VALLEY NATUROPATHIC CLINIC

139 Union Street, Berwick, N.S. B0P 1E0
Tel: 902-538-8733 | Fax: 902-375-3055
vnc.office@eastlink.ca

Date:_____

Thank you for taking the time to fill out this form. The information is very important in the assessment of your care.

Name:_____ Email:_____
Address:_____ City:_____
Postal Code:_____ Phone: (h)_____(c)_____
Age:_____ Gender:_____ Date of Birth:_____ Place of Birth:_____
Occupation:_____ Past Occupation:_____
Marital Status:_____ Number of Children:_____
Religion or Personal Philosophy:_____
Family Physician:_____ Phone:_____
Referred by (if applicable):_____
Main Health Concerns:_____

MEDICAL HISTORY

General

Date of Last Physical Exam:_____ Weight:_____ Height:_____
Maximum Weight:_____ Energy Level (Scale of 1 to 10, 10 highest):_____
Blood Type:_____ Do you usually wake up refreshed?_____
Have you ever smoked? **Y** (yes, presently), **P** (yes, in the past) Cigarettes per day:_____
For how long?_____ Have you ever used recreational drugs? **Yes No**
If yes, what drugs?_____ For how long?_____
Do you drink alcohol? **Yes No** Number of drinks per week:_____
Do you exercise? **Yes No** Type of exercise:_____ Hours per week:_____
Do you have any known allergies? **Yes No** If yes, please specify:_____
Current Medications and Dosage:_____
Reasons for Medication(s):_____
Past Medications:_____ Taken for how long?_____
Current Vitamins and Other Supplements:_____
Other Treatments Tried in the Past:_____

REVIEW OF THE BODY SYSTEMS

Please circle **Y** *if you have the condition now or* **P** *if you had the condition in the past.*

Skin:

Rashes	**Y**	**P**	Hives	**Y**	**P**	Acne	**Y**	**P**
Boils	**Y**	**P**	Itching	**Y**	**P**	Eczema	**Y**	**P**
Lumps	**Y**	**P**	Dry Skin	**Y**	**P**			
Night sweats?	**Yes**	**No**	How often?_____					

Other:_____

Head:

Headache	**Y**	**P**	Injuries	**Y**	**P**	Migraine	**Y**	**P**
Dizziness	**Y**	**P**	Other:_____					

Ears:

Discharge	**Y**	**P**	Ringing	**Y**	**P**
Itching	**Y**	**P**	Earache	**Y**	**P**
Excessive Wax	**Y**	**P**	Decreased Hearing	**Y**	**P**
Infections	**Y**	**P**	Other:_____		

Eyes:

Glasses / Contacts	**Y**	**P**	Since when?_____		
Prescription Changes:_____			Near-sighted/Far-sighted:_____		
Impaired Vision	**Y**	**P**	Tearing or Dryness	**Y**	**P**
Eye Pain	**Y**	**P**	Double Vision	**Y**	**P**
Glaucoma	**Y**	**P**	Itching	**Y**	**P**
Cataracts	**Y**	**P**	Blurring	**Y**	**P**
Redness	**Y**	**P**	Blind Spot(s)	**Y**	**P**
Light Sensitivity	**Y**	**P**	Night Vision	**Y**	**P**
Discharge	**Y**	**P**	Other:_____		

Nose & Sinuses:

Nose Bleeds	**Y**	**P**	Stuffiness	**Y**	**P**
Hay Fever	**Y**	**P**	Allergies	**Y**	**P**
Injury	**Y**	**P**	Sinus Problems	**Y**	**P**
Frequent Colds	**Y**	**P**	How many per year:_____		
Obstructions	**Y**	**P**	Other:_____		

Mouth & Throat:

Hoarseness	**Y**	**P**	Sores	**Y**	**P**
Gum Problems	**Y**	**P**	Dryness of Mouth	**Y**	**P**
Dental Cavities	**Y**	**P**	Loss of Taste	**Y**	**P**
Many Sore Throats	**Y**	**P**	How many per year:_____		
Other:_____					

Neck:

Lumps	**Y**	**P**	Goitre	**Y**	**P**
Pain	**Y**	**P**	Stiffness	**Y**	**P**
Swollen Glands	**Y**	**P**	Other:_____		

Respiratory:

Wheezing	**Y**	**P**	Asthma	**Y**	**P**
Frequent Cough	**Y**	**P**	Sputum	**Y**	**P**
Difficult Breathing	**Y**	**P**	Bronchitis	**Y**	**P**
Chest Pain	**Y**	**P**	Pneumonia	**Y**	**P**
Bloody Sputum	**Y**	**P**	Pleurisy	**Y**	**P**
Emphysema	**Y**	**P**	Last Chest X-Ray:_____		
Last Tuberculin Test:_____			Other:_____		

Breasts:

Lumps	**Y**	**P**	Pain	**Y**	**P**
Tenderness	**Y**	**P**	Do you self-examine?	**Yes**	**No**
Other:_____					

Cardiovascular:

Heart Disease	**Y**	**P**	Chest Pain	**Y**	**P**
Angina	**Y**	**P**	Ankle Swelling	**Y**	**P**
High Blood Pressure	**Y**	**P**	Palpitations	**Y**	**P**
Murmurs	**Y**	**P**	Rheumatic Fever	**Y**	**P**
Last ECG Test:_____			Other:_____		

Gastrointestinal:

Difficulty Swallowing	**Y**	**P**	Diarrhea	**Y**	**P**
Heartburn	**Y**	**P**	Rectal Bleeding	**Y**	**P**
Change in Thirst	**Y**	**P**	Hemorrhoids	**Y**	**P**

Change in Appetite	**Y**	**P**	Jaundice	**Y**	**P**
Nausea/Vomiting	**Y**	**P**	Hernias	**Y**	**P**
Indigestion	**Y**	**P**	Constipation	**Y**	**P**
Belching/Gas	**Y**	**P**	Bowel movements per day:_____		

Urinary:

Pain on Urination	**Y**	**P**	Kidney Stones	**Y**	**P**
Increased Frequency	**Y**	**P**	Blood in Urine	**Y**	**P**
Inability to Urinate	**Y**	**P**	Frequent Infections	**Y**	**P**

Other:_____

Musculoskeletal:

Joint Pain or Stiffness	**Y**	**P**	Muscle Spasm/Cramps	**Y**	**P**
Arthritis	**Y**	**P**	Weakness	**Y**	**P**
Broken Bones	**Y**	**P**	Backache	**Y**	**P**
Numbness/Tingling	**Y**	**P**	Other:_____		

Peripheral Vascular:

Cold Hands/Feet	**Y**	**P**	Varicose Veins	**Y**	**P**
Deep Leg Pain	**Y**	**P**	Thrombophlebitis	**Y**	**P**

Other:_____

Reproductive:

Sexual Difficulties	**Y**	**P**	Venereal Disease	**Y**	**P**
Are you sexually active?	**Yes**	**No**			
Type of Birth Control:_____			Since when:_____		

Males

Prostate Disease	**Y**	**P**	Premature Ejaculation	**Y**	**P**
Impotence	**Y**	**P**	Other:_____		

Females

Menopause	**Yes**	**No**	Age:_____	Symptoms:_____	
Regular Menstrual Cycle?	**Yes**	**No**			
Number of Days Between Cycles:_____			Age of First Menstruation:_____		
Number of Pregnancies:_____			Of Miscarriages?_____	Of Abortions?_____	

Premenstrual Syndrome Symptoms:

Depression/Irritability	**Y**	**P**	Cravings	**Y**	**P**
Bloating	**Y**	**P**	Weight Gain	**Y**	**P**
Increased Appetite	**Y**	**P**	Breast Tenderness	**Y**	**P**

Other:_____

Neurological:

Fainting	**Y**	**P**	Loss of Memory	**Y**	**P**
Seizures/Convulsions	**Y**	**P**	Involuntary Movements	**Y**	**P**
Paralysis	**Y**	**P**	Loss of Balance	**Y**	**P**
Muscle Weakness	**Y**	**P**	Speech Problems	**Y**	**P**

Other:_____

Endocrine:

Thyroid Problems	**Y**	**P**	Hormone Therapy	**Y**	**P**
Diabetes	**Y**	**P**	Hypoglycemia	**Y**	**P**

Other:_____

Blood/Lymphatic:

Anemia	**Y**	**P**	Lymph Node Swelling	**Y**	**P**

Easy Bleeding/Bruising **Y** **P** Blood Transfusions **Y** **P**
Other:_____

Psycho/Social:

Depression **Y** **P** Emotional/Physical Abuse **Y** **P**
Mood Swings **Y** **P** Phobias **Y** **P**
Anxiety/Nervousness **Y** **P** Sleep Problems **Y** **P**
Alcohol or Drug Abuse **Yes** **No** Other:_____
Have you ever had psychiatric/psychological counseling?_____
How content are you with your life? (Scale of 1 to 10, 10 very content):_____
What would you like to change in your life?_____
Do you express your emotions easily?_____
Other:_____

FAMILY HISTORY *Please check all that apply.*

	Mother	Father	Brother/Sister	Grandparents
Cancer				
T.B.				
Heart Disease				
Arthritis				
Diabetes				
High Blood Pressure				
Asthma				
Kidney Disease				
Anemia				
Other				

CHILDHOOD DISEASES *Please circle.*

Measles Rheumatic Fever Mumps Whooping Cough
German Measles Diphtheria Chicken Pox Other:_____

VACCINATIONS *Please circle.*

Tetanus Pertussis Diphtheria Polio Measles Mumps
Rubella Other:_____
Did you have a reaction to any of these vaccinations (e.g. fever)? **Yes** **No**
If yes, what type of reaction?_____

OTHER *Please list, in order of appearance from your birth, all hospitalizations, surgeries, diseases, major accidents, and traumas (emotional and physical). Use extra sheets of paper, if necessary.*

Age:_____ _____
Age:_____ _____
Age:_____ _____
Age:_____ _____
Age:_____ _____

Is there anything else that you feel I should know about you?_____
_____
_____
_____
_____
_____