Synergy Naturopathic Clinic

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Please fill out this form as completely as possible. All information provided is confidential.

Name: _____ Date: _____

If patient is a child: Parent/Guardian'sName: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Telephone (home): _____ (work): _____

May we leave a message regarding your appointments at the above number(s)? □ Yes □ No

Gender: □ M □ F Age: _____ Date of Birth(D/M/Y): _____

Marital Status: □ Single □ Partner □ Married □ Separated □ Divorced □ Widow(er)

Occupation: _____

Next of kin or other to reach in case of emergency: _____

Relationship: _____Phone: _____

Referred by: _____

OTHER HEALTH CARE PROVIDERS

Name	Type of practitioner	Telephone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

MAIN HEALTH CONCERNS (Please list in order of importance)

1. _____
2. _____
3. _____
4. _____
5. _____

Please indicate any major hospitalizations, surgeries, or serious injuries

Year	Hospitalization, surgery, injury	Complications/outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY

Please check if you have or had any of the following conditions:

- ☐ Arthritis
- ☐ Allergies/Hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Cancer
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Depression
- ☐ Diabetes
- ☐ Chemical sensitivities
- ☐ Epilepsy
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hypothyroidism
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Liver or gallbladder disease
- ☐ Mental illness
- ☐ Migraine headaches
- ☐ Neurological disorder
- ☐ Osteoporosis
- ☐ Other _____

FAMILY HISTORY

Please check if any close relative has or had any of the following conditions:

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Neurological disorders
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide
- ☐ Tuberculosis
- ☐ Other _____

Do you have any known allergies or hypersensitivities (e.g. food, environmental, chemicals, medication)?

Please list all prescription medications, over-the-counter medications, vitamins, herbs, homeopathics, etc. you are currently taking.

Please list any dietary restrictions (religious, vegetarian, vegan, salt restriction, etc.).

Please describe a typical day's diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many times have you been treated with antibiotics (approximately)? _____

LIFESTYLE

☐ Tobacco:
Cigarettes: #/d_____
Cigars: #/d _____
years: _____

☐ Alcohol:
Wine: # glasses/d or wk_____
Liquor: # ounces/d or wk ___
Beer: #glasses/d or wk_____

☐ Caffeine:
Coffee: # 6 oz cups/d_____
Tea: # 6oz cups/d_____
Pop with caffeine: # cans/d__
Other sources:_____

☐ Water: # glasses/d_____

☐ Exercise
days/wk_____
duration per workout_____

- ☐ Walk
- ☐ Run/jog
- ☐ Swim
- ☐ Yoga
- ☐ Aerobics classes
- ☐ Weight lift
- ☐ Other _____

REVIEW OF SYSTEMS
Please check any symptoms or condition which you are currently experiencing.

GENERAL
- ☐ Poor appetite
- ☐ Change in appetite
- ☐ Poor sleep
- ☐ Fatigue
- ☐ Chills
- ☐ Fever
- ☐ Night sweats
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight loss
- ☐ Weight gain
- ☐ Bleed or bruise easily
- ☐ Poor memory

SKIN, HAIR AND NAILS
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash
- ☐ Hives
- ☐ Itching
- ☐ Hair changes
- ☐ Nail changes
- ☐ Skin changes

HEAD
- ☐ Headaches
- ☐ Head injury
- ☐ TMJ Problems

EARS
- ☐ Impaired hearing
- ☐ Earaches
- ☐ Infections
- ☐ Dizzy spells
- ☐ Ringing

EYES
- ☐ Impaired vision
- ☐ Eye pain
- ☐ Itching
- ☐ Tearing
- ☐ Dryness
- ☐ Blurry vision
- ☐ Night blindness
- ☐ Cataracts
- ☐ Wear corrective lenses

NOSE AND SINUS
- ☐ Frequent colds
- ☐ Stuffiness
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Hay fever
- ☐ Loss of smell

MOUTH AND THROAT
- ☐ Frequent sore throats
- ☐ Loss of taste
- ☐ Sore tongue
- ☐ Hoarse voice
- ☐ Canker sores
- ☐ Bleeding gums
- ☐ Bad breath

RESPIRATIORY
- ☐ Breathing difficulty
- ☐ Cough
- ☐ Wheezing
- ☐ Bronchitis
- ☐ Asthma
- ☐ Pneumonia
- ☐ Pain on deep breath
- ☐ Phlegm production
- ☐ Cough blood

CARDIOVASCULAR
- ☐ Irregular heartbeat
- ☐ Dizziness
- ☐ Fainting
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling of hands/feet

CIRCULATION
- ☐ Cold hands/feet
- ☐ Numb hands/feet
- ☐ Tingling hands/feet
- ☐ Leg/foot ulcers
- ☐ Varicose veins
- ☐ Blood clots

GASTROINTESTINAL
- ☐ Trouble swallowing
- ☐ Reflux
- ☐ Heartburn
- ☐ Indigestion
- ☐ Ulcer
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal pain or cramps
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Laxative use
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Change in bowel movements
- ☐ Blood in stool
- ☐ Mucus in stool
- ☐ Undigested food in stool
- ☐ # bowel movements/day __

URINARY

- ☐ Frequent urination
- ☐ Urgency
- ☐ Pain on urination
- ☐ Do you wake to urinate? Y/N
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Distinctive or odd colour
- ☐ Strong odour
- ☐ Blood in urine
- ☐ Kidney stones

FEMALE HEALTH

- ____ age of first menses
- ____ duration of menses
- ____ length of cycle
- ____ # of pregnancies
- ____ # of births
- ☐ Date of last PAP test: _____
- ☐ Light menses
- ☐ Heavy menses
- ☐ Bleeding between cycles
- ☐ Clots
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Premenstrual syndrome (PMS)
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Painful intercourse
- ☐ Decreased sex drive
- ☐ Breast lumps
- ☐ Difficulty conceiving
- ☐ Menopausal symptoms
- ☐ Surgical menopause
- ☐ Birth control: _____

MALE HEALTH

- ☐ Hernia
- ☐ Testicular masses
- ☐ Testicular pain
- ☐ Penile discharge or sores
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Decreased sex drive
- ☐ BPH
- ☐ Prostate cancer
- ☐ Date of last prostate exam: _____

MUSCULOSKELETAL

- ☐ Joint pain or stiffness
- ☐ Muscle spasm or cramps
- ☐ Muscle weakness
- ☐ Nerve pain (e.g. sciatica)
- ☐ Bone pain

NEUROLOGICAL

- ☐ Fainting
- ☐ Involuntary movement
- ☐ Paralysis
- ☐ Speech problems
- ☐ Loss of balance

ENDOCRINE

- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hot flashes
- ☐ Excess sweating
- ☐ Lack of sweating

Circle the level of stress you are experiencing on a scale of 1-10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major cause(s) of stress (e.g. changes in job, work, residence or finances, legal problems, etc.)

_____

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g. moles, rashes, etc.). Describe what you feel or observe in your own words.