

ADULT HEALTH HISTORY

Today's Date _____

Name _____ Date of Birth[DMY] _____

Address _____ City _____

Province _____ Postal Code _____ Country _____

Email _____ Phone Home _____ Cell _____ Work _____

Occupation _____ Age _____ Height _____ Weight _____ Sex M F

Marital Status Single Partner Married Separated Divorced Widow(er)

Emergency Contact: Name _____ Phone _____

Relationship to Patient? _____

Who referred you to Alta Vista Naturopathic Clinic? _____

Other Healthcare Providers

Medical Doctor: _____ Phone _____

Naturopathic Physician: _____ Phone _____

Chiropractor: _____ Phone _____

Other: _____ Phone _____

What are your health concerns? _____ Date Began? _____

Date of last physical exam _____

Laboratory procedures performed (eg blood, urine, stool, hair analysis, x-ray, CT scan, mammogram)

What types of therapy have you tried for this problem(s):

diet modification fasting vitamins/minerals herbs homeopathy chiropractic

acupuncture OTC drugs prescription medications IV therapy

Other _____

Current Medications [prescription and OTC]

Medication/Dosage _____ For? _____ Since when? _____

Do you currently use any of the following frequently [more than once a week]?

- Aspirin Tylenol Ibuprofen Antacids Laxatives Diet pills
- Recreational drugs: What and how often? _____ Tobacco _____ pack(s)/day

Major Hospitalizations, Surgeries, Injuries [please list all procedures, complications and dates]

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you wear:

- Corrective lenses Dentures Hearing aid(s) Medical devices/prosthetics/implants

Recent changes in your ability to:

- see taste hear smell feel hot/cold sensations mobility

Please indicate the Vaccinations/Immunizations you have had:

- DPT (diphtheria, pertussis, tetanus) Haemophilus Influenza B Hepatitis A
- MMR (measles, mumps, rubella) Flu Hepatitis B
- Tetanus Booster: When? _____ Polio Smallpox
- Other: _____ Varicella (chicken pox) HPV (Gardasil)

Please indicate if you had any adverse reactions: _____

Women

Are you pregnant? Y N Maybe If yes, what week/month? _____

Pregnancies: Full term _____ Premature _____ Miscarriage _____ C-Section _____ Abortions _____

Last PAP? _____ Any Abnormal PAP smears? Y N Outcome? _____

Monthly Breast Exam? _____ Last Mammogram? _____

Age of first menses? _____ Do you have irregular periods? Y N

Duration of menses? _____ Days between menses? _____ Start of last menses? _____

Please describe your cycle [check all that apply]:

- Heavy flow Light flow Cramping Clots
- Vaginal discharge Vaginal sores Painful intercourse Breast lumps
- PMS Describe _____

Any recent changes in normal menstrual flow [large clots, heavier, scant, etc]? _____

Are you using Birth Control? What type and how long? _____

Surgical Menopause? _____

Menopause

Date of last menstrual cycle_____ Length of cycle_____days Interval between cycles_____days

Are you taking HRT? Y N Hot Flashes? Y N Frequency _____

Mood changes? Y N Night Sweats? Y N

HEALTH HABITS

Circle your level of stress on a scale of 1-10 [1 being the lowest] 1 2 3 4 5 6 7 8 9 10

Can you identify the major cause of stress? _____

Hobbies _____

Do you consider yourself: Underweight Overweight Just right Your weight_____

Have you had an unintentional weight loss or gain of 10 lbs or more in the last 3 months? _____

Exercise

5-7 days/week 3-4 days/week 1-2 days/week

45 minutes or more duration per workout 30-45 minutes duration per workout

less than 30 minutes duration per workout

Type of Exercise:

Walk Run, jog, Jump rope Weights Swim Box Yoga

Pilates Elliptical Cycle Other _____

Nutrition and Diet

Mixed food diet [animal and vegetable sources] Vegetarian[type] _____

Vegan Salt restricted Fat restricted Starch/Carb Restricted

Calorie restricted Blood type diet Religious restrictions

Specific food restrictions

Dairy Wheat Eggs Soy Corn Gluten

Other _____

Please List Any food allergies that you know you have: _____

Eating Habits

Skip breakfast One meal/day Two meals/day Three meals/day

Graze [small frequent meals] Eat constantly whether hungry or not

- Eat only when hungry Generally eat on the run Add salt to food
 Food rotation

Food Frequency

Servings per day

- Fruits[not including citrus] _____ Citrus Fruits _____ Dairy _____
Dark green veggies _____ Deep coloured veggies _____ Beans/Peas/Legumes _____
Eggs _____ Fish _____ Meat/Poultry _____ Grains[unprocessed] _____

Beverage Frequency

Water glasses/day _____ Juice glasses/day _____ Soda[uncaffeinated] _____

Caffeine

Coffee 6oz cups/day _____ Tea 6oz cups/day _____ Soda cans/day _____
Other sources _____

Alcohol

Wine glasses/day or week _____ Liquor glasses/day or week _____ Beer glasses/day or week _____

Do You eat/use any of the following foods on a regular basis?

- Artificial sweeteners Candy Carbonated beverages Fast food
 Fried foods Margarine Microwave Plastic wrap
 Processed meat

Preferences

Strong like for any of these flavours: sour sweet bitter rich/fatty spicy salty
Strong dislike for any of these flavours: sour sweet bitter rich/fatty spicy salty

Supplements You Are Taking

- Multivitamin/mineral Vitamin C Vitamin E EPA/DHA
 Evening Primrose Oil Calcium Magnesium Zinc
 Minerals _____ Probiotic Digestive Enzyme Amino acids
 CoQ10 Antioxidants Herb teas Herb extracts
 Chinese herbs Ayurvedic herbs Homeopathy Bach flowers
 Protein shakes Super foods liquid meals Other _____

Environment

Is your job associated with potentially harmful chemicals? _____

Are you exposed to tobacco smoke [work, home, etc.]? Y N

Are you exposed to animals [work, home, etc.]? Y N

Do you

- Prefer warmth (ie foods, drinks, weather, etc)
- Prefer cool (ie foods, drinks, weather, etc)
- No Preference

Sleep

How many hours of sleep per night? _____ What time do you go to sleep? _____

Is your sleep disrupted at the same time each night? _____ What time? _____

Do you feel rested when you wake? Y N Sometimes

Do you have to get up more than once to urinate during the night? Y N # of times? _____

Time of the day you feel Best or the most energy?

- 7am-9am 9am-11am 11am-1pm
- 1pm-3pm 3pm-5pm 5pm-7pm
- 7pm-9pm 9pm-11pm 11pm-1am
- 1am-3am 3am-5am 5am-7am

Time of day you feel worst or least energy?

- 7am-9am 9am-11am 11am -1pm
- 1pm-3pm 3pm-5pm 5pm-7pm
- 7pm-9pm 9pm-11pm 11pm-1am
- 1am-3am 3am-5am 5am-7am