Moose Jaw Naturopathic Clinic

Lower Level Unit B70 – 500 – 1st Ave. N.W.
Moose Jaw, SK S6H 8C1
(306) 692-3848

Patient Intake Questionnaire

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: mo ___ day ___ yr _____

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 _____

Clinic Appointment Cancellation Policy

We request that 48 hours notice be given when canceling an appointment. This excludes cancellations due to poor road or weather conditions, or in the event of a sudden family crisis. In the event that sufficient notice is not received, then the clinic may ask for a credit card number to secure the next appointment, and if missed again, then the credit card would be processed for the cost of the appointment.

We Share the Air

Due to environmental sensitivities, please refrain from wearing colognes or perfumes.

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 allotted appointment time.

Disclaimer

While aiding in overall patient assessment, bioresonance and EIS scans do not diagnose, treat, cure or prevent any disease.

Moose Jaw Naturopathic Clinic

Dr. Douglas Amell Naturopathic Physician

Dr. Lynn Chiasson Naturopathic Physician

Lower Level Unit B70 500 1st Ave. NW, Moose Jaw, SK S6H 8C1

Phone (306) 692-3848 Located in the Lower Level of Co-op Supermarket Fax (306) 692-4889

HEALTH HISTORY SUMMARY

Date: _____ Appointment Date _____

Name: _____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone (Home): _____ (Work): _____ Cell _____

e-mail address _____ Blood Type (if known) _____

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? _____

Last physician or health practitioner seen? _____ When? _____

When was your last blood test? _____ What kind? _____

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 _____

5. _____ & length of time _____

6. _____ & length of time _____

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	_____	_____ diabetes	_____	____ gonorrhea	_____
_____ tonsillitis	_____	_____ asthma	_____	_____ syphilis	_____
_____ ear infections	_____	_____ eczema	_____	_____ venereal disease	_____
_____ chronic infections	_____	_____ heart disease	_____	_____ epilepsy	_____
_____ canker sores	_____	_____ herpes	_____	_____ high blood pressure	_____
_____ allergies	_____	_____ hepatitis	_____	_____ mononucleosis	_____
_____ thyroid problem	_____	_____ weight problem	_____	_____ 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	_____
Cortisone	_____	Laxatives	_____
Sedatives	_____	Antacids	_____

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? _____

What is your weakest organ system and why? _____

_____

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 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? _____

_____

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? _____

As an adult what has been your maximum weight? _____ and minimum weight? _____

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 _____

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**

Please check off any childhood illnesses you have had:

measles ____ mumps _____ chickenpox _____ whooping cough _____ polio ____ diphtheria ____ small pox ____

rheumatic fever _____ scarlet fever _____ tuberculosis _____ typhoid fever _____ mono _____ how long? _____

Previous surgeries and hospitalizations (include dates): _____

_____

_____

_____