



...so you can play!

Naturopathy - New Client Questionnaire

Name			Date
Birth Date d d / m m / y y y y	Age	Phone - Home	Work
Address			Cell
City		Province	Postal Code
Marital Status <input type="checkbox"/> single <input type="checkbox"/> common-law <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> remarried			
Occupation – present		Occupation – past	
Family Doctor		Other Health Care Practitioners	
How did you hear about us?			

Please state your primary reason for attending our clinic. Please list the first time you noticed the condition and describe any factors that you suspect may have played a role in its onset and perpetuation.

Regarding your chief concern, have any treatments, diets or therapies brought you real improvement or relief?

Please list any other health concerns.

1 _____

2 _____

3 _____

Please list any significant illnesses that you have had in the past.

1 _____

2 _____

3 _____

Have you ever been hospitalized? Please indicate reason and year.

Any significant adult trauma, grief or stress (e.g. accidents, falls, emotional, etc.)?

Any significant childhood trauma, grief or stress?

Please list all drugs and/or supplements that you are currently taking. Include dosage.

Please describe the type and frequency of your exercise.

Please indicate your frequency of use of the following.

Alcohol	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month	Pop (regular)	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month
Antacids	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month	Pop (diet)	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month
Cigarettes/Cigars	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month	Salt	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month
Coffee	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month	Sugar	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month
Drugs	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month	Tea	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month
Microwave	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month	TV (hrs)	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month
Pain Relievers	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month	Computer (hrs)	_____	<input type="checkbox"/> day	<input type="checkbox"/> week	<input type="checkbox"/> month

Did you ever smoke? Use alcohol excessively? Use recreational drugs to excess? Please give details and when you quit:

Do you have any allergies (i.e. food, environmental, drug, etc)?

Did you have a flu shot this year? YES NO

How many times total? _____

Have you received any other vaccinations in the last 5 years? YES NO

Which vaccinations and when?

Do you have any pets (include number and type)?

Where do you live? Apartment House How long have you lived there? _____

How old is your home? _____ Have you done any renovations recently? _____

Who do you live with? _____

What do you do in your spare time? Any hobbies?

Family History

Please indicate, where applicable, if anyone in your family currently has or has had any of the following conditions:

	Father	Mother	Brothers	Sisters	Maternal		Paternal	
					G.Mother	G.Father	G.Mother	G.Father
Age (if living)								
Health (G=good, P=poor)								
Anemia								
Asthma, Hay fever, Hives								
Cancer								
Cystic Fibrosis								
Diabetes								
Epilepsy								
Rheumatoid Arthritis								
Osteoarthritis								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Mental Illness								
Alcoholism								
Stroke								
Tuberculosis								
Other								
Cause of Death								
Age (at death)								

CONFIDENTIAL HEALTH APPRAISAL

For the following, please place a ✓ in the space if you currently have the symptom, a P if it has been a problem in the past.

VITALITY

- _____ Low stamina
- _____ Low ambition
- _____ Fatigue
- _____ Energy drop during the day
- _____ When?
- _____ Poor Sleep
- _____ Insomnia
- _____ Feel un-refreshed on waking
- _____ Unexplained weight gain/loss

HAIR

- _____ Thin
- _____ Excess loss
- _____ Graying
- _____ Excess growth
- _____ Prematurely gray
- _____ Grows slowly
- _____ Thinning eyebrows, underarm, pubic hair

SKIN / NAILS

- _____ Dryness/Cracking
- _____ Itching
- _____ Pimples/ Acne
- _____ Boils
- _____ Blotchy/ White Patches
- _____ Eczema
- _____ Psoriasis
- _____ Dandruff
- _____ Increased pigmentation
- _____ Easy bruising
- _____ Spots on nails
- _____ Nails brittle/ split
- _____ Bite nails
- _____ Fungal infection of nails

EYES

- _____ Watery
- _____ Burning
- _____ Redness
- _____ Dryness
- _____ Discharge
- _____ Itching

EYES

- _____ Double vision
- _____ Blurring
- _____ Sensitive to light
- _____ Cataracts
- _____ Glaucoma
- _____ Failing vision
- _____ Frequent conjunctivitis/ sties
- _____ Spots in front of eyes
- _____ Dark circles under eyes

EARS

- _____ Loss of hearing
- _____ Ringing in the ears
- _____ Wax build up
- _____ Frequent earaches

NOSE

- _____ Itching
- _____ Loss of smell
- _____ Discharge
- _____ Sneezing
- _____ Sinusitis
- _____ Polyps
- _____ Prone to nose bleeds

MOUTH / LIPS

- _____ Jaw clicks
- _____ Cold sores
- _____ Lips cracking
- _____ Canker sores
- _____ Peculiar taste in mouth
- _____ Bad breath
- _____ Impaired taste/ smell

TEETH

- _____ Cavities
- _____ Loose teeth
- _____ Dentures/ Bridges
- _____ Root canal
- _____ Sensitivity to hot/cold
- _____ Bleeding gums
- _____ Gum disease

TEETH

- Grinding teeth
- Braces

RESPIRATION

- Hay fever
- Asthma
- Coughing
- Bronchitis
- Shortness of breath
- Frequent sore throats
- Frequent colds/ coughs
- Phlegm
- Pneumonia

CIRCULATION / BLOOD

- Dizziness
- Cold hands/ feet
- Swelling hands/ feet
- Varicose veins
- Low/ high blood pressure
- Anemia
- Fainting

CARDIOVASCULAR

- Heart disease
- Palpitations
- Angina
- Heart murmurs
- Chest pain/heaviness

MUSCULO-SKELETAL

- Weakness
- Stiffness
- Aches
- Twitching
- Cramps
- Numbness/tingling
- Prone to sprains
- Joint pain
- Joint swelling
- Bursitis
- Arthritis
- Unsteady/lose balance

NEUROLOGICAL

- Headaches
- Migraines
- Forgetfulness
- Convulsions / seizures

GASTRO - INTESTINAL

- Poor appetite
- Large appetite
- Heartburn
- Indigestion
- Belching
- Excessive flatulence
- Bloating after eating
- Nausea/ Vomiting
- Ulcer
- Constipation
- Diarrhea
- Hemorrhoids
- Cravings
- Strong thirst
- No thirst
- Stomach pain, burning, aching after eating
- Digestive problems subside with rest relaxation
- Hungry shortly after eating
- Anal itching
- Pain under right side of rib cage
- Fatty foods cause indigestion
- History of worms/parasites
- Number of daily bowel movements

URINATION

- Dribbling
- Difficult
- Increased frequency of urination
- Blood in urine
- Painful urination
- Urination at night
- Unable to hold urine
- Kidney stones
- Bladder infection

FOR MALES

- _____ Frequent / urgent urination
- _____ Weak / delayed urinary stream
- _____ Urge to urinate several times per night
- _____ Dripping after urination
- _____ Lack of sex drive
- _____ Impotence
- _____ Difficulty attaining / maintaining erection
- _____ Painful testicles
- _____ Genital rash
- _____ Low sperm count
- _____ Low sperm motility

FOR FEMALES

- _____ Age at first period
- _____ Length of cycle
- _____ Length of period
- _____ Irregular periods
- _____ Bleeding between periods
- _____ Menstrual clots
- _____ Breast tenderness
- _____ Irritability / mood swings
- _____ Bloating during period
- _____ Vaginal discharge
- _____ Ovarian cysts
- _____ Uterine fibroids
- _____ Venereal disease
- _____ Breast lumps
- _____ Yeast infections
- _____ Menopause
- _____ Number of pregnancies
- _____ Number of live births
- _____ Type of birth control

INFORMED CONSENT

I, _____, consent to treatment as described by Tina Rogers, ND.

Signature: _____

Date: _____