Renée Isaacs Langdon, BSc (Hons), MSc, ND

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CONTACT INFORMATION

Last name: ____________________________ First name___________________ Date:_____________

Date of Birth: ___________ /____________/__________ Age: _____ Sex: □ F □ M
Month Day Year

Marital Status: S M D W Sep Occupation: ____________________________________

Full Address: ____ Suite #_________________

City:__________________________ Province:_____________________ Postal Code:______________

Telephone: (Home) _____________________________ (Work) ____________________________

Email address:____

Information can be conveyed through: □ Mail (newsletters, brochures etc.) □ Email □ Telephone

Chief Health Concerns: ____

____

Name of Medical Doctor: _____________________________ Telephone: _______________________

Date of Last Physical: ________________________

How did you hear about this clinic? ____

If referred please state by whom ____

Have you been treated by a Naturopathic Doctor before? □ Yes □ No

If 'yes', by whom? ____________________________________ When? ____________________

Other Health Care Providers you are seeing

1. ____ Tel: ___________________________

2. ____ Tel: ___________________________

3. ____ Tel: ___________________________

In Case of Emergency

Contact Name: ____

Telephone: (H)__________________ (W)________________ Relation: _______________________

Signature: ____ Date:________________________

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ADULT HEALTH ASSESSMENT QUESTIONNAIRE

This Health Assessment Questionnaire is a tool designed to provide insight into your personal health currently and historically. It will identify current strengths of your health, risk factors that may be present and highlight areas that may need strengthening or changing to achieve your health goals.

Effective Naturopathic medical care is only possible when a complete picture of the patient's physical, mental and emotional states is given. Therefore, please carefully and thoroughly complete this health questionnaire. Use the last three (3) months as a guide when answering the questions and select the answer that is best suited to each question.

1. GENERAL INFORMATION

Last name: ____________________________ First name___________________ Date:_____________

Date of Birth: ___________ /____________/__________ Age: _____ Sex: □ F □ M
Month Day Year

Marital Status: S M D W Sep Occupation: ___________________________________

Height: ______ feet _____ inches or _____ centimetres Weight: _________lbs or ________ kg

What do you think would be an acceptable body weight for you? ______lbs. or ______kg

No. of persons in household: _______ Relationship to you? ______________________________

No. of pets in household: __________ What type of pets? _______________________________

In your opinion, what are your most important health concerns/chief complaints?

1.______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________
7. ______________________________________
8. ______________________________________

Others: ____

Which of the above problems are of the most immediate concern to you? __________________________

____

Are there any traumatic events (surgeries, drug reactions, life trauma etc.) that you can identify as having caused or clearly aggravate your health problems? ____

____

____

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2. PAST MEDICAL HISTORY

What childhood illnesses have you had?

□ Asthma □ Chicken Pox □ Mumps □ Polio
□ Rheumatic Fever □ Scarlet Fever □ Roseola □ Measles
□ Rubella (German measles) □ Whooping cough □ Others ________________________

Your Health History (Please check the space that applies to you)

	PAST	NOW	No. of years		PAST	NOW	No. of years
Alcoholism				Hepatitis (type)			
Allergies				High Blood Pressure			
Anemia				Hypoglycemia			
Arthritis				Injury (Serious)			
Asthma				Jaundice			
Bleeding				Kidney Disease			
Cancer (Specify type)				Liver Disease			
Candida (yeast)				Overweight			
Colitis				Pneumonia			
Diabetes				Rheumatism			
Drug/alcohol abuse Specify:				Thyroid □Hypo □ Hyper			
Eczema				Tuberculosis			
Emphysema				Ulcers Specify:			
Heart Murmur				Venereal Disease (STDs) Specify:			
Headache				Other (Specify)			

Surgeries/Procedures	Date	Tests	Date
Abdominal/Gastrointestinal		Chest X-Ray	
Appendectomy (appendix)		Colon X-Ray	
Caesarean Section		Gallbladder X-Ray	
Cancer (type):		Kidney X-Ray	
Gallbladder		Sinus X-Ray	
Heart		Echocardiogram	
Hernia		Electrocardiogram	
Mastectomy (Breast)		Mammogram	
Ovaries/Womb - hysterectomy		Flu injections	
Sinuses		Hepatitis shots (specify type):	
Tonsillectomy (tonsils)		Measles, Mumps, Rubella shots	
Tubes in ears –1st set		TB test	
Tubes in ears – 2nd set		Tetanus shots	
Vasectomy		Typhoid shots	
Other (Specify):		Gastrointestinal series	
		Sigmoidoscopy	

pt.: ____ **DOB:** _______________

Medications *(Please list additional medications on a separate sheet if needed)*
Any known allergies or drug sensitivities? ____

Number of times on antibiotics in the last 10 years: _________________________

Medications	Allergic to	Taking	Dose/amount	Medications	Allergic to	Taking	Dose/amount
Antacids				Hormones			
Antibiotics				Inhalers			
Aspirin/Tylenol				Insulin			
Birth control pills				Laxatives			
Blood pressure				Opiates			
Caffeine				Penicillin			
Chemotherapy				Radiation			
Codeine				Recreational drugs			
Cortisone				Sedatives			
Demerol				Sleeping pills			
Diet pills				Stimulants			
Diuretics				Sulfa			

Vitamins, Supplements, Herbal or Homeopathic Remedies

Medications	Dose/Amount	Reason for Taking	Duration of Use

3. FAMILY MEDICAL HISTORY

Please indicate if any of your immediate family (mother, father, maternal/paternal grandparents, siblings, aunts, uncles) has ever had any of the following health concerns:

Health Concern	Family Member	Health Concern	Family Member
Alcoholism		Hypertension	
Allergies		Infertility	
Alzheimer’s		Intestinal Disease	
Anaemia		Learning Disability	
Arthritis		Mental Illness	
Asthma		Migraine headaches	
Bleeding (easily)		Neurological Disorders	
Cancer (Specify type)		Obesity	
Diabetes		Osteoporosis	
Drug Addiction		Sickle Cell Anemia	
Eczema		Stroke	
Epilepsy/Seizure		Suicide	
Genetic Disorder		Thyroid (hyper/hypo)	
Glaucoma		Tuberculosis (TB)	
Gout		Venereal Disease (Type)	
Heart Disease		Other:	

pt.: ____ **DOB:** _______________

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4. HEALTH HABITS

Diet

Please indicate the number of times per week that you eat or drink the following:

Food	Times/wk	Food	Times/wk	Food	Times/wk
Fruits/Fruit juices		Milk/Cheese products		Sweets/sweeteners	
Vegetables/Vegetable juices		Soy/Rice/Almond milk		Condiments	
Meat		Soft Drinks (regular)		Beer	
Nuts/Seeds/Legumes/Beans		Soft drinks/Pop (Diet)		Wine	
Grains (rice, millet, breads etc)		Coffee		Other alcoholic	
Oils (butter, margarine, etc.)		Tea		Bottled water	
Spices (Garlic, thyme etc.)		Herbal tea		Tap/filtered water	

Is there anything about your diet you would like to change: ______________________________________

On average how many meals do you eat per day: 1 2 3 4 5 +5

What is usually your largest meal: □ Breakfast □ Lunch □ Dinner

Do you usually eat on your own or with others? □ Alone □ With Others

List any foods that you crave ____

List any foods you exclude from your diet ____

Do you follow a specific diet regime? □ Vegetarian □ Vegan □ Other __________________

Do you monitor your intake of □ Fat □ Salt □ Sugar □ Fibre □ Carbohydrate □ Protein

Are you often thirsty? □ Yes □ No How many glasses of water do you drink in a day? __________

What temperature of drinks do you prefer? □ Hot □ Warm □ Cold □ Room Temperature

Exercise

How many times per week do you exercise? □ Never □ <1/wk □ 1-3/wk □ 3-5/wk □ > 5/wk

What types of exercise do you do? □ Mind/Body □ Strength Building □ Aerobic/Cardio □ Flexibility

Daily Activities

Please indicate the amount of time you spend doing the following activities on a typical day

Activity	Time (hrs)	Activity	Time (hrs)
Computer Related Work		Relaxing	
Driving a Vehicle		Sleeping	
Eating		Taking public transport/ passenger	
Exercising		Time spent inside a building	
Listening to Music		Time spent outdoors	
Personal Hygiene		Watching television	
Reading		Working	

Do you smoke or have you in the past? □ Yes □ No If yes how many times per day? _________

Do you now or have you in the past used marijuana or other drugs? □ Yes □ No

If yes, which drugs, how often and how long? ____

____

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5. ENVIRONMENTAL EXPOSURES

Which of the following are you routinely exposed to?

□ Forced Air □ Radiant Heat □ Gas Heat □ Oil Heat □ Electric Heat
□ Wood Stove □ Air Conditioning □ Electric Blanket □ Television □ Microwave
□ Feather Pillow □ Heated Waterbed □ Computer Screen □ Gas fumes □ Pollution
□ Water Pollution □ Hydro Towers □ Chemical Sprays □ Factory □ Paint fumes
□ Makeup/body creams □ Perfumes/Colognes □ Acrylic nails □ Tobacco smoke □ Deodorizers
□ Cleaning Products □ Other (Specify) ____

Are your home or work environments excessively □ Damp □ Moist

Which of the following are known allergies or are most bothersome to you?

□ Sunshine □ Dust □ Dampness □ Lack of Sunshine □ Mold □ Dryness
□ Summer □ Spring □ Winter □ Fall □ Heat □ Cold
□ New Moon □ Full Moon □ Perfume □ Tobacco Smoke □ Car Fumes □ Dogs
□ Cats □ Insects □ Seashore □ Mountains □ Tree Pollens □ Grasses/Weeds
□ Fluorescent Lighting □ Poor Air Ventilation
□ Changes of Weather (specify) _______________ □ Approach of Storms
□ Foods (specify) _________________________ □ Chemicals (specify) _________________________________
□ Other (specify) ____

6. GENERAL STATUS

Energy level

On a scale of 1 (low) to 10 (high) rate your energy level ____

What time of day is your energy highest ____________________ lowest __________________________?

What affects your energy? ____

Sleep

How many hours a day of sleep do you get? _________________ Do you nap? □ Yes □ No

Do you have trouble falling asleep? □ Yes □ No If yes what keeps you up? __________________________

Do you sleep straight through the night? □ Yes □ No If no how often do you get up? ______________________

Do you wake feeling rested? □ Yes □ No

Do you have recurring dreams/nightmares? □ Yes □ No If yes, what is the theme? ______________________

____

What position do you sleep in? ____

Breathing

How would you describe your breathing? ____

Body Temperature

What is your normal body temperature? □ Cold □ Cool □ Warm □ Hot □ Other _________________

Do you like to be warm or cool? ____

Does your body temperature change throughout the day? ____

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Perspiration

Describe your perspiration? ____

Are there any unusual circumstances that cause you to perspire? ______________________

Is there anything unusual about your perspiration? ______________________________

Appetite/Digestion

Describe your appetite? ____

Describe your digestion? ____

What makes your digestion worse? _____________________________________

What type of foods do you prefer? ☐ Salty ☐ Spicy ☐ Sweet ☐ Sour ☐ Bitter

What temperature of food do you prefer? __

____

How many bowel movements do you have per day? ____________________________

Relationships & Sexuality

How stressful is your home environment? ☐ Low ☐ Moderate ☐ High ☐ Unbearable

What is the quality of the major relationships in your life? ___________________________

Who are the most important people in your life? ________________________________

How stressful is your work environment? ☐ Low ☐ Moderate ☐ High ☐ Unbearable

How do you relate to most people? _____________________________________

Please describe your sexuality: ☐ Never been sexually active ☐ Abstainer ☐ Sexually active
☐ Heterosexual ☐ Homosexual ☐ Bisexual

Emotions/Experiences

How do you express love?____

What makes you happy? ____

What makes you sad? ____

Do you cry easily/often? ☐ Yes ☐ No Does being consoled help? ☐ Yes ☐ No

What makes you angry? ____

Do you get angry easily/often? ☐ Yes ☐ No How do you express your anger? _____________

____

What fears do you have? ____

List major experiences of grief/loss in your life ________________________________

____

What is the most traumatic experience in your life? ______________________________

Are there any known episodes of physical or sexual abuse in your past? __________________

Is there any information not covered above that would be relevant to your health profile? _________

____

pt.: ______________________________ **DOB:** ______________