Moose Jaw Naturopathic Clinic

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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

Date: _____

Name: _____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone (Home): _____ (Work): _____ daytime or eve? Blood Type: _____

e-mail address:_____

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? _____

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 _____

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? _____

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**

What is your weakest organ system and why? _____
_____

Previous surgeries and hospitalizations (include dates): _____

_____

_____

_____

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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.