BURNABYHEIGHTS INTEGRATIVE HEALTHCARE INC.

HEALTH HISTORY INTAKE FORM

Naturopathic health care and preventative medicine are only possible when the physician has a complete and thorough understanding of you, physically mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. All information is *confidential*. Please mark anything you do not understand with a question mark.

PERSONAL INFORMATION

Name: ____________________

Age: __________ Sex: M F

Home Address: ____________________

Birthday (Mo/Day/Yr): _____/_____/_____

City: ____________________

Marital Status: ____________________

Postal code: ____________________

Children (Sex/Age): ____________________

Home Phone: ____________________

Work Phone: ____________________

E-mail: ____________________

How did you hear about us? □newspaper ad □friend □yellow pages □other ____________________

Occupation: ____________________

BC Care Card Number: ____________________

Names of other Healthcare Providers:

Chiropractor: ____________________

Medical Doctor: ____________________

Massage Therapist: ____________________

Specialist: ____________________

YOUR MAIN HEALTH CONCERN(S): (please list in order of importance)

1) ____________________
2) ____________________
3) ____________________
4) ____________________

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 problems(s)? ____________________

Have you had any x-rays or special studies (CT, MRI, Echocardiogram), if so please list: ____________________

PAST MEDICAL HISTORY (please check and include date)

□ CANCER	□ DIABETES
□ HEART DISEASE	□ HIGH BLOOD PRESSURE
□ HEPATITIS	□ KIDNEY DISEASE
□ RHEUMATIC FEVER	□ THYROID DISEASE
□ VENERAL DISEASE	□ OTHER: ____________________

CHILDHOOD ILLNESSES

□ SCARLET FEVER	□ GERMAN MEASLES
□ MUMPS	□ DIPHTHERIA
□ MEASLES	□ OTHER: ____________________

Surgeries (list date): ____________________

Dr. Ardis Krueger, ND Dr. Agnieszka Matusik, ND Dr. Georgia Kyba, ND, BSc
Dr. Ann Izard, DC, B.Comm Michelle Coulombe, MA, CCC Marijana Cabrita, CCC
Amy Van Sickle, RM Emily deMontigny, RMT Sarah Lewis, RMT Marcella Reay, RMT
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Significant Trauma (auto accidents, falls, etc.): ____

Allergies: ____

VACCINATIONS

□ POLIO	□ TETANUS SHOT
□ MEASLES/MUMPS/RUBELLA (MMR)	□ DIPHTHERIA
□ PERTUSSIS	□ OTHER: ____________________________________

FAMILY MEDICAL HISTORY (please check those that apply)

	FATHER	MOTHER	SIBLING	PATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	MATERNAL GRANDMOTHER
AGE (if living)							
HEALTH(good/bad)							
CANCER (list type)							
DIABETES							
HEART DISEASE							
HIGH BLOOD PRESSURE							
HIGH CHOLESTEROL							
STROKE							
EPILEPSY							
MENTAL ILLNESS							
ASTHMA							
ALLERGIES							
KIDNEY DISEASE							
GLAUCOMA							
ANEMIA							
TUBERCOLOSIS							
RHEUMATOID ARTHRITIS							
AGE (at death)							
CAUSE OF DEATH							
OTHER: _________							

LIFESTYLE

Do you have any occupational stress (chemical, physical, psychological)? ____

Describe your weekly exercise? ____

Current Medications:

Prescriptions/Over the counter drugs: ____

Vitamins/Herbs____

____

Diet

Are you or have you ever been on a restricted diet? If so, what kind? ____

Please describe your daily diet.

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Drinks: ____

How many packs of cigarettes do you smoke per day? ________

Have you ever smoked in your life? _________________

How much coffee do you drink per week? _________________

How much alcohol do you drink per week? ___________

How much tea do you drink per week? _____________________

How much pop do you drink per week? ______________

GENERAL (Please check if any of the following symptoms are currently a problem or are a recurring problem, if in the past, indicate with a P)

Current Weight: __________________

Ideal Weight: ____________________

Weight 1 year ago: ________________

□Poor appetite
□Poor sleep
□Fatigue
□Fevers
□Chills
□Night sweats
□Sweat Easily
□Tremors
□Cravings
□Localized weakness
□Poor balance
□Change in appetite
□Bleed or bruise easily
□Weight loss
□Weight gain
□Sudden energy drop (time of day?)
□Strong thirst (hot or cold drinks)
□Peculiar tastes or smells

SKIN AND HAIR

□Rashes
□Ulcerations
□Hives
□Itching
□Eczema
□Pimples
□Dandruff
□Loss of hair
□Recent moles
□Change in hair or skin texture
□Any other hair or skin problems ____

GASTROINTESTINAL

□Nausea
□Indigestions
□Black stools
□Vomiting
□Belching
□Blood in stools
□Constipation
□Gas
□Rectal pain
□Diarrhea
□Bad breath
□Hemorrhoids
□Abdominal pain or cramps
□Chronic laxative use
□Any other stomach problems _______

MUSCULOSKELETAL

□Neck pain
□Muscle pain
□Knee pain
□Back pain
□Muscle weakness
□Foot/Ankle pain
□Shoulder pain
□Hand/Wrist pain
□Swelling of joints
□Joint nodules
□Any other joint or bone problems ______________________________________

RESPIRATORY

□Cough
□Coughing blood
□Pain with deep breath
□Bronchitis
□Pneumonia
□Asthma
□Difficulty breathing lying down
□Production of phlegm (colour?)
□Any other lung problems __________

HEAD/EYES, EARS, NOSE, AND THROAT

□Dizziness	□Concussions	□Migraines
□Glasses	□Eye strain	□Eye pain
□Poor vision	□Night blindness	□Colour blindness
□Cataracts	□Blurry vision	□Earaches
□Ringing in ears	□Poor healing	□Spots in front of eyes
□Sinus problems	□Nosebleeds	□Recurrent sore throats
□Grinding teeth	□Facial pain	□Sores on lips or tongue
□Teeth problems	□Jaw clicks	□Headaches (where/when)

□Any other head or neck problems ______________________________

CARDIOVASCULAR

□High blood pressure	□Low blood pressure	□Fainting
□Irregular heart beat	□Swelling of hands	□Swelling of feet
□Cold hand or feet	□Phlebitis	□Difficulty breathing
□Blood clots	□Chest pain	□Dizziness

□Any other heart or blood vessel problems ______________________________

GENITO-URINARY

□Pain on urination	□Inability to hold urine	□Kidney stones
□Increased frequency in the day	□Increased frequency in the night	□Male: Dribbling
□Frequent infections (bladder/ kidney)	□Male: Prostatitis/ Benign prostatic hypertrophy	□Male: Decreased force of stream

PREGNANCY AND GYNECOLOGY

Age at first menses: ____________	Number of births: ____________	Premature births: ____________
First date of last menses: ________	Abortions: ______________	Miscarriages: ______________
Duration of menses: ____________	Frequency of menses: ________	Birth control: ______________
□Painful menses	□Light menses	□Clots
□Heavy menses	□Irregular menses	□Last PAP/Prostate Exam ________
□Breast lumps	□Vaginal discharge	□Vaginal sores

□Changes in body/psyche prior to menstruation (describe): ______________________________

NEUROPSYCHOLOGICAL

□Seizures	□Dizziness	□Loss of balance
□Areas of numbness	□Lack of coordination	□Blood in stools
□Concussion	□Depression	□Poor memory
□Quick temper/irritable	□Anxiety	□Easily susceptible to stress
□Have you ever been treated for emotional problems?	□Have you ever considered or attempted suicide?	□Any other neurological or psychological problems ________

COMMENTS

Please indicate any other problems you would like to discuss.

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INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic physicians assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities may include: diet and nutritional supplements, vitamin-mineral injections and intravenous treatments, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, physical medicine and lifestyle counselling.

Individual diets and nutritional supplements are one of the means recommended to address deficiencies, treat disease processes, and to promote health. The benefits may include increased energy, increased gastrointestinal function, improved immunity, and general well-being.

Botanical medicine is plant based medicine that involves the use of herbal teas, tinctures, capsules and other forms of herbal preparations that may assist in recovery from injury and disease.

Homeopathy is a form of medicine that uses minute doses of the very thing that causes symptoms in healthy people. These tiny doses of plant, animal, or mineral origins may be used to stimulate the body's ability to heal itself. Homeopathy can be a powerful tool that effects healing on a physical and emotional level.

Traditional Chinese Medicine and Acupuncture. Eastern herbs and dietary changes may be recommended to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tincture or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medicine theory.

Physical medicine refers to the use of hands-on techniques such as massage therapy as well as various types of electrical stimulation and therapeutic ultrasound for the purposed of treating musculoskeletal and neurological problems.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and to stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, your naturopathic physician will perform a thorough case history; conduct a physical examination, and when indicated, take saliva, blood and/or urine samples. Even the safest therapies may cause complications in certain physiological conditions (e.g., pregnancy, breastfeeding, very young children, or those taking multiple medications or with multiple medical conditions). Some therapies must be used in caution; therefore, it is important that you inform us of any medical conditions or change in medical conditions you have as well as any medications or supplements that you are taking. If you are pregnant or if you are breast–feeding, please advise your naturopathic physician immediately.

There may be some slight health risks associated with naturopathic medicine. These include but are not limited to:

Aggravation or pre-existing symptoms
Allergic reactions to supplements or herbs
Pain, bruising or injury from injections, blood draws or acupuncture
Fainting or puncturing of an organ with acupuncture needles

Please initial beside each statement below.

___I understand that a record will be kept of the health services provided to me. This health record will be kept confidential and will not be disclosed or released to others without my consent, unless required by law. I understand that I may look at my medical records at any time and can request a copy of them by paying the appropriate fees.

___I understand that the naturopathic physician will answer any questions that I have to the best of his or her abilities. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions here).

___I understand that charges are to be paid at the times of the visit unless specific arrangements have been made prior to my scheduled appointment. Payment for all dispensary items is due at the time of the visit.

___I understand that missed appointments or late cancellations (less than 24 hour notice) will be subject to a $25 fee.

___I understand that it is my responsibility to comply with the recommendations of the naturopathic physician in terms of treatment schedule and maintaining regular follow up appointments.

__ I have read and understand this document and accept the risks involved with receiving naturopathic treatment.

As a patient, you are responsible for the total charges incurred for each visit. We accept cash, debit, visa, or mastercard. If you have extended health coverage for naturopathic physicians, you are responsible for billing your own insurance company. We will provide you with the necessary documentation to do this. If you are on premium assistance with MSP, then you will receive $23 reimbursement for 10 visits per calendar year.

I have read and understand the above-stated policies and information. I understand that I am free to withdraw from treatment and to discontinue further participation in these procedures at any times.

Patient name (please print) ______________________________

Signature of Patient/Guardian: ___________________________ Date: ______________