INTEGRATIVE
Naturopathic Medical Centre

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Personal Information		
Name:		Date:
Birth date (mm/dd/yy):		Gender:
Care Card #:	Height:	Weight:
Address:		City:
Province:		Home Phone:
Cell Phone:		Work Phone:
Occupation:		
Marital status: Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐		
Emergency Contact Name:		
Relationship:		Phone:

How did you hear about our clinic?

Appointment reminders	
How would you like to receive reminders of your upcoming appointments? (**choose one option**)	
Email ☐ **OR** Telephone ☐	
Email Address:	Phone number:
Would you like to receive emails that include newsletters, health tips, and upcoming events? Yes ☐ No ☐	
Email Address (if not indicated above):	

Personal Health History	
Medical Doctor:	Phone:
Other Health Care Provider:	Phone:

List any allergies or sensitivities (medications, foods, environmental, etc.):	
Allergen	**Reaction**

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Personal Health History	
What are your goals for your health at this time?	
What is your primary health concern?	
When did this condition first begin?	
Is this a reoccurring problem? Yes ☐ No ☐	Is this getting better or worse? Better ☐ Worse ☐
What do you feel is the cause of this problem?	
What does it feel like?	
What aggravates your symptoms?	
What alleviates your symptoms?	
Are there any other related symptoms?	
Are you receiving treatment for this? Yes ☐ No ☐	
If yes, what kind?	
Have you ever received Naturopathic Treatment? Yes ☐ No ☐	
Have you ever received Chiropractic Treatment? Yes ☐ No ☐	
Have you ever received Acupuncture Treatment? Yes ☐ No ☐	
Have you had a personal injury or accident in the past year? Yes ☐ No ☐	
Have you had an ICBC or WCB claim? ICBC ☐ WCB ☐	
Past 5 years?	
Over 5 years?	
Please describe:	
Other health concerns? (Please list)	
Have you ever been treated for a serious or infectious disease (pneumonia, tuberculosis, Lyme etc)? Yes ☐ No ☐	

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Personal Health History				
List any prescribed medication, over-the-counter drugs, vitamins and nutritional supplements:				
Medication	**Age Started**	**Length of Use**	**Dose**	**Side Effects**

List any birth control use or hormone replacement therapy (oral, injection, IUD):				
Medication	**Age Started**	**Length of Use**	**Dose**	**Side Effects**

Family Health History					
	Describe	**Family member**		**Describe**	**Family member**
Allergies/Asthma			Heart Attack/Disease		
Alzheimer's/Parkinson's			Liver Disease		
Anxiety/Depression			Lung Disease		
Autoimmune Disease			Overweight/Obese		
Cancer			Prostate Disease		
Diabetes			Stroke		
Gastrointestinal Disease			Thyroid Disease		
Other relevant family history:					

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Lifestyle & Health Habits				
Exercise	☐ No exercise			
	☐ Mild exercise (climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (workout/recreational, less than 4 times per week for less than 30 minutes, yoga or pilates)			
	☐ Regular vigorous exercise (4 or more times per week for 30 + minutes)			
	☐ Other (please describe):			
Diet	Are you dieting? ☐ Yes ☐ No	If yes, how so?		
	Avoiding anything?	# of meals you eat per day:		
	Indicate below your intake of meals per day:			
	High sugar intake	☐ Most meals	☐ About ½ my meals	☐ Few meals
	High salt intake	☐ Most meals	☐ About ½ my meals	☐ Few meals
	High fat intake	☐ Most meals	☐ About ½ my meals	☐ Few meals
Caffeine	Number of cups/cans per day/week:			
	☐ Pop/soda	☐ Coffee	☐ Tea	☐ None
Alcohol	Do you drink alcohol? ☐ Yes ☐ No			
	If yes, what kind?			
	How many drinks per week?	How many drinks per month?		
Tobacco	Do you use tobacco? ☐ Yes ☐ No			
	If yes, in what form (cigarettes, chew, pipe, etc.)?			
	Frequency of use per day:			
	Age you started:	How many years:	Year you quit:	
Substance Use (optional)	Do you use any recreational drugs? ☐ Yes ☐ No			
	If yes, please describe:			
	Do you use any other drugs or substances not listed already? ☐ Yes ☐ No			
	If yes please describe:			
Sexual Health	Are you currently sexually active? ☐ Yes ☐ No			
Environmental Exposure	Do you have mercury or silver amalgam fillings? ☐ Yes ☐ No			
	Have you had any root canals? ☐ Yes ☐ No			
	Do you use hair dyes?	Frequency:		
	Do you use pesticides or herbicides?	Frequency:		
	Are you frequently exposed to any chemicals? (paints, solvents, cleaning solutions, plastics, etc.) ☐ At work ☐ At home ☐ None			
	Other toxins (mold, asbestos, radiation, etc.):			

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General Health			
Check and briefly explain if you have or in the past have had any symptoms in the following areas:			
☐	Skin (e.g. eczema, rashes, hives)	☐	Heartburn/Indigestion/Acid Reflux
☐	Hair loss/growth	☐	Gas/Bloating
☐	Head/Neck	☐	Bowels (constipation, loose stools)
☐	Ears, Nose/Sinuses	☐	Bladder/Urination
☐	Throat	☐	Back/Spine
☐	Lungs/Asthma	☐	Reproductive/Libido
☐	Chest/Heart	☐	Gynecological/Periods
☐	Immune system (e.g. colds/infections)	☐	Hormones
☐	Circulation	☐	Emotional

Recent changes in:

☐	Appetite/Thirst	☐	Weight
☐	Focus/Concentration	☐	Energy level
☐	Memory	☐	Ability to sleep (e.g. falling/staying asleep)
☐	Mood (e.g. anxiety, low mood)	☐	Temperature
☐	Other pain/discomfort		

Are there any significant life events or stressors that contribute to your overall health? Is there anything else that you feel is important about your health or lifestyle? (please describe)

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Please complete the following in chronological order from birth to present using the approximate age of occurrence:

Surgery	Age

Serious Infections/Diseases (pneumonia, mono, TB, cancer, heart attack, chronic bronchitis, colitis, etc.)	Age

Dental Intervention Root canals & extractions, first silver amalgam filling, braces, retainer, etc.	Age

Injuries/Accidents	With stiches? Y/N	Age