INTEGRATIVE
Naturopathic Medical Centre

CLIENT & HEALTH HISTORY QUESTIONNAIRE

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

PERSONAL INFORMATION	
Date:	
Name:	
Birth date (DD/MM/YY):	
Address:	
City:	
Province:	Postal Code:
Home Phone:	Business Phone:
Cell Phone:	Email Address:
We offer our patients exclusive e-subscription to our quarterly newsletter. Would you like to receive this health information? Yes ☐ No ☐	
Care Card Number:	
Occupation:	
Emergency Contact Name:	
Relationship:	Phone:
Medical Doctor:	Phone:
Doctor's Referral: Yes ☐ No ☐	
How did you hear about our clinic?	

PERSONAL HEALTH HISTORY	
Medication(s), Illnesses and Surgeries	
Weight:	Height:
Are you taking any medication? Yes ☐ No ☐	
What type? painkiller ☐ muscle relaxant ☐ anti-inflammatory ☐ sleep ☐	
depression ☐ Laxative ☐ other ☐ ______________	
Have you had any motor vehicle accidents, surgery, or other illnesses?	
Are you seeing another practitioner? MD ☐ RMT ☐ Physiotherapist ☐	
Chiropractor ☐ Other ☐ ____________________	

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PERSONAL HEALTH HISTORY (cont'd)
About your current presenting condition (the reason you're seeking treatment)
When and how did this condition begin?
What aggravates it?
What relieves it?
Does the pain affect your daily activities? Yes ☐ No ☐ If so, how?
Is the pain worse at certain times of the day? And if so, when?
Have you had previous treatment?
What do you do to maintain or improve your health?
Is the condition/pain getting: progressively worse ☐ better ☐ stays the same ☐
Other symptoms felt:
grinding ☐ popping ☐ dizziness ☐ numbness ☐
weakness ☐ nausea ☐ vomiting ☐
Has this condition occurred before? Yes ☐ No ☐
Was it resolved? Yes ☐ No☐

☐ Allergies	☐ Frequent Colds/Flu	☐ High/Low Blood Pressure
☐ Bruise easily	☐ Gout	☐ Osteoarthritis
☐ Cancer	☐ Head Injuries	☐ Painful Menstruation
☐ Colon Problems	☐ Headaches	☐ Poor Circulation
☐ Contagious Conditions	☐ Heart Condition	☐ Pregnancy
☐ Diabetes	☐ Hemophilia	☐ Respiratory Conditions
☐ Digestive Problems	☐ Infections	☐ Rheumatoid Arthritis
☐ Dislocations	☐ Insomnia	☐ Seizures/Convulsions/ Epilepsy
☐ Enlarged Glands	☐ Jaw Pain	☐ Sinus Infections
☐ ExcessiveThirst/Urination	☐ Kidney Condition	☐ Spinal Injury
☐ Fainting	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Fever	☐ Neurological Conditions	☐ Varicose Veins
☐ Fractures	☐ Numbness/Tingling/Pain in Hands, Arms or Legs	

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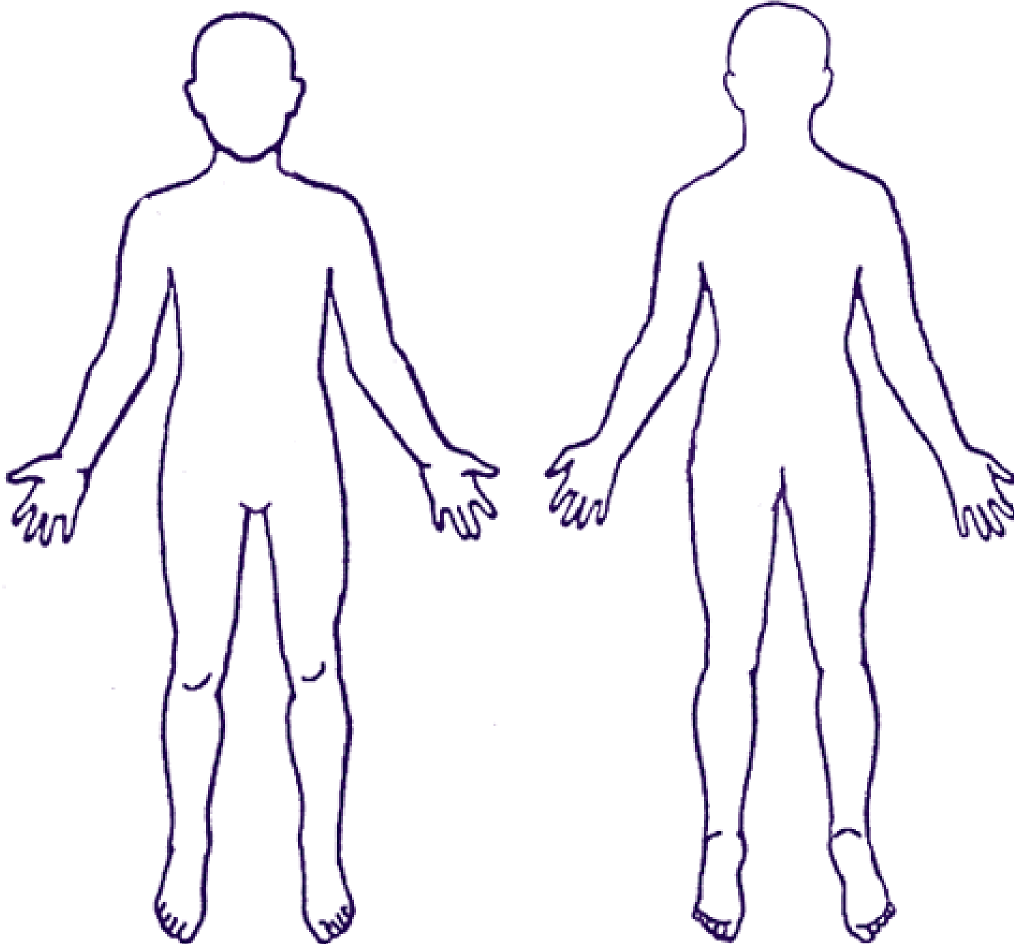
If you can, show in the diagrams, areas of concern, discomfort or pain:



CANCELLATION POLICY AND MISSED APPOINTMENTS
Your appointment time is reserved especially for you. If you find it necessary to reschedule an appointment, **2 business days' notice** (48 hours) is required or you will be billed a **cancellation fee** of up to a full appointment charge.
I agree to pay my therapist for professional services according to the agreed upon fee schedule. ____________________ Date   ____________________ Patient Signature (Parent or Guardian)