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 _____

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* *Same-sex* # 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 _____

Specialists _____ Location/Phone _____

Other _____ Location/Phone _____

MAIN HEALTH CONCERNS

What are your health concerns, in order of importance to you?

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Are there any traumatic events (surgeries, drug reactions, life trauma etc.) that you can identify as having caused or clearly aggravated your health problems? _____

_____

Do these problems affect your work, family life or recreational activities? *Y* *N*

Do these problems cause you stress, anxiety, and/or depression? *Y* *N*

How would you describe your general state of health? *Excellent* *Good* *Fair* *Poor*

MEDICAL INFORMATION

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

_____

_____

List any hospitalizations / major illnesses / surgeries (include month/year) _____

_____

PATIENT NAME: _____

Has there been an event or illness from which you have never fully recovered from? _____

Approximately how many times each year do you get colds or the flu? _____

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.

_____

_____

_____

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? _____