BALANCE
INTEGRATED HEALTHCARE

Naturopathic Health History

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for treatments is confidential except as required or allowed by law to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Date of Birth: _____ Gender: _____

Address: _____
Number Street Suite City Province Postal Code

Occupation: _____ E-mail: _____

Tel (home): _____ Tel (work): _____ Cell: _____

Physician's Name: _____ Tel: _____

Physician's Address: _____
Number Street Suite City Province Postal Code

In Emergency Notify: _____ Relationship: _____ Tel: _____

Date of last visit to physician or health practitioner: _____ How did you hear about us? _____

What is your main reason for coming in today? _____

_____

If you have a specific health condition, please describe it in detail. _____

When was the very first time you noticed your condition and how long has your main health problem been troubling you?

_____

Please describe carefully any factors that you suspect may have played a role in its onset and its continuation.

_____

Is your current health problem getting better, worse, or the same?

_____

Describe the treatment that you have received for this problem and from whom.

_____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current problem or for any other problem? ☐ No ☐ Yes

What was the therapy and the result?

_____

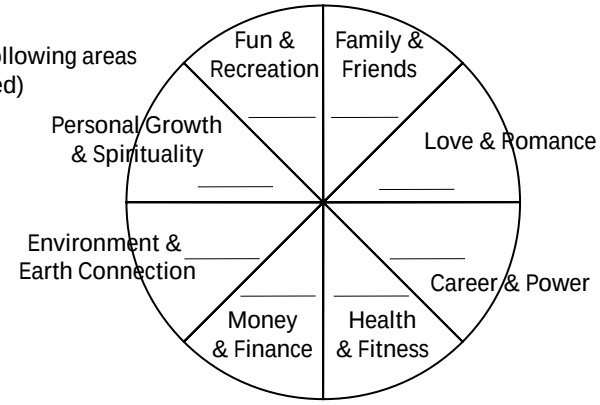
Please list other health problems, and their duration, in order of importance:

1) _____

2) _____

3) _____

Please indicate on the pie chart your level of personal satisfaction in the following areas of your life by assigning a number from 0-10 in each area (10 = very satisfied)



What is the general state of your health?

- ☐ Excellent
- ☐ Good
- ☐ Average
- ☐ Fair
- ☐ Poor

Describe, on average, your energy level on a scale from 1–10 (with 10 being the highest) _____

During the day, when is your energy level the best / the worst? _____

Do you exercise? ☐ No ☐ Yes If so, what type and how often? _____

Please list the 5 most significant and stressful events in your life (from the most recent) date

1) _____ _____

2) _____ _____

3) _____ _____

4) _____ _____

5) _____ _____

Are any of these situations continuing to impact your life? ☐ No ☐ Yes

Are you currently working with a professional counsellor, psychologist, social worker or other therapist? Please specify:

_____

Have you in the past? ☐ No ☐ Yes If so, when? _____

Are you currently working with a Doctor of conventional medicine? Please explain:

_____

Which of the following conditions have you experienced?

☐ measles	☐ mumps	☐ chicken pox	☐ small pox	☐ whooping cough
☐ polio	☐ diphtheria	☐ typhoid fever	☐ rheumatic fever	☐ scarlet fever
☐ tuberculosis	☐ herpes	☐ ear infections	☐ pneumonia	☐ tonsillitis
☐ canker sores	☐ epilepsy	☐ thyroid problems	☐ chronic infections	☐ gonorrhea
☐ syphilis	☐ insomnia	☐ hepatitis	☐ weight problem	

Review of Systems

Please circle if you are currently experiencing ("C") or have experienced in the past ("P") any of the following:

General

P C Headaches
P C Migraines
P C Fatigue
P C Fever
P C Sweats
P C Heat or cold intolerance
P C Dizziness
P C Fainting
P C Poor/disturbed sleep
P C Recent weight change
P C Numbness/Tingling in arms/hands/legs
P C Allergies
P C Seizures

Gastrointestinal

P C Constipation
P C Diarrhea
P C Abdominal bloating
P C Abdominal pain
P C Gas
P C Heartburn
P C Undigested food in stool
P C Blood in stool
P C Belching
P C Change in appetite
P C Nausea/Vomiting
P C Colitis
P C Crohn's
P C IBS
P C Hemorrhoids
P C Hernia

Respiratory

P C Asthma
P C Emphysema
P C Persistent cough
P C Chronic bronchitis
P C Shortness of breath
P C Excessive phlegm production
P C Spitting up blood
P C Smoker

Eyes, Ears, Nose, Throat, Mouth

P C Ear infections
P C Ringing in ears
P C Deafness
P C Vertigo
P C Ear discharge
P C Eye pain
P C Eye infections
P C Failing vision
P C Glaucoma
P C Cataracts
P C Mercury tooth fillings
P C Gum disease
P C Frequent colds/flus
P C Recurrent Strep throat
P C Sinus infection
P C Sore throat
P C Hoarseness
P C Cold sores
P C History of head injury

Skin

P C Hives/allergy
P C Acne
P C Eczema
P C Psoriasis
P C Itching
P C Bruises easily
P C Varicose veins
P C Warts
P C Change of mole
P C Skin dryness
P C Fungal infections

Musculoskeletal

P C Muscle pain
P C Muscle weakness
P C Muscles spasms/cramps
P C Jaw pain
P C Spinal curvature
P C Arthritis
P C Osteoporosis
P C Bursitis
P C Tendonitis
P C Gout
P C Joint pain, If so, which joint(s)? _____

Cardiovascular

P C Palpitations
P C Murmurs
P C Elevated cholesterol
P C High or Low blood pressure
P C Previous Heart attack
P C Heart disease
P C Varicose veins
P C Ankle swelling
P C Poor circulation
P C Cold hands and/or feet
P C Shortness of breath
P C Chest pain/Angina
P C Anemia

Kidneys and Reproductive

P C Inability to control urine
P C Frequent urination
P C Urination during the night
P C Urinary tract infection
P C Painful urination
P C Blood in urine
P C Kidney infection
P C Kidney stones
P C Sores in genitals
P C PMS
P C Menopause
P C Endometriosis
P C Hysterectomy
P C STDs
P C Pregnancy

Emotional

P C Depression
P C Anxiety
P C Mood swings
P C Anger
P C Eating disorder
P C Phobias
P C Psychiatric issues
P C Drug abuse
P C Thoughts of suicide
P C Psychological counseling

Have you had any illnesses not listed? If yes, please specify: _____

Have you had any hospitalizations, surgeries, or injuries? If yes, please specify: _____

_____

Do you have allergies to any drugs, herbs, foods, animals, or other? ☐ No ☐ Yes If yes, please list:

_____

Which of the following do you currently use? Please indicate amount (how much, how often, and how long):

alcohol _____ hormones _____

coffee _____ sedatives _____

tobacco _____ laxatives _____

antacids _____ cortisone _____

Other medications (please give the full name, dosage, and how long you have been taking the medication):

drug, vitamin or herb name	dosage	duration

How many times have you been treated with antibiotics? _____

For what condition(s)? _____

Family History

Please list ages, health problems and, if deceased, cause of death:

	living age	health problems	cause of death
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Vaccinations

Please indicate your vaccination history, including age and any adverse reactions:

	DATE	REACTION
DPT (diphtheria, pertussis, tetanus)		
MMR (measles, mumps, rubella)		
Flu		
Polio		
Hepatitis B		
Others		

Diet

Please describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (type and quantity) _____

Do you have any food cravings? _____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? _____

Is there any additional information that you would like to add?

_____

_____

_____

_____

_____

_____

_____

Signature _____ Date _____

Thank you for taking the time to fill out this form. All information is confidential and will not be released for legal or medical purposes without your consent.

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Consent Information

We would like your consent. We want you to understand the services we hope to provide to you, the cost involved and what we do with personal information we obtain from you. If you have any questions on any of the following information, please do not hesitate to ask.

Consent for Treatment
I have read and understood all of the associated forms, answered them truthfully and to the best of my knowledge and fully consent to treatment at Balance Integrated Healthcare. I understand that there is a 12-hour cancellation policy and if I fail to notify the clinic, then I may be charged for my session.

Consent for the Cost of our Services
I understand the costs of the services that I am being provided at Balance Integrated Healthcare.

Consent for Personal Information
I understand that in order to provide me with the services I am seeking, Balance Integrated Healthcare will collect some personal information about me (e.g. home telephone number, address, emergency contacts).

I have reviewed Balance Integrated Healthcare's privacy policy about the collection, use and disclosure of personal information, the steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given the chance to ask any questions I have about the privacy policy and they have been answered to my satisfaction.

I understand that, as explained in Balance Integrated Healthcare's Privacy Policy, there are some rare exceptions to these commitments.

I understand that if I do not check off the following boxes I will receive the following:

- ☐ Please **DO NOT** send me the monthly Balance Integrated Healthcare *Healthy Insights* newsletter (find out about a new health topic every month) written by one of the practitioners at Balance Integrated Healthcare. (email required).

- ☐ I would **NOT** like to receive email/mail notices of promotions and special offers from Balance Integrated Healthcare (helps you stay on top of all the events at Balance Integrated Healthcare including upcoming seminars/workshops and newly acquired services!)

I hereby agree to Balance Integrated Healthcare collecting, using and disclosing personal information about me only with my expressed written authorization.

Signature Name (please print) Date

Notes (office use only)