VITALITY HEALTH

411 Huronia Road Unit 6A
Barrie, ON L4N 9B3
705.733.2033
www.vitalityforlife.ca

Contact Information

Full Name:_____ Date of Birth:_____
Day/Month/Year

Sex: M F Marital Status:_____

Email:_____

Occupation:_____

Address:_____

_____

_____

Telephone: (home)_____ (work)_____

Name of Medical Doctor:_____

Telephone:_____

Date of last visit to Medical Doctor:_____

Date of last physical exam:_____

How did you hear about our clinc?_____

Have you been treated by a Naturopathic Doctor before? Yes No

If 'yes' by whom?_____ When?_____

In Case of Emergency:

Contact:_____ _____ _____
Name Relation Telephone

_____ _____/_____/_____
Signature Date: Month/ Day / Year

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Health Questionnaire

Name:_____ **Age:**_____
Last Name First Name

Birthday:_____/_____/_____ **Sex:** M F
day/month/year

Marital Status:_____ **Nationality:**_____

Occupation:_____

Address:_____

_____

_____

Email:_____

Telephone: (home)_____(work)_____

Current Health Concerns:	How long ?

What kind of **treatment** (if any) have you received for the problem(s)?

_____

_____

Are you currently working with a **Medical Doctor**?

Name:_____Phone:_____

Are you currently on any **medications?** (include name, dose and how long you have been on it)

_____ _____

_____ _____

Are you currently on any **vitamins** or **herbal** remedies?

_____ _____

_____ _____

Medical History: (Please provide information for each of the following ie. Dates, details)

- Surgeries:_____Date:_____
- Past Hospitalizations:_____Date:_____
- Accidents/Trauma:_____Date:_____
- Which **vaccines** have you received? (please include approximately when they were last given)

  Hepatitis B_____ DPT_____ HiB (influenza)_____

  Polio (injected or oral)_____Measles/Mumps/Rubella_____

  Tetanus_____ Chickenpox_____ Flu shot_____

*Did you experience any reactions to the above vaccines?

_____

- List of **Medications/ Herbs** taken in the past:

  1._____ 2._____

  3._____ 4._____

  5._____ 6._____

Family History: (Please list age & health problems, or age & cause of death)

	Age	**Health Problems**
Mother	_____	_____
Father	_____	_____
Siblings	_____	_____
	_____	_____
	_____	_____
Grandma(Maternal)	_____	_____
Grandma(Paternal)	_____	_____
Grandpa(Maternal)	_____	_____
Grandpa(Paternal)	_____	_____

Please list the 3 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations still impacting your life? **Y N**

1. _____date_____
2. _____date_____
3. _____date_____

Present Health Situation:

Current weight_____ Weight 1 year ago_____

As an adult, what has been your maximum_____ & minimum weight_____

Please rate the following by putting a line at your current situation

(0=lowest/poor, 10=highest/excellent):

Overall Health

0 ----------5----------10

Energy

0 ----------5----------10

Sleep

0 ----------5----------10

Level of Pain (if any) – '10' is most painful

0 ----------5----------10

Eating Habits

0 ----------5----------10

Feeling of control over your life

0 ----------5----------10

Feeling of control over your health

0 ----------5----------10

Body image (are you content with how your body looks)

0 ----------5----------10

Job satisfaction

0 ----------5----------10

Supportive/Relaxing Home environment

0 ----------5----------10

Stress Level

0 ----------5----------10

Review of Systems:

- Indicate whether you experience, or have ever experienced any of the following

  Please circle one of the following: **Y**=yes, **N**=no, **P**=in the past

Skin

Rashes	**Y N P**	Itching	**Y N P**	Eczema/hives	**Y N P**
Psoriasis	**Y N P**	Acne/boils	**Y N P**	Color changes	**Y N P**
Lumps	**Y N P**	Night sweats	**Y N P**	Dryness/moistness	**Y N P**
Temperature	**Y N P**	Nail changes	**Y N P**	Change in mole	**Y N P**
Skin cancer	**Y N P**	Excessive sun exposure	**Y N P**	Photosensitivity	**Y N P**

Comments:_____

Head, Nose & Sinuses

Headaches	**Y N P**	Head Injury	**Y N P**	Dizziness	**Y N P**
Nasal discharge	**Y N P**	Frequent Colds	**Y N P**	Nose bleeds	**Y N P**
Sinus infections	**Y N P**	Hay fever	**Y N P**	Cavities	**Y N P**
Frequent sore throat	**Y N P**	Tonsillitis	**Y N P**	Sore mouth/tongue/gums	**Y N P**
Hoarseness	**Y N P**	Loss of taste	**Y N P**		**Y N P**

Comments:_____

Eyes

Blurred vision	**Y N P**	Eye pain	**Y N P**	Do you wear glasses?	**Y N P**
Tearing/dryness	**Y N P**	Double vision	**Y N P**	Glaucoma	**Y N P**
Cataracts	**Y N P**	Bothered by sun	**Y N P**	Itching	**Y N P**
Redness	**Y N P**	Discharge	**Y N P**	Blind spot	**Y N P**

Comments:_____

Ears

Impaired hearing	**Y N P**	Earache	**Y N P**	Dishcharge	**Y N P**
Infections	**Y N P**	Dizziness	**Y N P**		

Comments:_____

Neck

Lumps	**Y N P**	Swollen glands	**Y N P**	Goiter	**Y N P**
Pain/stiffness	**Y N P**				

Comments:_____

Respiratory

Cough	**Y N P**	Sputum/Mucus	**Y N P**	Spitting up blood	**Y N P**
Wheezing	**Y N P**	Asthma	**Y N P**	Bronchitis	**Y N P**
Pneumonia	**Y N P**	Do you get sick often?	**Y N P**	Emphysema	**Y N P**
Difficult breathing	**Y N P**	Pain on breathing	**Y N P**	Shortness of breath	**Y N P**
Tuberculin test	**Y N P**	Shortness of breath lying down	**Y N P**	Date of last chest X-ray	
Tuberculosis	**Y N P**	Do you smoke? How much?	**Y N P**		**Y N P**

Comments:_____

Cardiovascular

Heart disease	**Y N P**	Angina	**Y N P**	High blood pressure	**Y N P**
Murmurs	**Y N P**	Rheumatic fever	**Y N P**	Chest pain	**Y N P**
Swelling in ankles	**Y N P**	Palpitation/fluttering	**Y N P**	Cyanosis (blue skin)	**Y N P**
Heart monitor	**Y N P**	Have you had an ECG	**Y N P**		

Comments:_____

Gastrointestinal

Ulcer	**Y N P**	Trouble swallowing	**Y N P**	Change in thirst	**Y N P**
Change in appetite	**Y N P**	Nausea	**Y N P**	Vomiting	**Y N P**
Vomiting blood	**Y N P**	Belching/passing gas	**Y N P**	Indigestion	**Y N P**
Jaundice (yellow skin)	**Y N P**	How many bowel movements per day?		Food allergy	**Y N P**
Liver disease	**Y N P**	Gallbladder disease	**Y N P**	Heartburn	**Y N P**
Diarrhea	**Y N P**	Rectal bleeding	**Y N P**	Hemorrhoids	**Y N P**
Black stool	**Y N P**	Abdominal pain	**Y N P**	Constipation	**Y N P**

Comments:_____

Urinary

Pain on urination	**Y N P**	Inability to hold urine	**Y N P**	Increased frequeny	**Y N P**
Frequency at night	**Y N P**	Frequent infections	**Y N P**	Kidney stones	**Y N P**
Blood in urine	**Y N P**	Urgency	**Y N P**	Hesitancy	**Y N P**

Comments:_____

Breasts

Lumps	**Y N P**	Pain/tenderness	**Y N P**	Nipple discharge	**Y N P**
Fibrocystic breasts	**Y N P**	Do you do self exams?	**Y N P**	Have you breast fed?	**Y N P**
Date of last mammogram		Date of last in-office exam		Breast augmentation surgery?	**Y N P**

Comments:_____

Female Reproductive

Age menses began		# of days of flow (menses)		Length of cycle (ie. 28days)	
Bleeding between periods	**Y N P**	Are cycles regular	**Y N P**	Painful periods	**Y N P**
Excessive flow	**Y N P**	PMS	**Y N P**	Endometriosis	**Y N P**
Pain on intercourse	**Y N P**	Birth control used?		Number of live births	
# of pregnancies		# of abortions		# of miscarriages	
Sexual difficulty	**Y N P**	Difficulty conceiving	**Y N P**	Are you sexually active	**Y N P**
Venereal disease	**Y N P**	Vaginal discharge	**Y N P**	Vaginal itching	**Y N P**
Excessive dryness	**Y N P**	Date of last menses		Date of last PAP	

Comments:_____

Male Reproductive

Discharge/sores	**Y N P**	Hernia	**Y N P**	Testicular pain	**Y N P**
Sexual difficulty	**Y N P**	Venereal disease	**Y N P**	Are you sexually active	**Y N P**

Comments:_____

Muskuloskeletal

Arthritis	**Y N P**	Joint pain/stiffness	**Y N P**	Broken bones	**Y N P**
Weakness	**Y N P**	Muscle spasms/cramps	**Y N P**	Joint swelling	**Y N P**
Backache	**Y N P**				

Comments:_____

Peripheral Vascular

Varicose veins	**Y N P**	Deep leg pain	**Y N P**	Cold hands/feet	**Y N P**
Thrombophlebitis	**Y N P**	Leg cramps	**Y N P**	Extremity numbness	**Y N P**
Extremity coldness	**Y N P**	Extremity swelling	**Y N P**	Extremity ulcers	**Y N P**

Comments:_____

Neurologic

Fainting	**Y N P**	Seizures/convulsions	**Y N P**	Paralysis	**Y N P**
Muscle weakness	**Y N P**	Numbness/tingling	**Y N P**	Loss of memory	**Y N P**
Loss of balance	**Y N P**	Involuntary movement	**Y N P**	Speech problems	**Y N P**

Comments:_____

Endocrine

Thyroid trouble	**Y N P**	Heat/cold intolerance	**Y N P**	Excessive thirst	**Y N P**
Excessive hunger	**Y N P**	Excessive urination	**Y N P**	Excessive sweating	**Y N P**
Diabetes	**Y N P**	Hypoglycemia	**Y N P**	Hormone therapy	**Y N P**

Comments:_____

Blood / Lymphatic

Anemia	**Y N P**	Easy bleeding	**Y N P**	Easy bruising	**Y N P**
Past transfusions	**Y N P**	Lymph node swelling	**Y N P**		

Comments:_____

Allergic History

Drug sensitivity	**Y N P**	Reaction to vaccine	**Y N P**	History of anaphylaxis	**Y N P**
List Allergies:					

Mental / Emotional

Depression	**Y N P**	Mood swings	**Y N P**	Anxiety / nervousness	**Y N P**
Insomnia	**Y N P**	Psychiatric disorder:			

Comments:_____

Habits / Hobbies

How many meals do you eat in a day		Do you snack throughout the day?	**Y N P**
Do you watch television? How many hours?_____	**Y N P**	Do you work on a computer daily? How many hours?_____	**Y N P**
Do you consume alcohol? How much?_____/week	**Y N P**	Do you use recreational drugs? How often?_____	**Y N P**

How old is your home?_____ Is it carpeted? **Y N** Do you have Pets? **Y N**

- What is your water source? (filtered, well, distilled, tap, bottled) _____
- How much water do you drink every day?_____
- Are you exposed to second-hand smoke? **Y N**

What do you enjoy most in your life_____

Do you take vacations? How often_____

What do you do for exercise? How often_____

What are your interests/hobbies_____

What do you worry most about in life_____

What is the biggest factor stopping you from achieving your ultimate health goals?

_____

_____

Is there anything else that you feel is important to help me understand your current health situation?-

_____

_____

Did you know that Vitality For Life offers the following service?
Please check if you would like more information in the following areas:

☐ Chiropractic
☐ Massage Therapy
☐ Hot Stone Massage
☐ Orthotics
☐ Acupuncture
☐ Aromatherapy Massage

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4 Day Diet Diary

Please keep track of all foods that are eaten (don't worry about quantities) for 4 days, and note the time that you ate them. Include all beverages and snacks consumed during this time as well, and comment on how you felt throughout the day (energy level, indigestion, bloating/gas).

Day: 1	2	3	4
Morning:			
Afternoon:			
Evening:			
Comments:			