Client Health History

General Information

Name_____ Birthdate_____ Age_____ Sex M F

Address_____ Postal Code_____

Telephone: Home_____ Work_____ May leave message? Y N

Occupation_____ Employer_____

Practitioner name and phone_____ Last physical exam_____

Laboratory tests performed?_____ Your blood type_____

How did you hear about our clinic?_____

Would you like to receive our newsletter? Email Address: _____

Note: This questionnaire is intended to provide a well-rounded perspective of your current health and well being. There will be opportunity to elaborate on any questions. All information is kept confidential.

Major Health Concerns

What is your main reason for coming in today?_____

Please list other health concerns in order of importance to you:

Concern	Since	Details

Current treatments, including any medications taken (prescription or over-the-counter):

Treatment	Since	Provider

Your Health History

Please list any surgeries, injuries, hospitalizations or diagnostic procedures you have had:

Occurrence	Since	Details/Complications

Please list the most significant stressful events in your life. Are any of these events continuing to impact you?

Are you currently, or have you in the past, worked with a counselor, psychologist, social worker, pastor or other therapist? Y N When?_____

Do you use any of the following? If so, how often?

Antacids: _____ Laxatives: _____ Drugs: _____ Over the Counter Meds: _____

Tobacco: _____ Alcohol: _____ Caffeine: _____ Hormones: _____

Which of the following conditions have you had? Please indicate "now (n) or past (p)":

Abscesses		Diabetes		HIV		Peritonitis		Stroke	
Abortion		Emphysema		Influenza		Pleurisy		Syphilis	
Alcoholism		Epilepsy		Kidney Disease		Pneumonia		Tonsillitis	
Allergies		Gall Stones		Leukemia		Rheumatic Fever		Thyroid problem	
Amnesia		Goiter		Malaria		Rubella		Tuberculosis	
Arthritis		Gonorrhea		Measles		Scarlet Fever		Typhoid Fever	
Asthma		Gout		Miscarriage		Sexual Abuse		Venereal Warts	
Cancer		Hay Fever		Mononucleosis		Skin Disease		Warts	
Chicken Pox		Heart Disease		Mumps		Strep Throat		Whoop. Cough	
Cold Sores		Hepatitis		Parasites		Sinusitis		Worms	
Depression		Herpes Genitalia		Pelvic Inflam Dz.		Sunstroke		Yellow Fever	

List any other major conditions you've had:_____

From all of the above are there any conditions or life events after which you have never felt totally well again, or which have been more severe than usual? Please describe:_____

_____

Have you ever had a reaction to a vaccination?_____

Are you aware of any contact with environmental hazards (e.g. chemicals, pollutants, etc.) at the workplace, home, or during leisure activities?
If so please describe._____

Family Health History

In the following table, please indicate which of the following ailments, have affected your relatives. Please specify any other major ailments not listed here.

Alcoholism Allergies Arthritis	Asthma Cancer Depression	Diabetes Epilepsy Gout	High Blood Pressure Heart Disease Hypoglycemia	Mental Illness STD Stroke	Thyroid Dz Tuberculosis Ulcer

Relative	Age (If living)	Age at death	Ailments and Cause of Death
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles			
Paternal Grandmother:			
Paternal Grandfather:			
Paternal Aunts/Uncles			

General Health

Please answer the following questions, or circle the option which best applies to you.

You currently live with? SPOUSE, PARTNER, PARENTS, FRIEND, CHILDREN, ALONE

Ages of children_____

Present weight?____One year ago?_____Current energy level (1=poor, 10=excellent)? _____

When in the day is your energy the best?_____Worst?_____

Have you ever experienced persistent fatigue or weakness?_____

What is your level of work satisfaction (1=very unsatisfied, 10=extremely satisfied)?_____

Do you exercise? Y N How much and how often? _____

Do you take vacations? Y N When and how long was your last vacation? _____

Do you have a religious or spiritual practice? Y N

Do you have problems falling or staying asleep? Y N

What is the quality of your sleep? _____Do you ever sweat while sleeping? Y N

Do you wake feeling refreshed? Y N Do you ever nap during the day? Y N

Compared to those around you do you generally feel warmer, cooler, or average? _____

How often do you get colds, influenza, sore throat during the year? _____

Do you experience symptoms (e.g. agitation, fatigue sweating, others) if you skip a meal? Y N

Do you get lightheaded if you rise quickly from a sitting or lying position? Y N

Any known or suspected allergies?_____

What do you feel is your weakest organ system and why?_____

Emotionally, do you have a tendency toward: ANXIETY, DEPRESSION, MOOD SWINGS, ANGER, FEARS

Digestion

Which of the following do you experience? Please indicate "now (n) or past (p)":

Gas		Bloating		Abdominal pain/discomfort		Fullness		Heartburn	
Diarrhea		Small and hard stools		Yellow or light coloured stools		Rectal bleeding		Constipation	
Hemorrhoids		Loose stools		Strong smelling stools		Nausea			

How often do you have a bowel movement? _____ Has this changed in recent years? Y N

Do you ever have any of the following in your stool? BLOOD, MUCUS, UNDIGESTED FOOD

Kidneys and Bladder

How many bladder infections have you had in the last 3 years? _____

How were they treated? _____

Your usual urine colour is? DARK YELLOW, BRIGHT YELLOW, PALE, CLEAR, CLOUDY

Does your urine have a strong odor? Y N

Which of the following do you experience? Please indicate "now (n) or past (p)":

difficulty holding urine		difficulty passing urine		pain with urination		burning with urination		blood in urine		kidney stones	

When you exercise you perspire? NONE LIGHTLY, MODERATELY, HEAVILY
Do you perspire at other times? Y N
Where on your body do you tend to perspire? _____

Female Reproduction

Age at first menses? _____ Are your cycles regular? Y N
Average number of days? _____ Is your period? HEAVY, MEDIUM, LIGHT
Is blood? LIGHT RED, DARK RED, MEDIUM, CLOTTED Is there spotting between periods? Y N
Do you experience any of the following related to your cycle?

water retention		headaches		depression		mood swings	
breast tenderness		irritability		cravings		other	

Do you get vaginal itching, vaginal discharge? Y N
Do you get breast lumps? Y N
Number of pregnancies _____ abortions _____ miscarriages? _____
Have you had difficulty becoming pregnant? Y N Do you use birth control? Y N
If so, what type do you currently use? _____
Do you have any sexual difficulties? Y N
Have you ever been physically or sexually abused? Y N
Have you experienced menopausal symptoms? Y N
Do you get annual Pap smears? Y N Have any been abnormal? Y N

Male Reproduction

Do you ever experience? TESTICULAR PAIN, TESTICULAR MASSES/LUMPS
Do you have any abnormal discharge from penis? Y N Sores on penis? Y N
Any history of sexually transmitted disease? Y N
Do you wake at night to urinate? Y N Has this changed in recent years? Y N
Are you aware of any prostate problems? Y N When was your last prostate exam? _____
Do you have difficulty getting or maintaining an erection? Y N
Do you have any sexual difficulties? Y N
Have you ever been physically or sexually abused? Y N
Do you use birth control? Y N
If so, what type do you currently use?_____

Other Symptoms

Which of the following do you experience? Please indicate "now (n) or past (p)":

Rashes		Dry Skin		Headaches		Swollen Glands		Heart Flutters	
Acne		Chest Pain		Sinus Problems		Wheezing		Ankle Swelling	
Easy Bruising or Bleeding		Persistent Itching		Muscle Cramps		Joint Pain		Numbness Or Tingling	
Excess Thirst Or Hunger				Difficulty Breathing				Canker Sores	

Thank you for taking the time to fill in this questionnaire.

BELMONT Naturopathic Chiropractic Massage Therapy
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Tom Daly BSc ND

Declaration and Consent to Treatment

Patient's Name:_____ Date: _____
please print

Assessment and Treatment

Tom Daly practices naturopathic medicine using a combination of the following forms of treatment: standard medical techniques (i.e. physical examination and lab work), nutrition, traditional Oriental medicine, homeopathic medicine, botanical medicine (i.e. herbs), physical treatments and lifestyle counselling.

"I am here to apply the unique skills, knowledge, and principles of naturopathic medicine toward the betterment of individual and community health and well-being. I will create an accessible, family-centered practice with a special enthusiasm for pediatric care. Through ongoing personal and professional development, I will provide expert medical guidance built upon a foundation of caring and committed relationships."

I understand that Tom Daly is a licensed Naturopathic Doctor (N.D.). Any treatment or advice provided to me as a patient of Tom Daly is not exclusive from any treatment or advice that I may receive in the future from another licensed health care provider. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.

I understand that I have the right to ask any questions regarding the nature of my treatment, including foreseen risks and benefits. I understand that, as in any medical treatment, results are not guaranteed.

I understand that in the event of a medical emergency, I am advised to seek conventional medical care at a hospital or clinic if I am unable to reach my naturopathic doctor.

I understand that the products available through the clinic dispensary may also be available through retailers of natural health products in the community.

Patient Fees

Adult	$125 per hour
Senior (65+) or Student/Child (17 and under)	$100 per hour
Telephone Consultations	$1 per minute after 5 minutes; long-distance charges where applicable
Missed appointments without 24 hours cancellation notice	Billed at hourly rate

**prices subject to change*

I have read all the above and accept that these are the terms and conditions while under the naturopathic care of Tom Daly, B.Sc. N.D.

Signature: _____ Date: _____
Patient or Parent/Guardian