

Naturally Well Naturopathic Clinic

804 Greenbank Rd., Nepean, ON, K2J 1A2

Tel: 613-825-2524

Please bring this fully completed form to your first visit

Name: _____ Date: _____

Birthdate: _____

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 this 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?

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

Candida (Yeast Syndrome)	Bipolar Disease
	Clinical Depression
	Suicidal Tendencies

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

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

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: _____

Personal Habits and Lifestyle

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 _____

Factors That Affect You

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.

<i>Condition</i>	<i>Effect</i>	<i>Condition</i>	<i>Effect</i>
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 your 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.