Dr. Gayle Maguire, BSc, ND Active Sports Therapy Calgary, AB. Ph: (403) 278-1405

Naturopathic Health Questionnaire

Welcome to Naturopathic medical care at Active Sports Therapy! We know that your health is influenced by many factors. Your questionnaire provides valuable information which helps us to understand the underlying causes of your health concerns. Fill out the questions to the best of your ability and bring the form in with you to your first visit to our clinic.

GENERAL CONTACT INFORMATION

Name:

_____

(last name) *(first name)* *(middle initial)*

Age: _____ **Gender:** □ Female □ Male **Date of Birth:** _____/_____ /_____

Address:

_____

(street address) *(city)* *(province)* *(postal code)*

Telephone: Home _____ **Work** _____ **Cell** _____

May we leave messages on your phone line? ____ Preference (circle all applicable): Home/ Work/ Cell

Email: _____ **Fax:** _____

Occupation: _____ **How did you hear about this clinic?** _____

Emergency Contact:

_____

(name) *(relationship)* *(telephone)*

Primary physician? _____ **Last physical exam?** _____

(name) *(telephone)* *(month) (year)*

Please complete the following questions:

MEDICAL HISTORY

What are the most important health concerns that you are seeking treatment for or are currently being treated for? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____

Please list any prescription medications, over the counter medications, vitamins or other supplements
you are taking, the dosage and the reason for using them:

1) _____
2) _____
3) _____
4) _____
5) _____

Please list any allergies or sensitivities (drugs, foods, environmental) that you are aware of?

_____
_____

Please list all significant conditions, concerns or traumas (i.e. surgery) you have had:
_____ year? _____ is it still affecting you?_____
_____ year? _____ is it still affecting you?_____
_____ year? _____ is it still affecting you?_____

Environmental Exposure
Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead,
mercury, cadmium, arsenic, etc) while at work, home or travelling? **Y N**
Do you have, or have you ever had, mercury dental fillings? **Y N**
Do you have any surgical implants or piercings (medical, cosmetic) **Y N**
Have you been vaccinated? **Y N**. Have you ever reacted to any vaccinations? **Y N**
How many times have you been on antibiotics in your life? _____ When was the last time? _____

Do you have a history of drug or alcohol abuse? **Y N**
Have you experienced violence, neglect or sexual abuse? **Y N** Is it ongoing? **Y N**
Please list the most significant events that have impacted your life?

1. _____ year? _____
2. _____ year? _____
3. _____ year? _____
4. _____ year? _____
5. _____ year? _____

TYPICAL FOOD INTAKE

Breakfast: _____
Lunch:
_____
Dinner: _____
Snacks: _____
Cravings:
_____
Aversions:
_____
Do you add salt to your food? **Y N** Do you drink coffee? **Y N** How many cups/day? _____
Water intake per day? _____ litres Other Beverages:
_____
Do you have any dietary restrictions?
_____

GENERAL

Weight ____lbs. Max weight _____lbs, when? _____ Height _____ Blood Type _____
Rate your energy level between: **(low)** 1 2 3 4 5 6 7 8 9 10 **(high)**
When during the day is your energy the best? _____ worst? _____
Rate your stress level between: **(low)** 1 2 3 4 5 6 7 8 9 10 **(high)**
What are sources of stress in your life?
_____

How do you cope with stress?

_____

FAMILY HISTORY

Please check any of the following conditions that have occurred in your family (grandparents, parents, siblings). ☐ **I don't know my family medical history**

Diabetes _____ Cancer _____ Multiple Sclerosis _____ Osteoporosis _____ Seizures ____
Arthritis _____ Asthma _____ Parkinson's _____ Thyroid Condition _____ Kidney Disease ____
Alzheimer's _____ Eczema _____ Heart Disease _____ Mental Illness _____ Addiction ____
Other _____

REVIEW OF SYSTEMS

Please check the box if you are currently experiencing the symptom, or have in the past.

Mental/Emotional: ☐Mood swings ☐. ☐ Anxiety or nervousness ☐. ☐ Poor concentration ☐.
☐Memory Problems ☐. ☐ Depression ☐. ☐ Anger ☐.
Endocrine: ☐Thyroid disease ☐. ☐ Heat or Cold Intolerance ☐. ☐ Diabetes ☐.
☐Sugar Sensitivities ☐.☐ Fatigue ☐. ☐ Weight loss/Weight gain ☐.
☐Tend to be a "night person" ☐ Slow starter in the morning ☐Difficulty relaxing
☐Feel "wired" ☐Clench/grind teeth ☐ Dizzy when stand too quickly
☐ Perspire easily ☐ Afternoon "crash"
Immune: ☐Chronic Infections ☐. ☐Chronic swollen glands ☐.
☐Slow wound healing ☐. ☐ Frequent colds ☐.
Skin: ☐ Rashes ☐. ☐ Eczema, Hives ☐. ☐Acne, Boils ☐. ☐ Itching ☐.☐ Night sweats ☐Dryness ☐Nail changes Other changes/findings: _____
Head: ☐Headaches ☐. ☐ Migraines ☐. ☐ Head Injury ☐
Eyes: ☐Visual disturbances. What kind? _____ ☐Dryness ☐Sun sensitivity
Ears: ☐Earaches ☐. ☐ Impaired Hearing ☐. ☐ Dizziness ☐. ☐ Ringing in Ears ☐.
Nose and Sinuses: ☐Nosebleeds ☐. ☐ Seasonal Hay fever ☐.
☐Sinus problems ☐. ☐ Loss of smell ☐.
Mouth and Throat: ☐ Frequent sore throat ☐. ☐ Sore tongue/lips ☐. ☐ Swollen glands
☐ Tonsils removed ☐. ☐ Loss of taste ☐. ☐ Hoarseness
Respiratory: ☐Cough ☐. ☐ Wheezing ☐. ☐Asthma ☐. ☐ Bronchitis ☐.
☐Emphysema ☐. ☐ Chronic Phlegm ☐. ☐Shortness of breath
Cardiovascular: ☐Heart disease ☐. ☐ High/Low Blood Pressure ☐. ☐ Palpitations ☐.
☐ Arrhythmia ☐. ☐ High Cholesterol ☐. ☐ Ankle swelling ☐ Past EKG
Peripheral vascular: ☐Cold hands/feet ☐Varicose veins ☐Leg cramps
Gastrointestinal: ☐ Heartburn ☐. ☐ Belching or Passing Gas ☐. ☐ Change in thirst ☐☐.Indigestion
☐Change in Appetite ☐. ☐ Constipation ☐. ☐ Diarrhea ☐.☐ Abdominal pain ☐Undigested food in stool ☐Black tarry stool ☐ Clay coloured stool ☐Floating stool ☐Stool that sticks to toilet bowl ☐Hemorrhoids ☐ Bloating ☐Bad breath ☐Sleepy after meals ☐ Better if don't eat ☐ Upset by greasy foods ☐Sea or motion sickness ☐ Poor tolerance to alcohol ☐Sensitive to chemical/smells ☐ Aspartame consumption or sensitivity ☐Nose runs while eating ☐Anal itching ☐ Fungal/Yeast infections ☐Feel worse in moldy/musty places

☐Dark circles under eyes
How many bowel movements do you have per day? _____ Per week? _____
Have you ever had parasites? **Y N**
Urinary: ☐ Increased frequency □. ☐ Frequency at night □. ☐Chronic Infections □. ☐ Incontinence □
How many times a day do you urinate? _____.
Musculoskeletal: ☐Joint Pain □. ☐ Stiffness in joints □. ☐Muscle spasms □. ☐ Arthritis □.☐Weakness ☐ Joint swelling
Neurological: ☐Fainting ☐Seizures ☐Paralysis Loss of memory ☐Involuntary movement ☐ Loss of balance ☐Speech problems

WOMEN'S HEALTH

Age of your first menstrual period? _____ When was your last menstrual period? _____

How many days do you bleed? _____ How long between your periods (onset to onset)? _____

Do you experience:	**When: (check boxes)**	
	Pre-menstrually	During menstruation
Heavy flow?		
Light flow?		
Clotting?		
Bleeding between periods?		
Cramping?		
Irritability		
"Blues" or depression		
Bloating &/or water retention		
Headaches		
Breast tenderness		
Cravings		
Low back pain		

Are you pregnant? **Y N**
Number of pregnancies _____ Number of births _____
Have you ever used birth control? **Y N** What type? _____ How long? _____
What type of sanitary product do you use (i.e. pad, tampon, etc)? _____
Please indicate if any of the following applies to you:
□☐ Vaginal Discharge. □ ☐Abnormal pap tests. ☐Oily skin ☐ Fibrocystic breasts
□ ☐Pain during intercourse. ☐□ Low libido. ☐Water retention ☐Polycystic ovaries
□☐ Vaginal Itching. □ ☐Vaginal dryness. □☐ Vaginal Odour.
When was your last Pap test? _____
Breast Health:
Do you perform monthly self breast exams? **Y N**
When was your last clinical breast exam? _____
Do you have regular mammograms? **Y N**
Have you experienced nipple discharge? **Y N** When? _____

MEN'S HEALTH

Please indicate if any of the following applies to you:
□ Hernia **Y N**
□ Testicular mass and or pain. **Y N** Do you perform self testicular exams? **Y N**

- Low sex drive **Y N**
- Discharge or sores **Y N**
- Impotence or Erectile Dysfunction **Y N**
- Difficulty with urination and/or frequent urination **Y N**
- Prostate condition. **Y N** Year of last prostate exam? ____ ____

LIFESTYLE

Do you exercise? **Y N** How & how often? _____
Do you fall asleep easily? **Y N** Average 6-8 hrs of sleep? **Y N**
Sleep soundly? **Y N** Wake rested? **Y N**
Do you smoke tobacco? **Y N** Do you chew tobacco? **Y N**
Do you use drugs? **Y N** Do you drink alcohol? **Y N**
Do you eat out regularly? **Y N** How often? _____

CONTEXT OF CARE OVERVIEW

Why did you choose to come to this clinic? _____
What do you know about our approach? _____
What three expectations do you have from this visit to our clinic?

1. _____
2. _____
3. _____

What long term expectations do you have from working with our clinic?
_____
What expectations do you have of me personally as your physician?
_____
What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)
1 2 3 4 5 6 7 8 9 10
What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

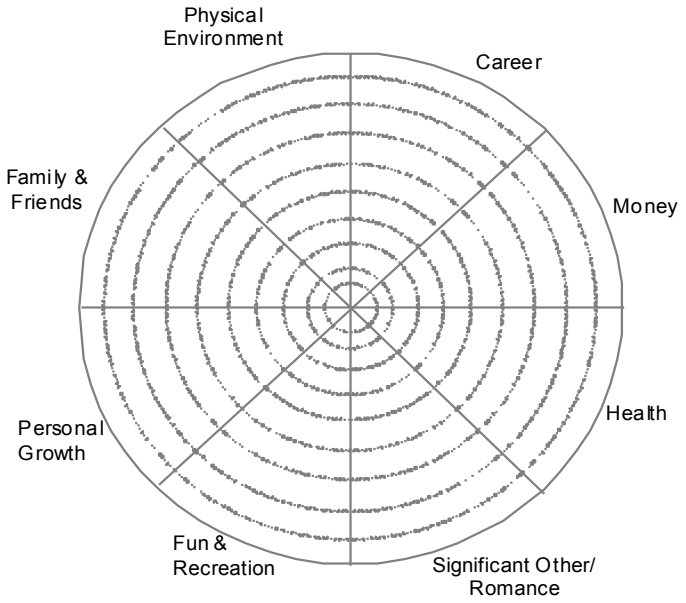
_____
_____
_____

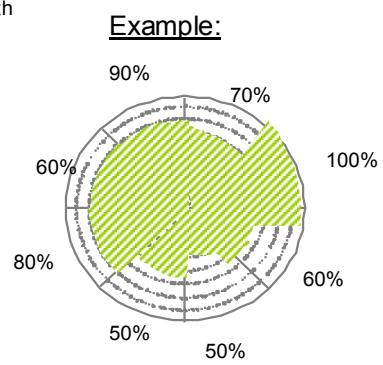
What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

_____
_____
_____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?
_____
Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making? _____
What do you LOVE to do? _____

WHEEL OF HEALTH





100
%

80%

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

Thank you for taking the time to fill out these forms!