



Dr Anita Bratt ND
Naturopathic Physician

Adult Health History Form

Name _____ Age _____ M F Today's Date _____
Your Care Card Number _____ Date of birth (D/M/Y) ____/____/____
Home Address _____
City _____ Province _____ Postal Code _____
Email Address _____ Occupation _____
Home Phone _____ Work Phone _____
Spouse's Name _____ Children (Name/Age) _____

Healthcare Providers:

Medical Doctor(s) _____ Naturopathic Doctor _____
Chiropractor _____ Other _____

Who referred you to our clinic?

Your Main Health Concern

Please list the reasons for your visit and when the concerns began:

1. _____
2. _____
3. _____
4. _____
5. _____

Your Past Medical History

(Please check and date)

- | | | |
|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> STD |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Significant Trauma (auto accidents, falls, other) _____ | | |
| <input type="checkbox"/> Allergies (drugs, chemicals, foods) List: _____ | | |

Surgeries/ Hospitalizations. List with dates:

Family Medical History

Please indicate blood relatives, and if on father's (F) or mother's (M) side of the family.

- | | | | |
|-----------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> Addiction |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Tuberculosis |

Please check if the following symptoms are a current or recurring problem.

General

- | | | |
|---|---|---|
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Unusual tastes or smells |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heat or cold intolerance |
| <input type="checkbox"/> Sudden energy drop/ time?_____ | | |

Skin and Hair

- | | | |
|----------------------------------|---|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Change in moles |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Acne |

Head/ Eyes/ Ears/ Nose/ Throat

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Neck masses | <input type="checkbox"/> Color blindness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Jaw clicks or pain |
| <input type="checkbox"/> Eye pain/ strain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Tooth pain |
| <input type="checkbox"/> Frequent colds/ flus | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Mercury fillings #_____ |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Recurrent sore throat |
| <input type="checkbox"/> Using glasses | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Mouth sores |

Heart and Circulation

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of hands or feet |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Blood clots | | |

Respiration

- | | | |
|---|---|--|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Production of phlegm | |

Digestion

- | | | |
|---|---|---|
| <input type="checkbox"/> Indigestion/ heartburn | <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Gas or bloating | <input type="checkbox"/> Nausea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Excessive hunger |

Genito-Urinary

- | | | |
|---|---|--|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones |
|---|---|--|
-

- Urgency to urinate
- Pain on urination
- Waking to urinate
- Decrease in flow
- Distinctive/ odd color
- Blood in urine
- Sores on genitals
- Impotency

Women

- Age of first menses _____ yrs
- Duration of period _____ days
- Days between cycles _____ days
- Date of start of last period _____
- Date of last PAP exam _____
- Any abnormal PAPs? No Yes
- Do you perform a monthly self-breast exam? No Yes
- Any pre-menstrual symptoms? No Yes. Describe _____
- Do you use birth control? No Yes. What type and for how long? _____
- Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions _____
- Irregular periods
- Heavy flow
- Vaginal discharge
- Pelvic pain
- Breast tenderness
- Cramps
- Light flow
- Clots
- Breast lumps
- Nipple discharge

Musculoskeletal

- Neck pain
- Back pain
- Hand / wrist pain
- Shoulder pains
- Knee pain
- Foot/ ankle pain
- Hip pain
- Joint pain or stiffness
- Muscle pain
- Muscle weakness
- Joint swelling
- Bone pain

Brain/ Nervous System/ Psychological

- Loss of balance
- Quick temper/ irritability
- Poor memory
- Anxiety
- Eating disorder
- Depression
- Susceptible to stress
- Dizziness
- Lack of coordination
- Addiction
- Difficulty concentrating
- Seizures
- Areas of numbness
- Mood swings

Have you ever been treated for emotional problems? No Yes. Describe _____

Have you ever considered or attempted suicide? No Yes. When? _____

Any significant life stresses? Describe. _____

Personal Habits

- Smoker No Yes # Years smoked _____ Amount/day _____
- Alcohol Use: No Yes Type & amount _____
- Recreational drug use: No Yes Type & amount _____
- Coffee cups/day _____ Tea cups/day _____ Cola cups/day _____

Do you exercise regularly? No Yes
 Type(s) of activity _____ How often/long? _____

Height _____ Weight _____ lbs Maximum weight _____ when(year)? _____

Sleep

- Good
- Difficulty falling asleep
- Frequent waking
- Nightmares
- Time to bed: _____ Wake at: _____ Refreshed in morning? No Yes

Current Medications

List all prescriptions, over-the-counter drugs, and vitamins/supplements. Please include doses.

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

Diet

Are there any foods that you avoid or restrict? _____

Do you crave any foods? _____

Bowel movements #/day _____

Please describe your average daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Comments

Please describe any other problems you would like to discuss.