HEALTH RECORD

HealthSource
INTEGRATIVE MEDICAL CENTRE

PATIENT INFORMATION Date _____

Name _____ Birth Date _____

Address _____ Gender *M* *F* Age _____

City _____ Province _____ Postal Code _____

Home Phone _____ Work Phone _____ Mobile _____

Fax _____ May we leave messages relating to your visits? *Y* *N*

Email _____

Do you give us permission to contact you about research studies you may be eligible for? Y N

May we email you information on free health & wellness seminars we hold in the community? *Y* *N*

May we email you educational articles we have written on researched health topics? *Y* *N*

Business Employer _____ Occupation _____

Marital Status: *Married* *Single* *Widowed* *Divorced* *Separated* *Common-law* # of children _____

Emergency Contact Name _____ Phone _____ Relationship _____

How did you hear about this clinic? _____ May we thank the person who referred you? *Y* *N*

Have you received Naturopathic treatment before? *Y* *N* If Yes, when and where? _____

OTHER HEALTH CARE PROVIDERS

Medical Doctor_____ Location/Phone _____

Oncologist _____ Location/Phone _____

Specialists _____ Location/Phone _____

Other _____ Location/Phone _____

MAIN HEALTH CONCERNS and DIAGNOSES

What is your exact diagnosis (type of cancer and staging) along with any other diagnoses?

_____

_____

Is this a primary (first time diagnosis) or recurrent cancer? _____

Is the disease localized or spread (metastasis)? _____

Are you currently receiving any conventional oncology treatments or do you have future treatments scheduled (please specify details)?

Chemotherapy (please specify which drugs and side affects you are experiencing): _____

_____

_____

_____

Radiation (please specify number of treatments and site being radiated): _____

_____

Surgery: _____

PATIENT NAME: _____

Please identify in detail any additional symptoms you are currently experiencing (pain, nausea, diarrhea, headaches, etc).

_____

_____

Have you received any conventional oncology treatments in the past? If so, please provide details.

_____

_____

_____

Have you received any naturopathic or complimentary medical care? If so, please provide details.

_____

_____

_____

What goals do you have for natural treatment of your cancer? _____

_____

SUPPORTING DOCUMENTATION Please send the following if available:

Reports	**Faxed**	**Pending**	**Imaging**	**Faxed**	**Pending**
Referral History and Physical			PET Scan		
Blood Work			Ultrasound		
Pathology Reports			Genetic Markers		
X-Ray Reports			Bone Scan		
Chemo Schedule			CT Scan		
MRI			Mammogram		
Pulmonary Function Tests			Receptor Status		

MEDICAL INFORMATION

Known **allergies** (prescription or over-the-counter medications, vaccinations, natural medicines, food)

_____

_____

List any hospitalizations / major illnesses / surgeries other than what was described above (include month/year)

_____

Has there been an event or illness (other than cancer) from which you have never fully recovered? _____

Please list all medications you are currently using or have used (up to 5 years). Include all over-the-counter medications and hormones. List dosages and approximate length of time you have been on each medication.

_____

_____

_____

_____

PATIENT NAME: _____

Please list names, brands and dosages of all vitamins, minerals, herbs, and other natural products you are currently using.

_____

_____

_____

_____

Were you ever on antibiotics for an extended period of time? *Y* *N* Reason: _____

FAMILY HEALTH HISTORY

Please indicate if any of your family members (immediate and extended family) have experienced the following:

Condition	**Relative**	**Condition**	**Relative**
Alcoholism/Addiction		High blood pressure	
Alzheimer's Disease		Insomnia	
Allergies/Hay fever		Kidney problems	
Arthritis		Liver disease	
Asthma		Mental health problems	
Cancer (indicate type)		Migraine	
Depression		Osteoporosis	
Diabetes		Skin Conditions (Eczema, Psoriasis)	
Digestive problems		Thyroid problems	
Heart disease		Other (indicate)	

If any of the above family members are deceased, please list their age at death and cause: _____

_____

ENVIRONMENTAL EXPOSURES

Do you have pets in your home? *Y* *N* Type of pets? _____

Is your home or work environment excessively: *Damp* *Dry* *Hot* *Cold*

Please list past or present exposure to harmful chemicals: _____

_____

LIFESTYLE INFORMATION

Have you ever been a smoker? *Y* *N* #/day? _____ Are you currently a smoker? *Y* *N* #/day? _____

# of caffeinated beverages consumed per day _____ # of alcoholic beverages consumed per week _____

The amount of water consumed per day _____ Total hours of exercise per week _____

Hours of sleep you get on average each night _____ Rate your stress level: *Low* *Average* *High* *Unbearable*

What factors most contribute to your stress? *Health* *Work* *Family* *Marriage* *Other:* _____

What are your hobbies and interests? _____

_____

Is there anything else that you feel has not been covered? _____

_____

_____