Moose Jaw Naturopathic Clinic

***Dr. Douglas Amell,** Naturopathic Doctor*
***Dr. Joel Guillemin,** Naturopathic Doctor*
125 – 3rd Avenue N.W., Moose Jaw, SK S6H 8B1

Phone (306) 692-3848 **(on 3rd Ave. NW just south of High Street)** **Fax (306) 692-4889**

HEALTH HISTORY SUMMARY

These forms must be completed before arriving, and brought to the appointment. Please arrive 15 minutes early so the receptionist can process your paperwork without sacrificing any of your allotted appointment time.

Date: ___________________

Name: ____ Age: _________

Address: ____City: __________________________________

Postal Code: ________________________________Province: ________________________

Phone (Home): ____________________ (Work): ___________________ (Cell):______________________

E-mail address:____ Blood Type: ___________

Birthdate (mm/dd/yy): ___/___/_____ Place of Birth (Closest Major Centre):________________________

Occupation: _____________________________ Full or Part time? Employer: _________________________

Extended Health Care Carrier (If any): ____

Emergency Contact: ________________________________ Relationship to you: ______________________

Contact's Phone: __________________________________ Current Physician: _______________________

How did you find out about the naturopathic services at this clinic: _________________________________

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Scent Free Environment

Due to environmental sensitivities and allergies, please refrain from wearing colognes, perfumes and scented products when visiting the clinic.

Clinic Appointment Cancellation Policy

We request that a minimum of 3 business days notice be given when cancelling an appointment. This allows one of the many people on our waiting list the opportunity to fill that appointment slot. We are understanding of situations such as cancellations due to poor road or weather conditions, or in the event of a sudden family crisis, and do not charge for these missed appointments.

Current Health Concerns

What is the **main** reason for coming today? If you have a specific health condition, please describe it in detail. When was the first time you noticed your condition, and describe carefully any factors that you suspect may have played a role in its onset and continuation?

List in order of importance other health concerns:

1. ____ & length of time ____________________

2. ____ & length of time ____________________

3. ____ & length of time ____________________

4. ____ & length of time ____________________

Your Health History

The general state of your health is: Excellent _____ Good _____ Average _____ Fair _____ Poor _____,

And on the average describe your energy level from 1 – 10 (10 = highest & 1 + lowest) _____

When during the day is your energy the best? __________________ and worst? ___________________

Current approximate height? __________ weight? _____________ weight one year ago? ____________

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist? ______ Have you in the past? _________ If so, please give dates: ______________________

Are you currently working with a Doctor of conventional medicine (MD)? **Yes or No**

What is your weakest organ and why?
____

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? ***(yes or no) Please circle.***

1) ____ date ______________

2) ____ date ______________

3) ____ date ______________

4) ____ date ______________

5) ____ date ______________

Which of the following have you had and indicate "now" or "past"; also how often and when?

Now or Past		Year	Now or Past		Year	Now or Past		Year
_____	pneumonia	______	_____	thyroid problem	______	_____	hepatitis	______
_____	tonsillitis	______	_____	diabetes	______	_____	weight problem	______
_____	ear infections	______	_____	asthma	______	_____	epilepsy	______
_____	chronic infections	______	_____	eczema	______	_____	high blood pressure	______
_____	canker sores	______	_____	heart disease	______	_____	mononucleosis	______
_____	allergies	______	_____	herpes	______	_____	anemia	______

List all known allergies to any drugs, herbs, foods, animals or other: ______________________________

____

Which of the following do you currently use?

	Amount (how often, how much, how long?)		Amount (how often, how much, how long?)
Alcohol	______________________	Tobacco	______________________
Hormones	______________________	Coffee	______________________
Antacids	______________________	Laxatives	______________________

Other medications: give full name / dosage /and how long you have been taking it

______________________ / ______________________ / ______________________
______________________ / ______________________ / ______________________
______________________ / ______________________ / ______________________
______________________ / ______________________ / ______________________

Vitamins/Herbs

______________________ / ______________________ / ______________________
______________________ / ______________________ / ______________________
______________________ / ______________________ / ______________________
______________________ / ______________________ / ______________________

Family History
Please list ages, health problems, and if deceased, cause of death:

Living (age?)	Health Problems	Died (age)	Cause
Your mother ____	______________________________________	_______	_______________________
Your Father ____	______________________________________	_______	_______________________
Your Brothers ___	______________________________________	_______	_______________________
___	______________________________________	_______	_______________________
___	______________________________________	_______	_______________________
Your Sisters ___	______________________________________	_______	_______________________
___	______________________________________	_______	_______________________
___	______________________________________	_______	_______________________
Mother's Mom __	______________________________________	_______	_______________________
Mother's Dad ___	______________________________________	_______	_______________________
Father's Mom ___	______________________________________	_______	_______________________
Father's Dad ___	______________________________________	_______	_______________________

What is your nationality? Please list all backgrounds and approximate %:

____

Are you currently living with? Spouse ____ partner ____ parents ____ friends ___ children ____ alone ____
Are you?: Married ____ separated ____ divorced ____ widowed ____ single ____ in supportive relationship ____
What is your current level of education? _________________ Are you satisfied with this? **Yes or No**
Any children? _____ If so, how many? _______ Ever have toxemia during pregnancy? **Yes or No**
Do they have any health problems?

____

How long has your **main** concern been bothering you? ____

Is your current **main** concern getting (better / same / worse) and for how long? ____________________________

What kinds of treatments have you received for your main health concern and from whom?
____
____
____

Circle if you have ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health care practitioner for your current problem (**yes or no**), or for any problem.

What was the therapy and what were the results? ____
____
____

Previous surgeries and hospitalizations (include dates): ____

____

____

____

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Please answer the following questions to the best of your ability. It is important that if you do not know the answer, or do not understand the question, then please leave the answer blank.

Name: ____ (Please print)

Date of Birth: Month ___ Day ___ Year _____

Place of Birth: ____

1. Are you pregnant? ______
2. Do you have a pacemaker? ______
3. Number of organs removed (Remember your tonsils & appendix) _____
4. Number of different pharmaceuticals used currently _____
5. Amount of cigarettes you smoke per day on average (or cigars) _____
6. Have you used any prednisone, cortisone, steroid creams, or any steroid inhalers in the past year? (i.e. Pulmacort, Nasonex, etc.) If yes, how many times or frequency? _____
7. Number of metal amalgam fillings in in your teeth, if known _____
8. Number of street drugs used per month _____
9. Number of all known allergies _____
10. Personal stress you are under (0 – 10) i.e. 10 = at the end of your rope _____
11. Number of items eaten per day whose major ingredient is white flour or sugar (Include bread, soft drinks, ice cream, desserts, etc.) _____
12. Number of exercise sessions per week 20 min. or more, that would produce a sweat (not work –related) _____
13. Number of alcoholic drinks per day on average _____
14. Number of cups of coffee, tea per day or any caffeine product (including cola's or diet cola's) _____
15. Number of extreme toxic exposures in the past year (radiation, insecticides, chemicals, chemo treatments) _____
16. Number of ***major*** traumatic events in your lifetime (emotional & physical) e.g. marriage breakup, death of a loved one, major broken bones, major surgery. _____
17. Number of ***major*** infections past and present (ones that hospitalized you, or serious pneumonia, or bronchitis) _____
18. Number of glasses of water you drink per day on average _____

19. If you had a magic wand, how much weight would you take off? _____

20. Amount of negativity in your personality (1-10) 10 most negative _____