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# *Health Questionnaire*

Welcome to Integra Naturopathics. We know that your health is influenced by many factors. Your questionnaire provides valuable information which helps us to understand the underlying causes of your health concerns. Fill out the questions to the best of your ability and bring the form in with you to your first visit to our wellness centre.

## GENERAL CONTACT INFORMATION

**Name:** ______________________________________________
*(last name)* *(first name)* *(middle initial)*

**Age:** ________ **Gender:** Female Male **Date of Birth** (M/D/Y) : _____/_____/______

**Address:** ______________________________________________
***(street address)*** *(city)* *(province)* *(postal code)*

**Telephone: Home** ______________________ **Work** ______________________ **Cell** ______________________

**May we leave messages on your phone line?** ____ **Preference (circle all applicable):** Home/ Work/ Cell

**Email:** ______________________________________________

**Occupation:** ________________________ **How did you hear about this clinic?** ______________________

**Emergency Contact:** ______________________________________________
*(name)* *(relationship)* *(telephone)*

## PLEASE COMPLETE THE FOLLOWING QUESTIONS

**What are your most important health concerns that you are seeking treatment for or are currently being treated for? List as many as you can in order of importance.**

**1)** ______________________________________________

**2)** ______________________________________________

**3)** ______________________________________________

**4)** ______________________________________________

## MEDICAL HISTORY

**Please list any prescription medications or over the counter medications you are taking, the dosage and the reason for using them:**

**1)** ______________________________________________
**2)** ______________________________________________
**3)** ______________________________________________
**4)** ______________________________________________

**Do you have sensitivities or allergies to any of the following categories: Drugs, Food, Environmental (please list)** ________________________________________________

________________________________________________

**List all surgeries you have had:**

______________________ year? __________ purpose? ______________
______________________ year? __________ purpose? ______________
______________________ year? __________ purpose? ______________

## NUTRITION

Breakfast: ________________________________
Lunch: ________________________________
Dinner: ________________________________
Snacks: ________________________________
Beverages: ________________________________
Cravings: ________________________________
Aversions: ________________________________

Do you add salt to your food? Yes No
How many coffee's and/or black tea day do you drink? ____________________
Do you drink pop, how much? ____________________
Do you have any dietary restrictions? ____________________

## GENERAL

Weight _____lbs Weight one year ago _____lbs Max weight _____lbs Height ________

Rate your energy level between: **(low)** 1 2 3 4 5 6 7 8 9 10 **(high)**

When during the day is your energy the best? __________ worst? __________

Rate your stress level between: **(low)** 1 2 3 4 5 6 7 8 9 10 **(high)**

## FAMILY HISTORY

**Please check any of the following conditions that have occurred in your family (grandparents, parents, siblings).**

| | | | |
|---|---|---|---|
| Diabetes | _____ | Cancer | _____ |
| Multiple Sclerosis | _____ | Osteoporosis | _____ |
| Arthritis | _____ | Asthma | _____ |
| Parkinson's | _____ | Thyroid Condition | _____ |
| Alzheimer's | _____ | Eczema | _____ |
| Heart Disease | _____ | Mental Illness | _____ |
| Other | ________________________ | | |

# CONTEXT OVERVIEW

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?

## REVIEW OF SYSTEMS

**Please check the box if you are currently experiencing or have experienced it within the last year.**

**Mental/Emotional**

Mood swings
Anxiety or nervousness
Poor concentration
Memory Problems
Depression
Anger

**Endocrine**

Thyroid disease
Heat or Cold Intolerance
Diabetes
Sugar Sensitivities
Fatigue
Weight loss/Weight gain

**Immune**

Chronic Infections
Chronic swollen glands
Slow wound healing
Frequent colds

**Skin**

Rashes
Eczema, Hives
Acne, Boil
Itching

**Head**

Headaches
Migraines
Head Injury

**Ears**

Earaches
Impaired Hearing
Dizziness
Ringing in Ears

**Nose and Sinuses**

Nosebleeds
Seasonal Hay fever
Sinus problems
Loss of smell

**Mouth and Throat**

Frequent sore throat
Sore tongue/lips
Tonsils removed
Loss of taste

**Respiratory**

Cough
Wheezing
Asthma
Bronchitis
Emphysema
Chronic Phlegm

**Cardiovascular**

Heart disease
High/Low Blood Pressure
Palpitations
Arrhythmia
High Cholesterol

**Gastrointestinal**

Heartburn
Belching or Passing Gas
Change in thirst
Change in Appetite
Constipation
Diarrhea
How often do you have a bowel movement? _______
Have you ever had parasites? _________

**Urinary**

Increased frequency
Frequency at night
Chronic Infections
Incontinence

**Musculoskeletal**

Stiffness/Pain in joints
Arthritis

## WOMEN'S HEALTH

Age of your first menstrual period __________
How many days do you bleed? __________
When was your last menstrual period? __________
How long is your typical menstrual cycle? __________

**Do you experience:**

| | | | | | |
|---|---|---|---|---|---|
| Heavy flow | **Yes** | **No** | Light flow | **Yes** | **No** |
| Clotting | **Yes** | **No** | Bleeding between periods | **Yes** | **No** |

Do you suffer from pre-menstrual symptoms? **Yes** **No**
If yes, which ones?
- Pain or cramping
- Bloating and/or water retention
- Breast tenderness
- Mood Swings
- Headaches
- Cravings

Are you pregnant? Yes No
Number of pregnancies ____________
Number of miscarriages ____________
Have you ever had a hysterectomy? Yes No
Have you ever used birth control? What type? ____________

**Please indicate if any of the following applies to you**
- Vaginal Discharge
- Pain during intercourse
- Vaginal Itching
- Vaginal Odour
- Abnormal pap tests
- Low libido
- Vaginal dryness

When was your last pap test? __________

**Breast Health**
Do you perform monthly self breast exams? Yes No
When was your last breast exam? ________________________________
Do you have regular mammograms? Yes No

## MEN'S HEALTH

**Please indicate if any of the following applies to you**
- Hernia
- Testicular mass and or pain
- Low sex drive
- Discharge or sores
- Impotence
- Prostate condition. Year of last prostate exam? ____

## LIFESTYLE

| | | | | | |
|---|---|---|---|---|---|
| Do you exercise? | **Y** | **N** | How often? ________________________________ | | |
| Do you fall asleep easily? | **Y** | **N** | Average 6-8 hrs of sleep? | **Y** | **N** |
| Sleep soundly? | **Y** | **N** | Awake rested? | **Y** | **N** |
| Do you smoke tobacco? | **Y** | **N** | Do you chew tobacco? | **Y** | **N** |
| Do you use drugs? | **Y** | **N** | Do you drink alcohol? | **Y** | **N** |
| Do you eat out often? | **Y** | **N** | How often? ________________________________ | | |

Thank you for taking the time to fill out this form. We look forward to seeing you soon.