

# Moose Jaw Naturopathic Clinic

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125 – 3<sup>rd</sup> Avenue N.W., Moose Jaw, SK S6H 8B1

Phone (306) 692-3848

(on 3<sup>rd</sup> Ave. NW just south of High Street)

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## 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?   | _____ | 20 min. or more, that would produce a sweat (not work –related)   | _____ |
| 2. Do you have a pacemaker?  | _____ |   |       |
| 3. Number of organs removed (Remember your tonsils & appendix)   | _____ | 13. Number of alcoholic drinks per day on average   | _____ |
| 4. Number of different pharmaceuticals used currently  | _____ | 14. Number of cups of coffee, tea per day or any caffeine product (including cola's or diet cola's)   | _____ |
| 5. Amount of cigarettes you smoke per day on average (or cigars)   | _____ | 15. Number of extreme toxic exposures in the past year (radiation, insecticides, chemicals, chemo treatments)   | _____ |
| 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? | _____ | 16. Number of <i>major</i> traumatic events in your lifetime (emotional & physical) e.g. marriage breakup, death of a loved one, major broken bones, major surgery. | _____ |
| 7. Number of metal amalgam fillings in in your teeth, if known   | _____ | 17. Number of <i>major</i> infections past and present (ones that hospitalized you, or serious pneumonia, or bronchitis )   | _____ |
| 8. Number of street drugs used per month   | _____ | 18. Number of glasses of water you drink per day on average   | _____ |
| 9. Number of all known allergies   | _____ | 19. If you had a magic wand, how much weight would you take off?  | _____ |
| 10. Personal stress you are under (0 – 10) i.e. 10 = at the end of your rope   | _____ | 20. Amount of negativity in your personality (1-10) 10 most negative  | _____ |
| 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   | _____ |   |       |

## **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.