



#103 - 565 17th Street · West Vancouver BC · V7V 3S9
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www.westvanwellness.com

Health History Questionnaire

Please help us provide you with a complete evaluation by carefully filling out this questionnaire. All of your answers will be held absolutely confidential. If you have questions, please ask. Thank you.

Name _____ Age _____ M F Today's Date (Mo/Day/Year) _____

E-Mail Address _____ Birth Date (M/D/Y) _____

Home Address _____ City _____ Postal Code _____

Occupation _____ Home Phone _____ Cell Phone _____

Preferred method of communication: Home Phone Cell Phone Email

Spouse's Name _____ Children (Name/Age) _____

Names of Other Healthcare Providers:

Naturopathic Doctor _____ Medical Doctor _____ Specialist(s) _____
Massage Therapist _____ Chiropractor _____

Number of Visits to another Naturopathic Physician this year _____

How did you find out about our clinic? _____

Current Health Concern(s)

When did your problem(s) begin (be specific)? _____

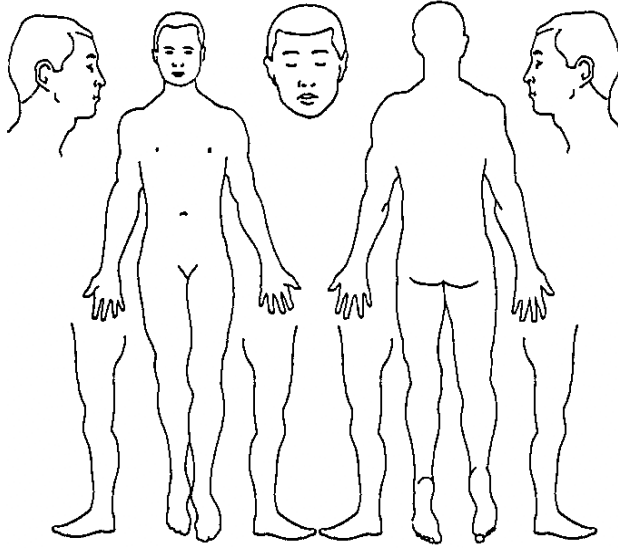
Have you been given any diagnosis? If so, what? _____

What measures have you taken to improve your problem(s)? _____

Current Medications (Prescriptions, Over the Counter Drugs, Nutritional supplements)

- 1) _____ Dosage: _____ 6) _____ Dosage: _____
2) _____ Dosage: _____ 7) _____ Dosage: _____
3) _____ Dosage: _____ 8) _____ Dosage: _____
4) _____ Dosage: _____ 9) _____ Dosage: _____
5) _____ Dosage: _____ 10) _____ Dosage: _____

Please Indicate any Painful or Distressed Areas:



Please check any of the below symptoms if they are currently a problem OR are a recurring problem:

General:

- | | | |
|---|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Strong thirst (cold or hot drinks) | |
| <input type="checkbox"/> Sudden energy drop (what time of day)? | | |

Skin and Hair:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Any other hair or skin problems? | |

Head, Eyes, Ears, Nose and Throat:

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Colour blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Headaches (where and when)? |

Cardiovascular:

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty in breathing |
| <input type="checkbox"/> Any other heart or blood vessel problems? | | |

Respiratory

- | | | |
|--|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with a deep breath |
| <input type="checkbox"/> Difficulty in breathing when lying down | <input type="checkbox"/> Production of phlegm (what colour)? | |
| <input type="checkbox"/> Any other lung problems? | | |

Gastrointestinal:

- | | | |
|--|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Black stools |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Belching | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Chronic laxative use | |
| <input type="checkbox"/> Any other problems with your stomach or intestines? | | |

Genitourinary:

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Decrease inflow | <input type="checkbox"/> Impotency | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Do you wake to urinate (how often)? | <input type="checkbox"/> Any particular colour to your urine? | |
| <input type="checkbox"/> Any other problems with your genital or urinary system? | | |

Obstetrics and Gynecology:

- | | | |
|---|---|--|
| <input type="checkbox"/> Age at first menses | <input type="checkbox"/> Number of births | <input type="checkbox"/> Premature births |
| <input type="checkbox"/> First date of last menses | <input type="checkbox"/> Abortions | <input type="checkbox"/> Number of pregnancies |
| <input type="checkbox"/> Days between menses | <input type="checkbox"/> Duration of menses | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Unusual menses 0 Heavy | <input type="checkbox"/> Light | <input type="checkbox"/> Clots |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Last PAP |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Changes in body / psyche prior to menstruation | | |
| <input type="checkbox"/> Do you practice birth control? What type and for how long? | | |

Musculoskeletal:

- | | | |
|---|--|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Foot/ ankle pain |
| <input type="checkbox"/> Hand/ wrist pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Joint or bone problems |

Neuropsychological:

- | | | |
|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Quick temper / irritable | <input type="checkbox"/> Easily susceptible to stress | |
| <input type="checkbox"/> Have you ever been treated for emotional problems? | | |
| <input type="checkbox"/> Have you ever considered or attempted suicide? | | |
| <input type="checkbox"/> Any other neurological or psychological problems? | | |

Comments

Please indicate any other problems you would like to discuss.
