



Integral Health Clinic

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Thank you for taking the time to fill out the requested information. It will help greatly in our study of your present health and will assist us in choosing an appropriate direction to take in working toward your desired restoration of health. Confidential when completed.

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____ / _____ / _____
(m) (d) (y)

Address: _____
Street City Postal code

Office phone: _____ Home phone: _____

Occupation: _____ E-mail: _____

Marital status: S M D W Sep Name of spouse: _____

Dependants: _____

How did you find out about the clinic? _____

MAIN HEALTH CONCERN

Present weight: _____ Normal weight: _____ Last time this weight: _____

What is your chief concern about your health? _____

If this is a chronic illness, how long have you had this condition? _____

Who diagnosed your illness? _____ When? _____

CURRENT TREATMENTS OR REGIMES

Name of family medical doctor: _____

What specialist(s) have you seen? _____



| TREATMENT OR REGIME | DOCTOR OR THERAPIST | LAST VISIT |
|---------------------|---------------------|------------|
| | | |
| | | |
| | | |
| | | |

What else would you like to see changed in your health? (Indicate how long each of these conditions have existed.)

1. _____
2. _____
3. _____

How long has it been since you were totally well? _____

PREVIOUS CONDITIONS
(please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Gallstone | <input type="checkbox"/> Bowel Disease |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Gout | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Candida |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Allergies | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Sinusitis (chronic) | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Cancer | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diphtheria |

Other (please specify): _____

Were any of the above severe? If so give age, severity and duration.



Describe your general state of health as a child:

Describe your general state of health as a teenager:

SURGERIES

| OPERATION | WHEN | COMPLICATIONS |
|-----------|------|---------------|
| | | |
| | | |
| | | |

ACCIDENTS

Please indicate the severity, injuries sustained, when it occurred, and any treatment required.

FAMILY HISTORY

Please indicate the age of all relatives living and indicate the age at which any family member became deceased. (L-living, D-deceased)

| RELATIVE | AGE | AILMENTS |
|----------|-----|----------|
| Mother | | |
| Father | | |
| Brothers | | |
| Sisters | | |
| Children | | |



| RELATIVE | AGE | AILMENTS |
|-----------------------|-----|----------|
| Maternal grandmother | | |
| Maternal grandfather | | |
| Maternal aunts/uncles | | |
| Paternal grandmother | | |
| Paternal grandfather | | |
| Paternal aunts/uncles | | |

ADDITIONAL HISTORY (FEMALE)

Age of first menses _____ Age of cessation of menses _____

Are your menses regular or irregular? _____

Check all that apply

- | | | |
|---------------------------|---------------------------|-------------------|
| _____ Menopause | _____ Tubaligation | _____ I. U. D. |
| _____ Pre-menstrual pain | _____ Birth control pills | _____ Blood Clots |
| _____ Post-menstrual pain | _____ Sensitive breasts | |

_____ Vaginal Discharge - consistency, colour, and odour: _____

Do you experience PMS symptoms? _____

If yes, what do you experience? _____

Have you ever experienced fibrocystic disease of the breast? _____

Have you ever had uterine fibroids? _____

Do you have recurring vaginal infections? _____ Never _____ Rarely _____ Frequently

How often do you experience cystitis (bladder infection)? _____ Never _____ Rarely _____ Frequently

of children _____ # of pregnancies _____ Miscarriages _____ Abortions _____

Complications associated with the above _____

ADDITIONAL HISTORY (MALE)

Any history of the following problems? **(check those that apply)**

_____ bladder _____ prostate _____ sexual function



MEDICATIONS

List all prescribed medications presently being taken.

| DRUG NAME | DOSAGE | FREQUENCY | HOW LONG |
|-----------|--------|-----------|----------|
| | | | |
| | | | |
| | | | |
| | | | |

List any prescribed medication you have had a bad reaction to in the past. Indicate the drug name, when you took it, and the reaction you had.

How many courses of antibiotics have you had in the past 10 years? _____

Have you ever had a bad reaction to an antibiotic? _____

List any over-the-counter medications you take (e.g. Tylenol, Tums, Cold/Flu Remedies). Indicate whether you take rarely **(R)**, occasionally **(O)**, frequently **(F)** or daily **(D)**.

Do you use/or have used any recreational drugs? _____

If yes, indicate type and frequency of usage.

Have you ever had a severe reaction from a vaccination? _____

If yes, explain vaccination type, when it was administered and the reaction.



LIFESTYLE

What quantity, per day, do you drink on average of the following :

_____ Coffee _____ Tea _____ Water _____ Milk
_____ Fruit juice _____ Soft drinks _____ Alcohol _____ Herbal tea
_____ Vegetable juice

List all food supplements you are presently taking. Indicate the total dosage taken in one day (i.e. if you take 2 tables of Vitamin C 500 mg/day, then total is 1000 mg/day).

Do you smoke? _____ If so, for how long? _____ How many cigarettes? _____
Have you ever smoked, and if so for how long? _____

Does anyone else smoke in your household or workplace? _____

How often would you have an alcoholic beverage? _____

How many hours of sleep do you get on average? _____

What do you do for exercise? (indicate type, how often you participate, and for how long each occasion) _____

When was your last vacation? _____

What do you do for recreation and relaxation? _____

What level of personal stress are you experiencing right now? **(check one)**

Minimal 1 2 3 4 5 Average 6 7 8 9 10 Unbearable

What level of occupational stress are you experiencing right now? **(check one)**

Minimal 1 2 3 4 5 Average 6 7 8 9 10 Unbearable

Is the main stressor **(check all that apply)**:

_____ Financial _____ Job related _____ Interpersonal
_____ Marriage _____ Health _____ Unfulfilled expectations
_____ Spiritual _____ Family members

Do you participate in any spiritual discipline or belong to a church or religious group? _____

Are you an active participant? _____

