



Family Fertility Clinic Naturopath Health History Form

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for treatments is confidential except as required or allowed by law to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Patient Information

Name: _____	Date of Birth: _____	Age: _____
Address: _____	City: _____	Postal Code: _____
Daytime Telephone: _____	Evening Telephone: _____	
Email: _____	Occupation: _____	
Physician's Name: _____	Telephone: _____	
Date of last visit to physician or health practitioner? _____		
In Emergency Notify: _____	Relationship: _____	
Emergency Contact Number: _____	Referred by: _____	

What is your main reason for coming in today?

If you have a specific health condition, please describe it in detail.

When was the very first time you noticed your condition and how long has your main health problem been troubling you?

Please describe carefully any factors that you suspect may have played a role in its onset and its continuation.

Is your current health problem getting better, worse, or the same?

Describe the treatment that you have received for this problem and from whom.

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current problem or for any other problem? **YES / NO** (please circle)

What was the therapy and the result?

Please list other health problems, and their duration, in order of importance:

1) _____ Duration: _____

2) _____ Duration: _____

3) _____ Duration: _____

4) _____ Duration: _____

5) _____ Duration: _____

Health History

The general state of your health is: Excellent / Good / Average / Fair / Poor (please circle)

Describe, on average, your energy level on a scale from 1-10 (10 is highest) _____

During the day, when is your energy level the best / the worst? _____

Please list the 5 most significant and stressful events in your life, from the most recent to the most distant:

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Are any of these situations continuing to impact your life? **YES / NO** (please circle)

Are you currently working with a professional counselor, psychologist, social worker or other therapist? Please specify: _____

Have you in the past? _____ If so, when? _____

Are you currently working with a Doctor of conventional medicine? **YES / NO** (please circle)

Please explain: _____

Which of the following conditions have you experienced? (Please circle)

Measles	rheumatic fever	allergies	gonorrhea
Mumps	scarlet fever	thyroid problems	Syphilis
chicken pox	Tuberculosis	chronic infections	Epilepsy
small pox	Depression	asthma	anemia
whooping cough	ear infections	Eczema	anxiety
polio	pneumonia	herpes	weight problem
diphtheria	tonsillitis	hepatitis	Insomnia
typhoid fever	Canker sores	heart disease	high blood pressure

Have you had any illnesses not listed? If yes, please specify: _____

Do you have allergies to any drugs, herbs, foods, animals, or other? **YES / NO** (please circle)

If yes, please list: _____

Which of the following do you currently use? Please indicate amount (how much, how often, and how long):

Alcohol: _____	Hormones: _____
Coffee: _____	Sedatives: _____
Tobacco: _____	Laxatives: _____
Antacids: _____	Cortisone: _____

Other medications (please give the full name, dosage, and how long you have been taking the medication):

Drug name	Dose	Duration of Use
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins and/or Herbs

_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Please list ages, health problems and, if deceased, cause of death:

	Living Age	Health Problems	Cause of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Brother/s	_____	_____	_____
	_____	_____	_____
Sister/s	_____	_____	_____
	_____	_____	_____
Mother's Mother	_____	_____	_____
Mother's Father	_____	_____	_____
Father's Mother	_____	_____	_____
Father's Father	_____	_____	_____

Is there any additional information that you would like to add?

Signature: _____ Date: _____

Thank you for taking the time to fill out this form. All information is confidential and will not be released for legal or medical purposes without your consent.

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