Naturally Well Naturopathic Clinic

117 Centrepointe Dr. Suite 255, Ottawa, ON, K2G 5X3
Tel: 613-225-1127 Fax: 613-225-1128

Please bring this fully completed form to your first visit

Name: ____ Date: ______________________

Address: ____
(street, house/apartment number) (city/town) (province) (postal code)

Telephone number: (home) _________________________ (work) ________________________

Email address: ____

Referred by: ____

Medical Doctor: ____

Chiropractor: ____

Other Primary Care Givers: ____

Other Naturopathic Doctors consulted: ____

Nearest Relative: ___________________________ Phone number: ______________________

Secondary Insurance Company (if it has Naturopathic coverage): ______________________________

Missed or cancelled appointment policy

When an appointment is booked, that time is reserved for you and your child. There is usually a lengthy waiting list. If you have to cancel, we require 48 hours notice so that your scheduled time can be given to another patient. Without proper notification, there will be a charge for missed appointments.

Please note that his information is confidential and will only be released with your permission.

Personal Profile and Health History

Name: ____ Date: ___________________________________

Age: ________ Sex: ________ Marital Status: ________ Height: ________ Weight: ________ Goal Weight: ________

If your present weight is different than your desired weight, how long has it been since you were at your normal or goal weight?
____

Name of Spouse (if applicable) ____

How long have you been married? ____ Is this your first marriage? Yes ____ No ____

If this is not your first marriage, how many times (including this marriage) have you been married? ________________________

Number of Dependents (if applicable) ____

Occupation (Nature of Work) ____

Number of hours worked in average work week. ____

Educational Background: ____

What hobbies do you have? ____

Diet: Non Vegetarian ________ Vegetarian ________ Vegan ________ For how long? _________________________________

Known Food Allergies/Intolerances: ____
____
____

Known Environmental Allergies/Sensitivities: ____
____
____

What is your primary health concern? ____
____

How long have you had this condition? ____

What is your medical diagnosis? ____

Name of the physician who made the diagnosis? ____

When was the diagnosis made? ____

What specialists have you seen? ____

How has this condition been treated until now? ____

Additional Health Concerns and Health Goals

What else would you like to see changed in your health? List all other health concerns in order of importance to you. If possible, indicate the month and year each particular health concern started. Also list any specific health goals would you like help with?

	Health Concerns/Goals	*Month/Year*	*Present Treatment/Comments*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

How long has it been since you experienced excellent health? ____

Please give a detailed history of your ***primary health concern*** from when you were first aware there was a health problem through to the present. Include pertinent dates.

____
____
____
____
____
____
____
____
____

Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident, mental upset or unusual stress in your life? If yes, please explain.

____
____
____
____
____
____
____

Every disease, serious illness, accident, physical or emotional trauma and drug leaves its mark and remains as a weak point in our body's system. Homeopathic medicine takes into account details of the past and will work to eliminate these weak points to strengthen your body. It is necessary for us to know about all of the ailments you have suffered from in the past and the treatments you have taken in order to provide you with the best care and course of action.

In the lists below, please circle all major illnesses that you have experienced.

Measles (Rubella) German Measles (Rubella) Chicken Pox Mononucleosis Mumps Scarlet Fever Whooping Cough Polio Reye's Syndrome	Colitis Irritable Bowel Syndrome Crohn=s Disease Diverticulitis Hiatal Hernia Constipation Hemorrhoids Stomach Duodenum Ulcers Appendicitis	Spleen Disease Gall Bladder Disease Jaundice Pancreatic Disease Hepatitis Other Liver Disease	Gonorrhea Chlamydia Syphilis HIV Genital Herpes Genital Warts Human Papillovirus (HPV)
Typhoid Cholera Malaria Food Poisoning Worms/Parasites Diarrhea Dysentery	Rheumatoid Arthritis Osteoarthritis Rheumatism Back Pain/Sciatica Fibromyalgia Gout	Kidney Problems Bladder Problems Diabetes Hypoglycemia Prostate Problems Eye Problems	Miscarriage Abortion D and C Uterine Prolapse Gestational Diabetes Preeclampsia Other Pregnancy Illness
Acne, Boils, Impetigo Carbuncles, Ringworm, Fungus, Scabies, Shingles, Poison Ivy, Eczema, Keloids, Psoriasis Warts Herpes Urticaria (skin allergy) Ulcers (any part of the body) Skin Cancer	Strep Throat, Scarlet Fever, Tonsillitis, Sinusitis, Allergies (environmental), Hay Fever, Bronchitis Pneumonia, Asthma, Pleurisy, Tuberculosis	Heart Problems Circulation Problems High Blood Pressure ILOW Blood Pressure Fainting Palpitations Anemia Varicose Veins Stroke Platelet Disorders Raynaud's Disease	PMS Fibrocystic Breast Disease Uterine Fibroids Endometriosis Ovarian Cysts Vaginitis (recurrent) Painful Periods Infertility
Malnutrition Rickets Osteoporosis Hemochromatosis Wilson=s Disease	Multiple Sclerosis Lupus Myasthenia Gravis	Migraine Headaches Dizziness (vertigo) Numbness Cramps Epilepsy Meningitis	Cushing=s Disease Addison=s Disease Hypothyroid Hyperthyroid (thyroiditis)
Cancer (specify type)	Chronic Fatigue Environmental Illness Candida (Yeast Syndrome)	Eating Disorder Schizophrenia Bipolar Disease Clinical Depression Suicidal Tendencies	Other:

In the lists below, please circle all surgeries, accidents or traumatic events that you have experienced.

Surgeries: (circle)	**Accidents:**	**Trauma: (circle)**
Tonsils Adenoids, Abdomen, Heart, Appendix. Hernia, Hemorrhoids, Joint Replacement, Kidney Stones, Gall Stones, Uterus, Penis, Prostate, Hydrocele, Cataract Other: Was the anesthesia: Local/General (circle)	Any major accident or injuries to the body or head? Any occasion of unconsciousness? Any hemorrhage or major bleeding from any part of the body?	Any serious shock, grief, major disappointments, severe fright, nervous breakdown, period of stress, overload Briefly describe:

Please list all surgeries, illnesses, accidents, traumatic events noted above that required treatment. Please include type of

surgery, age, duration, recovery and treatment including medications.

____
____
____
____
____
____
____

Immunizations

Have you received any of the following Immunizations? How many times?

Small Pox __________ DPT __________ Polio __________ Meningitis __________ MMR __________

BCG __________ Typhoid __________ Tetanus __________ Hepatitis __________ Flu __________ Hib __________

Cholera _________ Other __________

Were there any serious reactions to any of the above vaccinations? ____
____
____

Dental Work

How many silver amalgam fillings do you have? __________ How many root canals? __________

Family History

Please circle an "L" for living and "D" for deceased. Age is the present age or age at time of death.

Paternal Grandfather: L / D Age _____ Diseases Suffered/Cause of Death ____________________________________
____

Paternal Grandmother: L / D Age _____ Diseases Suffered/Cause of Death ____________________________________
____

Maternal Grandfather: L / D Age _____ Diseases Suffered/Cause of Death ____________________________________
____

Maternal Grandmother: L / D Age _____ Diseases Suffered/Cause of Death ___________________________________
____

Father: L / D Age _____ Diseases Suffered/Cause of Death ____
____

Mother: L / D Age _____ Diseases Suffered/Cause of Death ____
____

Paternal Uncles: Diseases Suffered ____
____

Paternal Aunts: Diseases Suffered ____
____

Maternal Uncles: Diseases Suffered ____
____

Paternal Aunts: Diseases Suffered ____

____

Brothers: Diseases Suffered ____
____

Sisters: Diseases Suffered ____
____

How many brothers and sisters do you have? Brothers _____ Sisters _____
What is your position in the family? (oldest, middle, youngest, etc…) ______________________________________

Briefly describe the nature of your relationship with your parents? Both as a child and an adult. _____________________
____
____
____

How is the health of your spouse? ____

Number of children: Living __________ Deceased __________ Cause of death for deceased: ________________________

<u>Personal Habits and Lifestyle</u>

How many cups/bottles/glasses do you drink on the average per day?
Coffee ____ Tea ____ Water ____ Milk 2% ____ Milk (skim) ____ Fruit Juice ____ Soft Drinks (diet) ____
Soft Drinks (reg.) ____ Vegetable Juice ____ Herbal Tea ____ Beer ____ Wine ____ Liquor ____

What is the source of your drinking water? Tap (city) ____ Well _____ Bottled (spring) _____ Filtered _____ Distilled _____

Do you use tobacco products? Yes _____ No _____

If yes, please circle the products you use and indicate how often. Cigarettes _____ Cigars _____ Chewing Tobacco _____
Snuff _____

Have you smoked in the past? Yes _____ No _____ If yes, for how long? ___________________

Does anyone in your household smoke? Yes _____ No _____

Have you ever used nonprescription, mood altering drugs (recreational drugs)? Yes _____ No _____ If yes, please indicate type, frequency and duration of use. ____

Do you regularly use (please circle): Laxatives, Sleeping Pills, Antacids, Pain Killers

If so, please indicate the type, frequency and amount. _____________________________________ _____________________

How frequently do you move your bowels? _______ (number of movements) Daily/Weekly?

Have you ever had a problem with an addiction? If yes please specify.
Food _____ Alcohol _____ Drugs _____ Other ____
____

How many hours of sleep do you get on the average? ____

Do you feel refreshed in the morning? ____

How many hours do you work each day? ____

Do you often feel overworked? ____

What do you do for exercise (indicate frequency, intensity and duration) ____
____
____

What do you do for recreation? ____
____

When was your last vacation? ____

How would you describe your present level of personal stress? Minimal _____ Average _____ Considerable _____ Unbearable _____

What is the main stressor? Financial _____ Job Related _____ Interpersonal _____ Marriage _____ Health _____ Expectations _____ Family Members _____ Spiritual _____

Food Supplements

List all food supplements you are currently taking. Indicate the total dosage taken in one day (i.e. if you take two tablets of Vitamin C 500 mg/day, the total daily is 1000mg).
____
____
____
____
____
____
____

Prescription Drugs

List all prescription drugs you are currently taking. Indicate the present dose and how long you have been on each medication.
____
____
____
____
____
____
____

List all prescription drugs you have taken in the past for longer than six months. Indicate how long you were on each medication.
____
____
____
____
____
____
____

How many times have you been prescribed antibiotics over the last 10 years? ____

Were you ever on antibiotics for an extended period of time? Please explain when and for how long. _____________________
____
____

Have you ever used probiotics (friendly microflora) following antibiotic use? Always _____ Often _____ Occasionally _____

Never _____

<u>Factors That Affect You</u>

Below and on the following page is a list of things that you may be exposed to. Each of these factors may have some unique effect on you (physically, mentally or emotionally). *Please write in what way you are uniquely affected by each of the following, taking careful consideration of the factors that have an effect on your main health concern.* For example, your symptoms may be much worse in hot weather. Hot weather may also make you may also feel weak and lightheaded as if you were going to faint.

This section is most important. Please take your time and think carefully about the effect of each factor before answering.

Condition	***Effect***	***Condition***	***Effect***
Hot weather		Smoke	
Cold weather		Dust	
Rainy weather		Perfume	
Cloudy weather		Open air (outdoors)	
Change of weather		Odors/strong smells	
Being in a draft		Tobacco smoke	
Wind		Lying on back	
Change of season		Lying on right side	
Thunderstorm		Lying on left side	
Exposure to the Sun		Lying on stomach	
Moonlight		Lying with head low	
Full moon		Sitting	
Near ocean/sea		Sitting erect	
Morning		Standing	
Afternoon		Walking	
Evening		Running	
Night		Climbing stairs	
Music		Going Downstairs	
Noise		Physical exertion	
Sudden noise		During urination	
Car travel		After urinating	
Before sleep		Before menses	
During sleep		During menses	
After sleep		After menses	

After afternoon nap		Overeating	
Loss of sleep		Vomiting	
Warm bath		Contradiction	
Cold bathing/swimming		When worried	
Getting feet wet		When sad	
Working in water		After weeping	
Reading		Consolation/sympathy	
Being in a shopping mall		When angry	
Being in the mountains		Touch	
Looking from heights		Tight clothing	
Watching moving objects		Before important meeting	
Before bowel movement		Before exams	
After bowel movement		In a crowd	
Warm drinks		In a closed room	
Cold drinks		When thinking of your illness	
After eating		When alone	
Chewing/biting		In company	
Swallowing		Laughing	
After fasting		Talking	
When constipated		Other:	

Food Cravings/Desires/Aversions

Please put one check if you like/dislike the food or if the taste or food disagrees with you. Put two checks if you strongly like/dislike the food or if it strongly disagrees with you.

Food	**Like**	**Dislike**	**Disagree**	**Food**	**Like**	**Dislike**	**Disagree**
Bitter				Spicy			
Extra Salt				Meat			
Sweet				Fish			
Sour				Cabbage			
Bread				Onion			
Butter				Warm Food/Drink			
Fats				Cold Food/Drink			
Milk				Fruits			
Coffee				Ice Cream			
Eggs				Chocolate			
Oysters				Other:			

Mind/Emotions

Your mind has tremendous influence on your body. In giving proper attention to the whole person, it is necessary to understand your emotional and intellectual nature. Please answer the following *freely, carefully and completely*. This information will help in formulating a correct homeopathic prescription, which, in turn, will help to improve your mental state and overall health.

Are you anxious? If yes, please indicate about what. ____
____
____
____
____
____
____

Are you fearful of anything such as (please circle):

animals | snakes | rodents | people | being alone | darkness | death | disease | robbers | ghosts | sudden noises | thunder | the unknown |heights | closed in spaces | failure | doing new things | speaking in public | anything not on the list

Please describe:
____
____
____
____
____

What are you jealous about? ____

Of whom are you jealous? ____

What symptoms do you get when you are jealous? ____

What makes you impatient? ____

What makes your hurried? ____

How long do you remember hurts caused to you by others? ____

How much and how often do you see revenge? ____

What are you proud of? ____

How would you describe your self-confidence? ____

Is your pride easily hurt? If yes, by what? ____

Are you ever depressed or brooding? ____

Do you ever become suicidal? If yes, when, and in what way do you contemplate ending your life? (please also specify if, even then, you are fearful of dying) ____

____
____

Do you weep easily? If yes, what makes you weep and how do you feel afterwards? ____________________________________
____

How do you feel if someone offers sympathy or consolation? ____

How do you feel when you are criticized? ____

What situations are you most sensitive to (where strong feelings are most likely to be aroused? Describe the situation and the feelings. ____
____
____

When are you cheerful? ____

Are you easily irritated? ____

What makes you angry? ____

What bodily symptoms do you develop when you are angry (trembling, sweating, etc…)? ________________________________
____

Do you have any unwanted thoughts at any time? If yes, describe these unwanted thoughts. _____________________________
____
____

Do you have any imaginary sensations or fears? ____
____
____

Do you hear voices, think you are called or have persistent recurring thoughts in your mind? _____________________________
____
____

How is your memory (if poor, specify if it is with names, faces, places, information that is read, etc…)? ______________________
____
____

Do you like company, or do you prefer to be alone? ____

How seriously are you affected by disorder and uncleanliness in your surroundings? ____________________________________
____

In your opinion, which aspects of your mind and moods are not agreeable to you? ______________________________________
____

How does the future look to you? ____
____

Are you worried or unhappy about any personal, domestic, economic, social or other present situations in your life? If yes, please describe. ____

____

____

____

Describe your posture while you sleep. ____

Are you able to sleep in any position? If not, specify in which position you can't sleep. ____________________

When you sleep, do you (circle those that apply): Snore | Grind your teeth | Dribble Saliva | Perspire | Keep your eyes or mouth open | Walk | Talk | Moan | Weep | Become restless | Wake up with a jerk | Legs jerk

Do you sleep with your window open or closed? ____

How much of yourself do you cover while you sleep? ____

Do you have to uncover any parts? ____

Circle the types of dreams you have:

Animals Cats/Dogs Wild animals Snakes	Robbers Thieves Anxious Fearful Ghosts	Traveling Riding Flying Swimming Drowning	Houses Fruits Trees Water Snow	Death (whose?) Dead bodies Dead persons Parts of the body Suicide
Being hungry Being thirsty Eating Drinking	Fire Lightening Storms Rain	Accidents Falling Shooting Wars	Talking Singing Dancing Pleasant	Business Money Day's work Forgotten work
Vomiting Passing stool Urinating Blood/bleeding Excrement/soiling	Romantic Sexual pleasure Rape Nakedness	Pain Illness Sickness Mutilations	Praying Religious Temple Church God	Failure/Exams Unsuccessful efforts (concerning what?) Missing Train Being unprepared
Grief Weeping Vexation Quarrels Jealousy Insults	Police Imprisonment Crime Murder Killing Poison	Misfortunes Insecurity Danger Being Pursued (by Whom? Why?)	Of event: Past Recent Future	Physical exertion Mental exertion Fatigue
Of People: Children Parties Feasts Marriage	Dreams in colour Nonsensical Confusing	Other:		

Spiritual/Religious Background

Whether we are religious or not, believe in God (or a Higher Power) or not, our religious or spiritual roots often have profound influences on our lives. Recent studies have demonstrated how our faith and spiritual practices affect our health. However, we also recognize that faith, religion and spiritual practices are very personal in nature. You are free to omit any question that you do not wish to answer.

What are your religious roots?
Agnostic ___ Buddhist ___ Christian ___ (please circle: Orthodox/Protestant/Roman Catholic)
Christian Science ___ Jehovah's Witness ___ Jewish ___ Hindu ___ Islam ___ Mormon ___ New Age ___ Other ___

Are you an active participant in your religious faith? ____

Do you participate in any other spiritual practices? (describe) ____

What spiritual disciplines do you practice regularly? Prayer ___ Meditation ___ Journaling ___ Study Group ___
Fasting (for spiritual purposes) ___ Other ___

Do you have any dietary restrictions that you adhere to as a part of your faith? ____

Your present faith/spiritual practices are: Very important ___ somewhat important ___ Not very important ___ to your everyday life.

Your experience with religion in the past has: Always been satisfying ___ generally satisfying ___ somewhat satisfying ___
has been unsatisfying ___ (if it has been unsatisfying please explain) ____
____
____

What has been the most important spiritual influence on your life? ____
____
____

Women's Health

Age of first menses? _____ Were there any difficulties with your period at that time? ____________________________________
____

Age of cessation of menses? _____ Were there any difficulties associated with menopause? ______________________________
____

Are your menses regular? _____ If not, describe your menstrual patterns. ____
____
____

Do you experience PMS? _____ If yes, describe the symptoms. ____
____

Is your sexual energy: Non-existent _____ Low _____ Medium _____ High _____ Very high _____

Is sexual intercourse ever painful? ____

What kind of birth control do you use? ____

What kind of birth control have you used in the past? ____

____

Have you ever had a sexually transmitted disease? ____
____

Number of pregnancies? ________ Deliveries? ________ Miscarriages? ________ Abortions? ________

Have you ever experience cystic breasts? ____

Do you have any discharge? _____ If yes, please describe the colour, odor and consistency. ____________________
____
____

Have you had uterine fibroids? ____

Do you have recurring vaginal infections? Never _____ Rarely _____ Frequently _____

Do you experience bladder infections? Never _____ Rarely _____ Frequently _____

Men's Health

Do you ever have difficulties getting and maintaining erections? _____ If yes, please explain. ___________________
____

Do you have difficulties with premature ejaculation while having intercourse? ___________________________
____

Is you sexual energy: Non-existent _____ Low _____ Medium _____ High _____ Very High _____

Are your erections ever painful? ____

Do you have difficulty voiding (urinating) completely? ____

How often do you get up to go the bathroom at night? ____

Have you ever been diagnosed with prostate problems? _______________________________________

Have you ever had a sexually transmitted disease? ____

How many children have you fathered? _________ ________ How many have you raised? ____________________

Have any of your partner's pregnancies ended in an abortion? _________________________________

Do you have any other problems concerning sex? _____ If yes, please explain. ___________________________
____
____

Thank you for taking the time to fill out this questionnaire. It will help greatly in our study of your present health concerns and in our understanding of your health goals. Your responses will assist us in choosing the appropriate remedies that will hopefully bring about your return to optimal health. Please know that all information is kept strictly confidential.