Thornhill Naturopathic HEALTH CLINIC

12A Centre Street
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HEALTH ASSESSMENT QUESTIONNAIRE - ADULT

This is a confidential health assessment questionnaire which is designed to provide insight into your health, family history and lifestyle. The following questions will assist me in providing you with the best possible care and in understanding the factors that may be playing a role in your health.

The questionnaire is **not** designed to give a medical diagnosis. It will identify the current strengths of your health, and any risk factors that might be present.

This questionnaire will take about 45 minutes to complete. It is divided into eleven categories.

General Guidelines to follow when filling out the questionnaire:

- Use the last three months as a guide when answering the questions.
- Select the answer that is best suited to each question
- Read all questions carefully prior to answering
- You may attach extra sheets or write on the back if more space is needed.

The health assessment questionnaire is broken down into the following categories:

A. General Information
B. Past and present health
C. External factors
D. Family medical History
E. Medications and Supplements
F. Exercise
G. Diet
H. Review of Physical Systems
I. Stress
J. Personal Values
K. Health Positioning Statement

A. GENERAL INFORMATION

Name: ______________________________ Date: ______________________

Date of Birth: ______________________ Occupation: ______________________

Number in household ________ Relationship(s) to you? ______________________

Number of pets ________ What kind of pets? ______________________

Height: ____ feet ____ ins. or ____ cms Weight: ______ lbs or ______ kg

What do you think is an acceptable body weight for you? __________ lbs/kg

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What are your current health concerns? ____

____

B. PAST AND PRESENT HEALTH CONCERNS

Did you have any health problems at birth? ____

____

How was your health as a child? ____

____

Describe your health during puberty /teenager: _______________________________________

____

Please list any injuries, hospitalizations, accidents, or medical concerns that you have had:

Event	When?	Treatments?

When did you notice any changes to your health? ____________________________________

____

____

Have you been diagnosed with any illnesses? Explain:__________________________________

____

____

What has been the most traumatic event in your life? _________________________________

____

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A TYPICAL DAY

During a typical day list the amount of time you spend doing the following activities:

Note: the total time will probably add up to more than 24 hours due to the nature of the question.

Activity	Time (hours)	Activity	Time (hours)
Reading		Watching television	
Listening to music		Driving a vehicle	
Taking public transport, passenger		Relaxing, meditating	
Working		Computer related work	
Preparing meals		Eating	
Exercising		House / yard work	
Being outside		Inside a building	
Sleeping		Personal hygiene	

Using the Scales provided identify your own observations on the categories listed.

*Scale: I - **not comfortable** at all with current situation or level of health*
2 - low level of comfort with current situation or level of health
3 - okay most of the time with current situation or level of health
4 - fairly comfortable with current situation or level of health
*5 - **high level of comfort** with the current situation or level of health*

Category	Satisfaction or Comfort Level with the Situation					Changed in Last 3 Months		Changed in Last Year	
a) DIET	I	2	3	4	5	YES	NO	YES	NO
b) EXERCISE	I	2	3	4	5	YES	NO	YES	NO
c) HEALTH	I	2	3	4	5	YES	NO	YES	NO
d) LIFESTYLE	I	2	3	4	5	YES	NO	YES	NO
e) ENVIRONMENT	I	2	3	4	5	YES	NO	YES	NO
f) WORK	I	2	3	4	5	YES	NO	YES	NO
g) FAMILY	I	2	3	4	5	YES	NO	YES	NO
h) RELATIONSHIPS	I	2	3	4	5	YES	NO	YES	NO

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C. EXTERNAL FACTORS

The following section identifies external and environmental factors that may be affecting your health.

ENVIRONMENT

Where did you grow up? ____________________

Where do you live currently? ☐ City ☐ Suburbs ☐ Country ☐ Farm

Type of home? ☐ Apartment/condo ☐ semi/townhouse ☐ detached house

Do you live near hydro towers? ☐YES ☐ NO In the past? ☐YES ☐ NO Number of years?________

Do you live near a factory? ☐YES ☐ NO In the past? ☐YES ☐ NO Number of Years? ________

Using the scale provided identify your known personal exposure to the following external products / substances and your concern about these exposures on your health.
Scale of exposure: a (never), b (seldom or less than once per week), c (1 - 3 times per week), d (3 - 7 times per week), e (often or more than 7 times per week).

PERSONAL EXPOSURE			Never	<1/wk	1-3/wk	3-7/wk	>7/wk
Gas fumes	YES	NO	a	b	c	d	e
Pollution	YES	NO	a	b	c	d	e
Water pollution	YES	NO	a	b	c	d	e
Chemical Sprays	YES	NO	a	b	c	d	e
Other	YES	NO	a	b	c	d	e

Please specify____________________

Level of Concern?			None	Little	Some	More	Very
Gas fumes	YES	NO	a	b	c	d	e
Pollution	YES	NO	a	b	c	d	e
Water pollution	YES	NO	a	b	c	d	e
Chemical Sprays	YES	NO	a	b	c	d	e
Other	YES	NO	a	b	c	d	e

PERSONAL

What are your hobbies? ____________________

____

How much time do you spend in nature? ____________________

Do you smoke? ☐YES ☐ NO ☐ In the past? ☐YES ☐ NO How many cigarettes per day? _________

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Does anyone in your house smoke? □YES □ NO □ In the past? □YES □ NO

How many cigarettes per day?__________

Do you use personal care products? □YES □ NO If so what brand? ______________________________

PERSONAL EXPOSURE

			Never	<1/wk	1-3/wk	3-7/wk	>7/wk
Makeup, body creams	YES	NO	a	b	c	d	e
Perfumes, cologne	YES	NO	a	b	c	d	e
Acrylic Nails	YES	NO	a	b	c	d	e
Sunscreen	YES	NO	a	b	c	d	e
Hair dye	YES	NO	a	b	c	d	e
Other	YES	NO	a	b	c	d	e

Please specify ____

Level of Concern?			None	Little	Some	More	Very
Makeup, body creams	YES	NO	a	b	c	d	e
Perfumes, cologne	YES	NO	a	b	c	d	e
Acrylic Nails	YES	NO	a	b	c	d	e
Sunscreen	YES	NO	a	b	c	d	e
Hair dye	YES	NO	a	b	c	d	e
Other	YES	NO	a	b	c	d	e

Please specify ____

Do you have any body piercings? □YES □ NO

Do you have any permanent tattoos? □YES □ NO

Have you had cosmetic surgery? □YES □ NO If yes, when? ______________________________

and what type ? ____

How many hours a day do you watch television? _________

Do you use wireless networks? □ at home? □ at work? if so, how many hours daily? _________

What type of telephones do you use? □ cord □ cordless □ cellular

How many hours a day do you spend on a cell phone or PDA? ______________________________

Do you use an ear piece for your phone? □YES □ NO

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Do you use a Bluetooth device? □YES □ NO

How many trips on an airplane do you take a year? ______________________________

HOUSEHOLD

Type of house you grew up in? ______________________________

Number of times you have moved home:__________ How old is you current home? __________

Have there been any recent home renovations? □YES □ NO If so what type? ______________

____

Is there a history of flooding or water damage in your house? □YES □ NO In the past? □YES □ NO

What type of cooking utensils (pots and pans) do you use? ______________________________

What type of food storage containers do you use? ______________________________

What type of water do you drink? ______________________________

What type of container do you use to carry drinking water? ______________________________

What type of cleaning products do you use? (natural /grocery brand/scented/unscented) __________

____

PERSONAL EXPOSURE			Never	<1/wk	1-3/wk	3-7/wk	>7/wk
Clothes dryer sheets	YES	NO	a	b	c	d	e
Fabric softener	YES	NO	a	b	c	d	e
Household deodorizers	YES	NO	a	b	c	d	e
Paints	YES	NO	a	b	c	d	e
Other	YES	NO	a	b	c	d	e

Please specify ______________________________

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Level of Concern?			None	Little	Some	More	Very
Clothes dryer sheets	YES	NO	a	b	c	d	e
Fabric softener	YES	NO	a	b	c	d	e
Household deodorizers	YES	NO	a	b	c	d	e
Paints	YES	NO	a	b	c	d	e
Other	YES	NO	a	b	c	d	e

Please specify ______________________________

Do you use compact florescent (CF) bulbs in your house? □YES □ NO If so where? ____________

Have you ever broken a (CF) bulb? □YES □ NO If so how did you clean it up? ____________

WORK

Do you enjoy your work? □YES □ NO Why?______________________________

Describe your work load? ______________________________

____

On average how many hours do you work in a day? ____________ in a week? ____________

Do you bring work home with you? □YES □ NO How often? ____________

How active is your work day? □ sedentary □ active Please describe? ____________

____

How would you describe your work environment? ______________________________

____

Are there any other external or environmental factors that you feel may be affecting your health?

____

____

____

____

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D. FAMILY MEDICAL HISTORY

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

Health Concern	Family Relative	Health Concern	Family Relative
Alcoholism		Hypertension	
Allergies		Infertility	
Alzheimer's disease		Intestinal disease	
Arthritis		Learning disability	
Asthma		Mental illness	
Cancer *(indicate type)*		Migraine headaches	
Diabetes		Neurological disorders	
Drug addiction		Obesity	
Eating disorder		Osteoporosis	
Genetic disorder		Stroke	
Glaucoma		Suicide	
Heart disease		Other	

Number of siblings: ____________________ Your birth order: ________________________________

E. MEDICATIONS AND SUPPLEMENTS

Please circle any of the following medications that you are taking?

antacids appetite suppressants aspirin / tylenol birth control pills
chemotherapy diuretics (water pills) laxatives pain relievers
radiation recreational drugs sleeping pills tranquillizers

Any known allergies or drug sensitivities? ____

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

Medications (if more space is needed please attach a separate sheet)

Listing of medications	Dosage / Amount	Reason for taking	Duration of use

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Vitamins, Supplements, Herbal or Homeopathic Remedies

(if more space is needed please attach a separate sheet)

Listing of medications	Dosage / Amount	Reason for taking	Duration of use

Other Treatments Please comment on any other treatments you have received

Treatments	Past	Current	Comments/Effectiveness
Acupuncture			
Aromatherapy			
Art Therapy			
Ayurvedic Medcine			
Biofeedback			
Chiropractic			
Chinese Medicine			
Colonics			
Cranial Sacral Therapy			
Energetic Therapies			
Herbal Remedies			
Homeopathy			
Hydrotherapy			
Hypnotherapy			
Iridology			
Magnetic Therapy			
Massage Therapy			
Music Therapy			
Naturopathic Medicine			
Osteopathy			
Physiotherapy			
Polarity Therapy			
Reflexology			
Reiki			
Shiatsu			
Other			

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F. EXERCISE

Using the scale provided identify the number of times a week that you engage in the following exercises. Scale: a (never), b (seldom or less than once per week), c (1 - 3 times per week), d (3 - 5 times per week), e (often or more than 5 times per week).

	Never	<1/wk	1-3/wk	3-5/wk	>5/wk
BODY / MIND EXERCISES					
Meditation/Prayer/Breathing Exercises	a	b	c	d	e
Visualizations (or similar)	a	b	c	d	e
Other	a	b	c	d	e
Please specify ______					
STRENGTH BUILDING					
Weight Training	a	b	c	d	e
Martial Arts (or similar)	a	b	c	d	e
Pilates	a	b	c	d	e
Other	a	b	c	d	e
Please specify ______					
CARDIOVASCULAR EXERCISES					
High Impact Aerobics, Step	a	b	c	d	e
Running / Jogging	a	b	c	d	e
Walking, Low Impact Aerobics	a	b	c	d	e
Cycling / Rowing, Swimming	a	b	c	d	e
Other	a	b	c	d	e
Please specify ______					
FLEXIBILITY					
YOGA, Tai Chi, Qi Gong (or similar)	a	b	c	d	e
General Stretching / Lengthening	a	b	c	d	e
Other	a	b	c	d	e
Please specify ______					

Do you belong to a gym? YES ____ NO ____ If yes, how often do you go? ________

What benefits have you found from exercising? ______________________

____

____

Circle the statement that describes you best?

A) I exercise because I have to (someone has advised an exercise program)
B) I exercise because I want to exercise for my own health and wellness.
C) I exercise because I enjoy exercising.

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G. GENERAL INFORMATION on DIET

On a scale of 1 - 10 (low - high) how would you rate your diet? ____________________

Why? ____

____

Is there anything about your diet you would like to change? ____________________

____

____

On average how many meals do you eat a day? 1 2 3 4 5 + 5

What is usually your largest meal? breakfast lunch dinner

What time is your last meal of the day? ____________________

Are there any foods that you crave? ____________________

____

Are there any foods that you avoid? ____________________

____

Do you follow any specific diet regime? vegetarian ______ vegan ______ other ____________

Do you usually eat on your own or with others? _________ alone ________ with others

Do you pay attention to the quality of the food that you eat? YES NO

Are you aware of any differences in how you feel with different foods? YES NO

What percentage of your diet is proteins: ____________ carbohydrates: ____________

fruit: __________ vegetables: __________ other: __________

Do you monitor your intake of FAT? YES NO
Do you monitor your intake of SALT? YES NO
Do you add SALT to most meals? YES NO
Do you monitor your intake of FIBRE? YES NO

Do you enjoy food? YES NO
Do you enjoy preparing food? YES NO
Do you look forward to meal time / eating? YES NO

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Circle all the statements that describe you best.

A) I look for quick, convenient food choices when grocery shopping and making meals.
B) I like to eat natural, whole and fresh food whenever I can.
C) I eat mostly organic fruits and vegetables
D) Someone else is usually responsible for what I eat.
E) I eat out whenever I can.
F) I enjoy food
G) I enjoy preparing food
H) I look forward to meal time/eating
I) I eat according to the season

Take an average of your diet over the last 3 months and using the scale provided identify the number of times a week that you consume the foods listed. Scale: a (never), b (seldom or less than once per week), c (1 - 3 times per week), d (3 - 7 times per week), e (often or more than 7 times per week).

	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
FRUITS					
Citrus (oranges, grapefruit)	a	b	c	d	e
Berries (strawberries, blueberries)	a	b	c	d	e
Plums, Peaches, Nectarines	a	b	c	d	e
Melons, Mangoes	a	b	c	d	e
Apples, Pears	a	b	c	d	e
Bananas	a	b	c	d	e
Other Fruits	a	b	c	d	e

Please specify ____

What percentage of the fruit that you eat is raw?______________________

VEGETABLES					
Root veg (potatoes, carrots, beets, yams)	a	b	c	d	e
Vine veg (tomatoes, cucumbers, zucchini)	a	b	c	d	e
Broccoli, cauliflower, cabbage	a	b	c	d	e
Greens (lettuce, swiss chard, kale)	a	b	c	d	e
Pickles (all types)	a	b	c	d	e
Other Vegetables	a	b	c	d	e

Please specify ____

What percentage of the vegetables that you eat is raw? ____________________

	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
PROTEIN SOURCES / MEAT					
Nuts and Seeds	a	b	c	d	e
Legumes / Beans	a	b	c	d	e
Fish / Seafood	a	b	c	d	e
Fowl (chicken, duck, turkey)	a	b	c	d	e
Red (beef, pork, lamb)	a	b	c	d	e
Luncheon meats / processed meat	a	b	c	d	e
Other Meats	a	b	c	d	e

Please specify ______________________________

	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
MILK PRODUCTS					
Soya / Almond / Rice Milk	a	b	c	d	e
Cows milk / 2%, 1% or Skim	a	b	c	d	e
Cheese / yoghurt	a	b	c	d	e
Ice cream	a	b	c	d	e
Other Milk products	a	b	c	d	e

Please specify ______________________________

	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
GRAINS					
Millet / kamut / quinoa / barley	a	b	c	d	e
Rye / pumpernickel bread, flour	a	b	c	d	e
Multi grain bread / flour / wild rice	a	b	c	d	e
Whole wheat bread / flour / brown rice	a	b	c	d	e
White / processed bread / white rice	a	b	c	d	e
Other grains	a	b	c	d	e

Please specify ______________________________

	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
OILS					
Butter	a	b	c	d	e
Margarine	a	b	c	d	e
Olive oil, Flax seed oil	a	b	c	d	e
Canola oil	a	b	c	d	e
Sunflower / Almond	a	b	c	d	e
Vegetables oils	a	b	c	d	e
Other	a	b	c	d	e

Please specify ______________________________

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	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
SPICES					
Salt	a	b	c	d	e
Pepper	a	b	c	d	e
Garlic, Onions	a	b	c	d	e
Thyme / Basil / Oregano	a	b	c	d	e
Other	a	b	c	d	e

Please specify ____________________

	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
CONDIMENTS					
Ketchup	a	b	c	d	e
Mustard	a	b	c	d	e
Store bought salad dressings	a	b	c	d	e
Mayonnaise	a	b	c	d	e
Other	a	b	c	d	e

Please specify ____________________

	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
SWEETS / SWEETENERS					
White or Brown sugar	a	b	c	d	e
Honey	a	b	c	d	e
Saccharine (Sweet and low)	a	b	c	d	e
Artificial Sweeteners (e.g. Aspartame)	a	b	c	d	e
Candy	a	b	c	d	e
Chocolate	a	b	c	d	e
Other	a	b	c	d	e

Please specify ____________________

	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
BEVERAGES					
Coffee	a	b	c	d	e
Tea	a	b	c	d	e
Herbal Tea	a	b	c	d	e
Tap or filtered water	a	b	c	d	e
Bottled or spring water	a	b	c	d	e
Soft drinks (diet)	a	b	c	d	e
Soft drinks (regular)	a	b	c	d	e
Fruit / Vegetable juices (prepared)	a	b	c	d	e
Fresh fruit or vegetable juices	a	b	c	d	e
Beer	a	b	c	d	e
Red wine	a	b	c	d	e
White wine	a	b	c	d	e
Other alcoholic beverages	a	b	c	d	e
Other	a	b	c	d	e

Please specify ____________________

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OTHER FOOD CONSIDERATIONS

Fried Foods	a	b	c	d	e
Refined /Processed (packaged)	a	b	c	d	e
Micro waved	a	b	c	d	e
Use of aluminium pans	a	b	c	d	e
Fast Foods	a	b	c	d	e
Eat watching television	a	b	c	d	e
Eat on the run	a	b	c	d	e
Eat in a quiet, peaceful atmosphere	a	b	c	d	e
Chew food at least twenty times	a	b	c	d	e
Relax after eating	a	b	c	d	e
Other	a	b	c	d	e

Please specify ____

Please list any other diet considerations that have not been included above:

____

____

____

____

____

____

____

____

____

____

____

____

____

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H. REVIEW OF PHYSICAL SYMPTOMS

Energy level

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

What time of the day is your energy the highest? ______________________________

What time of the day is your energy the lowest? ______________________________

What affects your energy? ______________________________

____

Sleep

How is your sleep? ______________________________

____

Do you ever suffer from insomnia? ________ How often?______________________________

How many hours a day do you sleep? __________ Do you nap? ______________________________

Are you a restful and sound sleeper? ___________ If no, please explain. ___________________

____

Do you wake feeling rested? ______________________________

Do you have frequent dreams and nightmares? ______________________________

Breathing

How would you describe your breathing? ______________________________

Body temperature

What is your normal body temperature? ______________________________

Do you like to be warm or cool? ______________________________

Does your body temperature change throughout the day? ______________________________

Perspiration

Describe your perspiration? ______________________________

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

Is there anything unusual about your perspiration? ______________________________

Weather

Are you affected by the weather? ______________________________

What is favourite type of weather? ______________________________

What is your least favourite type of weather? ______________________________

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GENERAL SIGNS and SYMPTOMS	*Past Concern?*	*Current Intensity 1 2 3 4 Low high*	*Length of Time (years)*	*Comments*
Dizziness				
Headaches				
Migraines				
Fever				
Frequent infections				
Rapid weight loss				
Rapid weight gain				
Overweight				
Underweight				
Sensitive to noise				
Sensitive to light				
Sensitive to odours				
Other sensitivities				

SKIN	*Past Concern?*	*Current Intensity 1 2 3 4* low high	*Length of Time (years)*	*Comments*
Rashes				
Eczema				
Psoriasis				
Dry scalp, dandruff				
Hair thinning/loss				
Acne / boils				
Itching				
Colour changes				
Pale complexion				
Changes in moles				
Warts				
Lumps / cysts				
Dry / cracked skin				
Moist / oily skin				
Visible veins				
Stretch marks				
Excess body odour				
Excessive sweating				
Jaundice (yellowing of skin)				
Skin cancer				

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HEAD AND MOUTH	*Past Concern?*	*Current Intensity* 1 2 3 4 Low high	*Length of Time (years)*	*Comments*
Frequent sore throats				
Sore tongue / mouth				
Sores in the mouth				
Cold sores / herpes				
Gum problems				
Bad breath				
Dental cavities				
Hoarseness				
Lumps / goiter				
Swollen glands				
Nose bleeds				
Hay fever				
Loss of smell				
Excess mucous				

Number of dental cavities? _______________ Number of amalgams (silver fillings)?__________________

Last dental check-up? _________________________________Do you ◻ floss regularly? ◻ brush regularly?

Have you had extensive dental work? ◻ YES ◻ NO

Have you had ◻ cosmetic dentistry ◻ oral surgery ◻ orthodontics ◻ periodontal surgery ◻ other

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EYES AND EARS	*Past Concern?*	*Current Intensity* *1 2 3 4* Low high	*Length of Time (years)*	*Comments*
Near sighted				
Far sighted				
Blurred vision				
Dry eyes				
Tearing				
Itchy eyes				
Eye pain				
Redness in eyes				
Eye discharge				
Dark circles under eyes				
Bothered by the sun				
Eye infections				
Glaucoma				
Cataracts				
Other eye concerns				
Diminished hearing				
Ear aches				
Ear infections				
Ringing in the ears (tinnitus)				

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VASCULAR SYSTEM	*Past Concern?*	*Current Intensity 1 2 3 4* Low high	*Length of Time (years)*	*Comments*
Hot hands / feet				
Cold hands / feet				
Deep leg pain				
High blood pressure				
Low blood pressure				
Chest pain				
Slow heart beat				
Fast heart beat				
Palpitations				
Cyanosis (blue skin)				
Extremity swelling				
Extremity numbness				
Varicose Veins				
Leg cramps				
Easy bleeding bruising				
Extremity ulcers				
Anaemia				
Angina				
Heart murmurs				
Rheumatic fever				
Other circulatory / heart concerns?				

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NERVOUS SYSTEM	*Past Concern?*	*Current Intensity 1 2 3 4* Low high	*Length of Time (years)*	*Comments*
Fainting				
Tics				
Seizures / Convulsions				
Paralysis				
Tingling				
Numbness				
Involuntary movement				
Loss of balance				
Speech problems				
Other Nervous System Concerns				

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DIGESTIVE SYSTEM	*Past Concern?*	*Current Intensity 1 2 3 4* Low high	*Length of Time (years)*	*Comments*
Change in appetite				
Change in thirst				
Food intolerances / allergies				
Trouble swallowing				
Loss of taste				
Taste sensitivity				
Bitter taste				
Nausea				
Vomiting				
Gas or belching				
Abdominal Bloating				
Heartburn / Reflux				
Indigestion				
Constipation				
Undigested food in stool				
Blood in stool				
Diarrhea				
Liver Disease				
Gallstones				
High cholesterol				
Diabetes				
Ulcers				
Haemorrhoids				
Hernias				
Crohn's/Ulcerative Colitis				
Irritable bowel syndrome				
Leaky gut syndrome				
Other				

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Appetite:

Describe your appetite: ______________________________

____

Describe your digestion: ______________________________

____

What makes your digestion worse? ______________________________

____

What happens if you skip a meal? ______________________________

____

What type of foods do you prefer? salty sweet spicy bitter sour

What temperature of food do you prefer? ______________________________

Thirst:

Describe your thirst: ______________________________

What temperature of drinks do you prefer? ______________________________

How many glasses of water do you drink in a day? ______________________________

What do you prefer to drink? ______________________________

Bowel Movements:

On average how many bowel movements do you have a day? ______________________________

Do you strain to have a bowel movement? ______ What colour are your stools? ______________

Describe the consistency / size of your bowel movements? ______________________________

____

____

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URINARY SYSTEM	*Past Concern?*	*Current Intensity 1 2 3 4* Low high	*Length of Time (years)*	*Comments*
Urinary pain, burning				
Difficult urination				
Increased frequency				
Frequency at night				
Inability to hold urine				
Frequent infections				
Blood in urine				
Urgency				
Hesitancy				
Kidney Stones				

Number of times a day would you urinate?____

How many times at night do you get up to urinate? ____

What is the colour of your urine? clear light yellow dark yellow other

Is there any odour to your urine? NO YES

If yes, please describe: ____

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RESPIRATORY SYSTEM	*Past Concern?*	*Current Intensity 1 2 3 4* Low high	*Length of Time (years)*	*Comments*
Cough				
Sputum				
Nasal discharge				
Sinus congestion				
Spitting up blood				
Wheezing				
Shortness of Breath				
Difficulty breathing				
Tonsillitis				
Asthma				
Bronchitis				
Pneumonia				
Tuberculosis				
Smoking				
Other concerns				

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MUSCLES / BONES	*Past Concern?*	*Current Intensity 1 2 3 4* Low high	*Length of Time (years)*	*Comments*
Broken Bones				
Bones break easily				
Painful Joints				
Swollen joints				
Lack of joint mobility				
Muscle strain				
Muscle spasms				
Muscle tension				
Muscle weakness				
Muscle atrophy (deterioration)				
Prolonged stiffness				
Heavy feeling in limbs				
Low back pain				
Weak, sore knees				
Osteoporosis				
Arthritis				
Other muscle or bone concerns				

Have you had any falls or injuries ? □ YES □ NO

If yes, describe: ____

____

How would you describe your posture? ______________________________

How would you describe your flexibility? ______________________________

Date of last bone scan? ______________________________

Results? ______________________________

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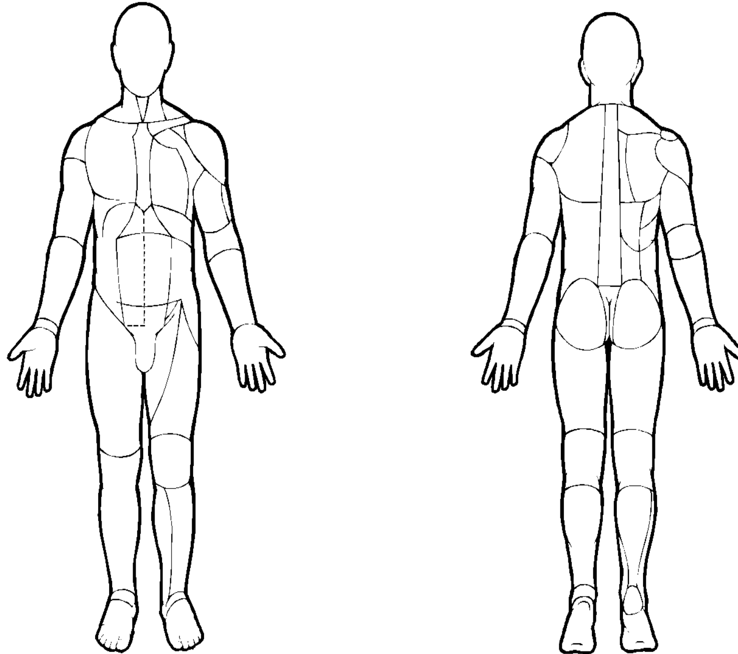
Please mark an 'x' to indicate areas where you feel pain, swelling or discomfort.



Please mark the diagram where you feel these sensations:

X for pain
Z for numbness
T for tingling
P for pins and needles
C for coldness
H for heat

FEMALE REPRODUCTIVE SYSTEM

Age menses began: ___________ Average number of days: _________ Length of cycle: _____________

Describe your flow: ______________________When is it the heaviest? __________________________

What is the flow like (clots, colour)? ____

What symptoms do you have before your period? ____

____

Any pain with your menses? ________________ If so, when is it the worse? ______________________

Are you practising birth control? _________ If so, what type and since when? ____________________

Number of pregnancies: _________________________ Number of live births: ___________________

Number of miscarriages: ____________________ Number of abortions: _________________________

Have you done any fertility treatments? ____

If yes, explain ____

Sexual preference: ______________________________Are you currently sexually active? YES NO

What is your sexual desire? - rate on a scale of 1 (low) to 10 (high) _____________________________

Last PAP (date): _________________________ Last menstrual period: __________________________

Any menopausal symptoms: ____________ If yes, describe: ____________________________________

____

____

____

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FEMALE REPRODUCTIVE SYSTEM	*Past Concern?*	*Current Intensity 1 2 3 4* Low high	*Length of Time (years)*	*Comments*
Bleeding between periods				
Discharge between periods				
Pain during intercourse				
PMS				
Breast discomfort / changes?				
Difficulty conceiving				
Uterine Prolapse				
Fluid retention				
Sexually transmitted diseases/herpes/HPV				
Hot flashes				
Night Sweats				
fungal / yeast infections				

MALE REPRODUCTIVE SYSTEM	*Past Concern?*	*Current Intensity 1 2 3 4* Low high	*Length of Time (years)*	*Comments*
Hernias				
Testicular masses				
Testicular pain				
Sexual difficulties				
Premature ejaculation				
Discharge or sores				
Prostatitis				
Sexually transmitted diseases/herpes/HPV				
Are you sexually active?	Yes	No		Rate your sex drive Scale 1 - 10:
Sexual preference:				

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EMOTIONAL / INTELLECTUAL CONCERNS	*Past Concern?*	*Current Intensity 1 2 3 4* Low high	*Length of Time (years)*	*Comments*
No free time				
Mood swings				
Overly emotional				
Fears, phobias				
Grief				
Worry				
Irritable				
Anxiety				
Anxiety about exams, public speaking				
Anger				
Depressed				
Cry often				
Nervousness				
Hyperactive				
Burnout				
Inability to let things go				
Confusion				
Lack of concentration				
Learning disability				
Feeling out of control				

Other Considerations	*Past Concern?*	*Current Intensity 1 2 3 4* Low high	*Length of Time (years)*	*Comments*
Abuse - emotional, physical, sexual				
Accidents, major falls				
Alcohol, drug abuse				
Change/loss of home				
Change/loss of Job				
Change/addition to household				
Death of a significant other				
Serious family illness				

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I. STRESS

Using the scale provided circle the level of stress that you feel for the following aspects of your life and the duration of this stress. Scale: 0 (None), 1 (low), 2 (average), 3 (high), Duration (in years)

	None (0)	Low (1)	Avg. (2)	High (3)	Duration (years)
Personal	0	1	2	3	
Health	0	1	2	3	
Financial	0	1	2	3	
Unfulfilled Expectations	0	1	2	3	
Relationships	0	1	2	3	
Marriage	0	1	2	3	
Career	0	1	2	3	
Family	0	1	2	3	
Spiritual	0	1	2	3	
Other	0	1	2	3	

Please specify ____________________

How do you deal with stress? ____________________

____

What impact does stress have on you? ____________________

____

What steps have you taken to deal with your stress? ____________________

____

Have you ever engaged in counselling or psychotherapy? ☐YES ☐ NO

If yes how long? __________

Do you take vacations regularly? ☐YES ☐ NO Date of last vacation: __________

Circle the statement that describes you best?

A) I am concerned about the level of stress in my life.

B) I feel I have an average amount of stress compared to most people.

C) I am not concerned about the stress in my life.

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J. PERSONAL VALUES

Check off which ones of the following values are important to you.

	Value		Value
Accomplishments / Results	________	Achievement	________
Adventure / Excitement	________	Aesthetics / Beauty	________
Aloneness	________	Altruism	________
Autonomy	________	Clarity	________
Commitment	________	Completion	________
Connecting / Bonding	________	Creativity	________
Environment	________	Emotional Health	________
Forward Action	________	Freedom	________
Honesty	________	Fun	________
Humour	________	Integrity	________
Intimacy	________	Joy	________
Leadership	________	Loyalty	________
Openness	________	Personal Growth / Learning	________
Mastery / Excellence	________	Orderliness / Accuracy	________
Nature	________	Partnership	________
Power	________	Privacy / Solitude	________
Recognition / Acknowledgement	________	Risk - taking	________
Romance / Magic	________	Security	________
Self-expression	________	Sensuality	________
Service / Contribution	________	Spirituality	________
Trust	________	Vitality	________
Visionary	________	Other	________

List the top six values that you have. (You can add your own values if you would like)

____

____

What are you pet peeves? ____

____

What do you want more of in life? ____

____

What do you want less of in life? ____

____

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K. HEALTH POSITIONING STATEMENTS

Please answer YES (you agree with the comment), SOMETIMES (you feel the comment is sometimes right and sometimes wrong), NO (you don't agree with the comment), or NO COMMENT (you do not have an opinion, or do not wish to voice your opinion) to the following questions.

Statement or Comment	Yes, I Agree	Sometimes Agree	No, don't Agree	No Comment
Everything happens for a reason.				
The body can heal itself.				
You can make yourself sick based on what you think.				
You can make yourself sick based on your emotions.				
Routine is the only way to get things accomplished.				
I believe how I live my life is an important factor in determining my state of health, and I live it in a manner consistent with that belief.				
I can strongly influence my rate of recovery from an illness or injury.				
Physical symptoms are often an indicator to change something in my life.				
I experience love for many people and aspects of my life.				
I don't think people should take themselves too seriously.				
I can manage my stress.				
My body is a mirror of my life.				

What are your short-term health goals? ______________________________

____

What are your long-term health goals? ______________________________

____

Please list any other relevant health / personal information that you feel is missing. ______________

____

Thank you.