DRONYK HEALTH CLINIC

# Adult Health History Summary

Name_____ Age _____Date of Birth_____

Address _____

City_____ Province_____ Postal Code_____

Phone (home) _____ (cell)_____Occupation_____

Email_____ May we contact you via email? □ YES □NO

Emergency Contact _____Phone #_____

How did you hear about our clinic? _____

Family Medical Doctor_____ Contact _____

## Current Health Concerns

What is your **main** reason for coming in today? Please include how long you have had this concern, whether it is getting better, worse or unchanged, and any treatments you have tried.

_____

_____

_____

_____

_____

_____

List in order of importance your health concerns:

1) _____ date of onset _____
2) _____ date of onset _____
3) _____ date of onset _____
4) _____ date of onset _____

Other concerns: _____

_____

_____

Have you ever seen a naturopathic doctor, chiropractor, acupuncturist or other natural health practitioner ( Y / N )? If yes, who did you see?

_____

**Your Health History**

The general state of your health is (please check):

Excellent _____ Good _____ Average_____ Fair _____ Poor _____

Please list the 5 most significant stressful events or ongoing stressors in your life:

1) _____ date (if applicable)_____
2) _____ date (if applicable)_____
3) _____ date (if applicable)_____
4) _____ date (if applicable)_____
5) _____ date (if applicable) _____

Please indicate any of the following that you have had or currently have with an 'N' (now) or a 'P' (past):

_____Asthma
_____Allergies
_____Alcoholism
_____Anemia
_____Arthritis
_____Blood Pressure Abnormalities
_____Bronchitis
_____Cancer
_____Chronic Fatigue
_____Carpal Tunnel Syndrome
_____Circulatory Problems
_____Colitis
_____Dental Problems
_____Depression
_____Diabetes
_____Drug Addiction
_____Eating Disorder
_____Epilepsy
_____Emphysema
_____Eye/Ear/Nose Problems
_____Environmental Sensitivities
_____Insomnia
_____Food intolerance
_____Gout
_____Heart Disease
_____Chronic Infection
_____Irritable bowel syndrome
_____Kidney/bladder disease
_____Learning disabilities
_____Mental Illness
_____Liver Disease
_____Gallstones
_____Migraine headaches
_____Sinus problems
_____Stroke
_____Thyroid trouble
_____Obesity
_____Pneumonia
_____Sexually transmitted disease
_____Skin problems
_____Tuberculosis
_____Ulcer
_____Urinary tract infection
_____Varicose Veins
_____Heart Burn
_____Fibromyalgia
_____Glaucoma
_____ Other_____

Please list current medications:

Name: _____ Dose: _____ Date of onset: _____

Name: _____ Dose: _____ Date of onset: _____

Name: _____ Dose: _____ Date of onset: _____

Name: _____ Dose: _____ Date of onset: _____

Name: _____ Dose: _____ Date of onset: _____

Name: _____ Dose: _____ Date of onset: _____

_____

Please list current supplements including the dose (this includes homeopathics, vitamins, minerals, tinctures):

_____

_____

_____

Do you have any allergies? (ie drug, food, plants, animals, etc)

_____

_____

Did you receive the full childhood vaccination schedule? _____

Any recent vaccinations? _____

Have you had any of the following childhood illnesses (please check applicable):

☐ Measles ☐ Mumps ☐ Chickenpox ☐ Whooping Cough ☐ Polio ☐ Mononucleosis

☐ Diptheria ☐ Rheumatic Fever ☐ Scarlet Fever ☐ Other _____

Which (if any) of the following do you currently use? Provide approximate frequency if applicable (ie. sometimes, often, seldom)

☐ Alcohol _____ ☐ Tobacco _____

☐ Hormones _____ ☐ Coffee _____

☐ Cortisone _____ ☐ Laxatives _____

☐ Sedatives _____ ☐ Antacids _____

☐ Recreational Drugs _____

**Family History**

Do you have any blood relatives (parents, siblings, grandparents) who have or have had any of the following conditions? Please fill out to the best of your knowledge, no need to ask family members. Check 'yes' and provide more information if applicable.

- ☐ Allergies _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Anemia _____
- ☐ Depression _____
- ☐ Skin Disease _____
- ☐ Heart Disease _____
- ☐ Genetic Disorder _____ (including mother, father, grandparents, siblings)
- ☐ Blood Pressure Abnormalities _____
- ☐ Stroke _____
- ☐ Ulcers _____
- ☐ Cataracts _____
- ☐ Thyroid Problems _____
- ☐ Hypoglycemia _____
- ☐ Seizures _____
- ☐ Sickle Cells _____
- ☐ Mental illness _____
- ☐ Any other significant family health history

_____

_____

**Personal Habits/Lifestyle**

What do you enjoy most in your life? _____

What are your main interests or hobbies? _____

What do you worry most about? _____

Do you have a spiritual practice? _____

Do you exercise? If yes, what type and frequency? _____

Do you have any sleep problems? _____

How many hours of sleep would you say you get per night, on average? _____

Do you wake feeling refreshed? _____ Do you awaken through the night? _____

Do you sweat at night? _____ How many hours of sleep do you think you need? _____

Do you enjoy your work? _____

Do you take vacations? _____

Are you in a happy and supportive relationship? _____

How often do you get colds, flus, and sore throats? _____

How much water do you drink per day (on average)? _____

Any environmental allergens or exposures to on a regular basis we should be aware of? _____

_____

**Digestion**

Do you have any problems with gas, bloating or excessive fullness? _____

If so, how long have you had this? _____

How often do you have a bowel movement?_____

Do you ever have any **blood, mucus, or undigested foods** in your stool? _____

Do you ever have any problems with constipation? Diarrhea?_____

Do you ever have heartburn?_____

Do you have disagreeable breath? _____

Have you travelled outside of Canada in the last 5 years?_____

Have you ever had a parasitic infection? _____

**Female Reproduction**

What age were you when you first got your period?_____

Have your periods ever stopped? ____ **If yes**, what age and for how long?_____

Are your cycles regular? _____

Your period cycle is _____days, and your period is present for (approx.)_____ days.

How heavy are your periods?_____ What colour is the blood?_____

Are there any clots? _____ Do you have any spotting? _____

Do you have cramps or pain associated with your periods? _____

Do you have any pre-menstrual symptoms? (ie. water retention, breast tenderness, irritability, depression, headaches, mood swings, crying, acne, bloating, cravings, etc) Please describe:

_____

Number of pregnancies_____ What type (if any) of birth control do you use? _____

**Male Reproduction**

How often to you urinate? _____ Do you need to void through the night?_____

Has this increased at all over the past 2 years? _____

Have you ever had any prostate problems? _____

Have you ever had your prostate examined?_____ If so, when?_____

**Do you have anything else you would like to comment on or discuss with the doctor?**

_____

_____

_____

_____

*Thank you for taking the time to fill out the intake form, this will help us to ensure you receive the best care, we look forward to helping you obtain your health goals.*