs, and any non-medical drugs.

**Diet**

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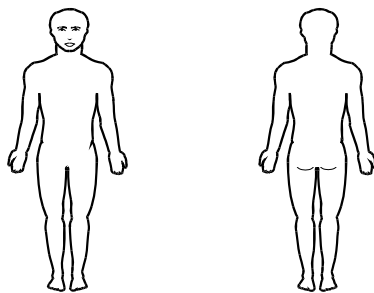
Are you or have you ever been on a restricted diet? If so, what kind?

Please describe your average daily diet:

- Morning                                       Afternoon                                       Evening

**Indicate Painful or Distressed Areas**

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Please check if the following symptoms are a current or recurring problem.

### General

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

### Skin and Hair

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

### Head, Eyes, Ears, Nose, And Throat

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- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Night blindness  | <input type="checkbox"/> Sinus problems          |
| <input type="checkbox"/> Neck pain     | <input type="checkbox"/> Colour blindness | <input type="checkbox"/> Nose bleeds             |
| <input type="checkbox"/> Concussions   | <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Jaw clicks or pain      |
| <input type="checkbox"/> Eye pain      | <input type="checkbox"/> Earaches         | <input type="checkbox"/> Tooth pain              |
| <input type="checkbox"/> Eye strain    | <input type="checkbox"/> Poor hearing     | <input type="checkbox"/> Mercury tooth fillings  |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Ringing in ears  | <input type="checkbox"/> Recurrent sore throats  |
| <input type="checkbox"/> Using glasses | <input type="checkbox"/> Facial pain      | <input type="checkbox"/> Sores on lips or tongue |

### Heart and Circulation

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- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting       | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Chest pain     | <input type="checkbox"/> Swelling of hands  |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Swelling of feet   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Blood clots    |   |

### Lungs and Breathing

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- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Cough                | <input type="checkbox"/> Pain with a deep breath         | <input type="checkbox"/> Pneumonia      |
| <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Production of phlegm, (colour)? | <input type="checkbox"/> Other problems |

### Digestion and Elimination

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- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Indigestion  | <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Rectal pain    |
| <input type="checkbox"/> Gas          | <input type="checkbox"/> Nausea                   | <input type="checkbox"/> Hemorrhoids    |
| <input type="checkbox"/> Bloating     | <input type="checkbox"/> Vomiting                 | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic laxative use     | <input type="checkbox"/> Diarrhea       |
| <input type="checkbox"/> Bad Breath   |   |   |

**Genito-Urinary**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Frequent urination      | <input type="checkbox"/> Unable to hold urine      | <input type="checkbox"/> Kidney stones     |
| <input type="checkbox"/> Urgency to urinate      | <input type="checkbox"/> Decrease in flow          | <input type="checkbox"/> Impotency         |
| <input type="checkbox"/> Pain on urination       | <input type="checkbox"/> Distinctive or odd colour | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Do you wake to urinate? | <input type="checkbox"/> Blood in urine            | <input type="checkbox"/> Other problems    |

**Women**

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- |                                  |   |  |
|----------------------------------|---|--|
| ___ Age of first menses          | <input type="checkbox"/> Unusual menses | <input type="checkbox"/> Irregular periods |
| ___ Duration of menses           | <input type="checkbox"/> Heavy          | <input type="checkbox"/> Painful periods   |
| ___ Days between menses          | <input type="checkbox"/> Light          | <input type="checkbox"/> Vaginal discharge |
| ___ Date of start of last menses | <input type="checkbox"/> Clots          | <input type="checkbox"/> Vaginal sores     |
| ___ Date of last PAP exam        |   | <input type="checkbox"/> Breast lumps      |
- Do you perform a monthly self - breast exam? \_\_\_\_\_
- Changes in body or emotions prior to menstruation?
- Do you practice birth control?       What type and for how long?
- Number of pregnancies \_\_\_\_\_ Number of births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

**Muscles, Joints, and Bones**

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- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Neck pain         | <input type="checkbox"/> Knee pain                     | <input type="checkbox"/> Muscle pain     |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Foot / ankle pain             | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Hand / wrist pain | <input type="checkbox"/> Hip pain                      |  |
| <input type="checkbox"/> Shoulder pains    | <input type="checkbox"/> Other joint or bone problems? |  |

**Brain, Nerves, and Emotions**

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- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Loss of balance          | <input type="checkbox"/> Depression            | <input type="checkbox"/> Concussion        |
| <input type="checkbox"/> Quick temper / irritable | <input type="checkbox"/> Susceptible to stress | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Poor memory              | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Lack of coordination  |  |
- Have you ever been treated for emotional problems?
- Have you ever considered or attempted suicide?
- Any other neurological or psychological problems?

**Comments**

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- Please describe any other problems you would like to discuss.

*If you like what we do, tell everyone. If you have concerns, tell us.  
To health and happiness! Congratulations on your new journey.*

# The Village Clinic

## Consent Form for Naturopathic Medicine

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic physicians 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 capacity to heal itself. Your Naturopathic Physician will take a thorough case history, may perform a pertinent physical exam and may suggest lab work or request copies of lab work previously completed by your family physician or specialist.

Please inform your Naturopathic Physician of any disease process you are suffering from and any medications, over the counter drugs and supplements you are taking. Please advise your Naturopathic Physician if you are nursing, pregnant or become pregnant throughout the course of your treatment.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, costs, benefits, risks, side effects and, in each case, the consequences of not having the diagnosis and/or treatment acted upon.

As with any form of medical intervention, there can be risks associated with treatment by naturopathic medicine. These include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, bruising or injury from injections
- fainting or puncturing of an organ with acupuncture needles

All visits are confidential. We are committed to preserving and safeguarding your right to privacy. A record will be kept of the health services provided to you. The record will be kept confidential and will not be released to others unless so directed by you or if the law requires it.

If required, the Naturopathic Physician may discuss your case with other healthcare providers. I give permission to the physicians and practitioners at The Village Clinic to collaborate on my case. \_\_\_\_\_  
Initial

\_\_\_\_\_

I understand that results are not guaranteed. I do not expect naturopathic physicians to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to naturopathic and collaborative care from The Village Clinic. I intend this consent form to cover the entire course of my treatment at The Village Clinic. I understand that I am free to withdraw my consent at any time.

Patient name: (please print) \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient or guardian: \_\_\_\_\_

Signature of Dr. Maria Fabbro ND: \_\_\_\_\_