Ottawa South
Naturopathic Clinic

613.822.6325
8072 Mitch Owens Rd.
Ottawa (Edwards), ON K0A 1V0
info@ottawasouthnaturopath.com
www.ottawasouthnaturopath.com

Thank you for taking the time to fill out the requested information. It will help greatly in our study of your present health and will assist us in choosing an appropriate direction to take in working toward your desired restoration of health. Confidential when completed.

PERSONAL INFORMATION

NAME: _____ AGE: _____ DATE OF BIRTH: _____/ _____ / _____
(M) (D) (Y)

ADDRESS: _____
STREET CITY POSTAL CODE

OFFICE PHONE: ( ) _____ HOME PHONE: ( ) _____
OCCUPATION: _____ E-MAIL: _____

MARITAL STATUS S M D W Sep NAME OF SPOUSE: _____
DEPENDANTS: _____

HOW DID YOU FIND OUT ABOUT THE CLINIC? _____

MAIN HEALTH CONCERN

PRESENT WEIGHT: _____ NORMAL WEIGHT: _____ LAST TIME THIS WEIGHT: _____

WHAT IS YOUR CHIEF CONCERN ABOUT YOUR HEALTH? _____

_____

_____

IF THIS IS A CHRONIC ILLNESS, HOW LONG HAVE YOU HAD THIS CONDITION?

_____

WHO DIAGNOSED YOUR ILLNESS? _____WHEN? _____

CURRENT TREATMENTS OR REGIMES

NAME OF FAMILY MEDICAL DOCTOR: _____
WHAT SPECIALIST(S) HAVE YOU SEEN? _____

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TREATMENT OR REGIME	DOCTOR OR THERAPIST	LAST VISIT

WHAT ELSE WOULD YOU LIKE TO SEE CHANGED IN YOUR HEALTH? (INDICATE HOW LONG EACH OF THESE CONDITIONS HAS EXISTED.)

1. _____

2. _____

3. _____

HOW LONG HAS IT BEEN SINCE YOU WERE TOTALLY WELL? _____

PREVIOUS CONDITIONS

(PLEASE CHECK ALL THAT APPLY)

_____MEASLES	_____GALLSTONE	_____BOWEL DISEASE
_____MUMPS	_____HIGH BLOOD PRESSURE	_____HIVES
_____SCARLET FEVER	_____PLEURISY	_____MALARIA
_____WHOOPING COUGH	_____ARTHRITIS	_____GONORRHEA
_____CROUP	_____RHEUMATISM	_____CHLAMYDIA
_____PNEUMONIA	_____GOUT	_____ASTHMA
_____TUBERCULOSIS	_____GENITAL HERPES	_____CONSTIPATION
_____MONONUCLEOSIS	_____HAY FEVER	_____ DIARRHEA
_____EAR INFECTION	_____CHICKEN POX	_____CANDIDA
_____DEPRESSION	_____ALLERGIES	_____ HYPOGLYCEMIA
_____SINUSITIS (CHRONIC)	_____SWOLLEN GLANDS	_____INFLUENZA
_____ECZEMA	_____CANCER	_____ SHINGLES
_____KIDNEY STONES	_____CHRONIC	_____ DIPHTHERIA

OTHER (PLEASE SPECIFY): _____

WERE ANY OF THE ABOVE SEVERE? IF SO GIVE AGE, SEVERITY AND DURATION.

_____

_____

_____

DESCRIBE YOUR GENERAL STATE OF HEALTH AS A CHILD: _____

_____

_____

DESCRIBE YOUR GENERAL STATE OF HEALTH AS A TEENAGER: _____

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_____

_____

SURGERIES

OPERATION	WHEN	COMPLICATIONS

ACCIDENTS

PLEASE INDICATE THE SEVERITY, INJURIES SUSTAINED, WHEN IT OCCURRED, AND ANY TREATMENT REQUIRED._____

_____

_____

FAMILY HISTORY:

PLEASE INDICATE THE AGE OF ALL RELATIVES LIVING AND INDICATE THE AGE AT WHICH ANY FAMILY MEMBER BECAME DECEASED. (L-LIVING, D-DECEASED)

RELATIVE	AGE	AILMENTS
MOTHER		
FATHER		
BROTHERS		
SISTERS		
CHILDREN		
MATERNAL GRANDMOTHER		
MATERNAL GRANDFATHER		
MATERNAL AUNTS/UNCLES		
PATERNAL GRANDMOTHER		
PATERNAL GRANDFATHER		
PATERNAL AUNTS/UNCLES		

ADDITIONAL HISTORY (FEMALE)

AGE OF FIRST MENSES _____ AGE OF CESSATION OF MENSES _____
ARE YOUR MENSES REGULAR OR IRREGULAR? _____

(CHECK ALL THAT APPLY)

_____MENOPAUSE
_____POST-MENSTRUAL PAIN
_____PRE-MENSTRUAL PAIN
_____TUBALIGATION
_____BIRTH CONTROL PILLS
_____SENSITIVE BREASTS
_____I. U. D.
_____BLOOD CLOTS

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_____VAGINAL DISCHARGE - CONSISTENCY, COLOUR, AND ODOUR: _____

DO YOU EXPERIENCE PMS SYMPTOMS? _____
IF YES, WHAT DO YOU EXPERIENCE? _____
_____

HAVE YOU EVER EXPERIENCE FIBROCYSTIC DISEASE OF THE BREAST? _____
HAVE YOU EVER HAD UTERINE FIBROIDS? _____
DO YOU HAVE RECURRING VAGINAL INFECTIONS? ____NEVER ___RARELY ____FREQUENTLY
HOW OFTEN DO YOU EXPERIENCE BLADDER INFECTION? ___NEVER ___RARELY ____FREQUENTLY

OF CHILDREN _____ # OF PREGNANICES _____ MISCARRIAGES _____ ABORTIONS _____
COMPLICATIONS ASSOCIATED WITH THE ABOVE _____
_____

ADDITIONAL HISTORY (IF MALE)

ANY HISTORY OF THE FOLLOWING PROBLEMS? **(CHECK THOSE THAT APPLY)**
____BLADDER ____PROSTATE ____SEXUAL FUNCTION

MEDICATIONS:

LIST ALL PRESCRIBED MEDICATIONS **PRESENTLY** BEING TAKEN:

DRUG NAME	DOSAGE	FREQUENCY	HOW LONG

LIST ANY PRESCRIBED MEDICATION YOU HAVE HAD A BAD REACTION TO IN THE PAST.
(INDICATE THE DRUG NAME, WHEN YOU TOOK IT, AND THE REACTION YOU HAD.)
_____
_____
_____

HOW MANY COURSES OF ANTIBIOTICS HAVE YOU HAD IN THE PAST 10 YEARS? _____
HAVE YOU EVER HAD A BAD REACTION TO AN ANTIBIOTIC? _____

LIST ANY OVER-THE-COUNTER MEDICATIONS (TYLENOL, TUMS, COLD/FLU REMEDIES) YOU TAKE. INDICATE WHETHER YOU TAKE RARELY **(R),** OCCASIONALLY **(O),** FREQUENTLY **(F)** OR DAILY **(D).** _____
_____

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_____

_____

DO YOU USE ANY RECREATIONAL DRUGS? _____IF YES, INDICATE TYPE AND FREQUENCY OF USAGE. _____

_____

_____

HAVE YOU EVER HAD A SEVERE REACTION FROM A VACCINATION? _____
IF YES, EXPLAIN VACCINATION TYPE, WHEN IT WAS ADMINISTERED AND THE REACTION.

_____

_____

_____

LIFESTYLE

WHAT QUANTITY, PER DAY, DO YOU DRINK ON AVERAGE OF THE FOLLOWING:

____COFFEE ____TEA _____WATER _____MILK
____FRUIT JUICE ____SOFT DRINKS _____ALCOHOL _____ HERBAL TEA
____VEGETABLE JUICE

LIST ALL FOOD SUPPLEMENTS YOU ARE PRESENTLY TAKING. INDICATE THE TOTAL DOSAGE TAKEN IN ONE DAY (I.E. IF YOU TAKE 2 TABLES OF VITAMIN C 500 MG/DAY, THEN TOTAL IS 1000 MG/DAY). _____

_____

_____

DO YOU SMOKE? _____ IF SO, FOR HOW LONG? _____ HOW MANY CIGARETTES? _____
HAVE YOU EVER SMOKED, AND IF SO FOR HOW LONG? _____
DOES ANYONE ELSE SMOKE IN YOUR HOUSEHOLD OR WORKPLACE? _____
HOW OFTEN WOULD YOU HAVE AN ALCOHOLIC BEVERAGE? _____

HOW MANY HOURS OF SLEEP DO YOU GET ON AVERAGE? _____

WHAT DO YOU DO FOR EXERCISE? (INDICATE TYPE, HOW OFTEN YOU PARTICPATE, AND FOR HOW LONG EACH OCCASION).____

_____

_____

WHEN WAS YOUR LAST VACATION? _____
WHAT DO YOU DO FOR RECREATION AND RELAXATION? _____

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WHAT LEVEL OF PERSONAL STRESS ARE YOU EXPERIENCING RIGHT NOW? (CHECK ONE)
MINIMAL 1 2 3 4 5 AVERAGE 6 7 8 9 10 UNBEARABLE

WHAT LEVEL OF OCCUPATIONAL STRESS ARE YOU EXPERIENCING RIGHT NOW? (CHECK ONE)
MINIMAL 1 2 3 4 5 AVERAGE 6 7 8 9 10 UNBEARABLE

IS THE MAIN STRESSOR (CHECK ALL THAT APPLIES)?

___FINANCIAL	___JOB RELATED	___INTERPERSONAL
___MARRIAGE	___HEALTH	___UNFULFILLED EXPECTATIONS
___SPIRITUAL	___FAMILY MEMBERS	

DO YOU PARTICIPATE IN ANY SPIRITUAL DISCIPLINE OR BELONG TO A CHURCH OR RELIGIOUS GROUP? _____ ARE YOU AN ACTIVE PARTICIPANT? _____