

ACACIA Integrative Health Clinic

Health History Form (GENERAL)

Name _____ Birth-date _____ Date _____ MSP # _____

Blood Type _____ Address _____ City _____ Prov/State _____

Postal Code _____ Phone (home) _____ Phone (work) _____

best time to call _____ Can we leave messages for you here? Y N Email _____

Occupation _____ full-time part-time

Emergency contact _____ relation? _____ Phone _____

How did you hear about us? _____

Please list below all other health professionals you are currently seeing (complimentary and conventional) and their contact numbers. Include their area of practice (GP, Chiropractor, etc...)

When was your last blood test? _____ What kind? _____

Current Health Concerns:

What is your main reason for seeking naturopathic care? _____

How long has this been troubling you? _____ Has it been getting: better worse remaining the same

List any treatments you have had for this condition (surgery, acupuncture, massage, etc...) and the results. Include dates: _____

In order of importance, list any other health concerns that are troubling you:

1) _____ Since when? _____

2) _____ Since when? _____

3) _____ Since when? _____

4) _____ Since when? _____

Other concerns: _____

List all medications, supplements, herbs, and homeopathic medicines you are currently taking. Include dosage and results: _____

If you have been treated homeopathically in the past, please list the remedies taken, at what dose (strength and frequency) and with what results? _____

ACACIA Integrative Health Clinic

Your Health History:

Your general state of health is: excellent good average fair poor

Current weight _____ Height _____ Weight 1 year ago _____ Max adult weight _____ Min adult weight _____

Please list the five most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (If so place a star next to the event)

1) _____ Date _____

2) _____ Date _____

3) _____ Date _____

4) _____ Date _____

5) _____ Date _____

Are you currently working with a professional counselor, psychologist, social worker, pastor, rabbi, psychiatrist, or other therapist?
YES NO Have you in the past? YES NO If yes, when? _____

Childhood Diseases: (please circle if you have had the following):

measles _____ mumps _____ chickenpox _____ whooping cough _____ polio _____ diphtheria _____ roseola _____
rheumatic fever _____ scarlet fever _____ small pox _____ typhoid fever _____ tuberculosis _____ rubella _____ mono _____

Previous surgeries and hospitalizations not mentioned above (include dates):

Which of the following have you had and indicate when.

Chronic infections _____	Hypoglycemia _____	Asthma _____	Heart attack _____
Pneumonia _____	Diabetes _____	Gonorrhea _____	Heart Failure _____
Tonsillitis _____	Cancer _____	Syphilis _____	Anemia _____
Ear Infections _____	Eczema _____	Venereal warts _____	Obesity _____
Heart disease _____	Epilepsy _____	Canker sores _____	Hyperthyroidism _____
Oral herpes _____	Genital herpes _____	Hypertension _____	Hypothyroidism _____
Allergies _____	Hepatitis _____		

How often do you get colds and flus? _____

Do you have any allergies to any drugs, herbs, foods, animals or other? (yes / no) Please list: _____

Do you currently use any of the following (indicate how often, how much and for how long):

Alcohol _____ Tobacco _____ Coffee _____
Soft drinks _____ Black tea _____ Marijuana _____
Laxatives _____ Other recreational drugs _____ Pain medication _____
Other intoxicants _____

Vaccination History:

Place the date of vaccination beside all that apply, and note any reactions or adverse effects.

Measles, Mumps, Rubella (MMR) _____

Polio _____ circle: oral live-virus polio vaccine killed-virus

Diphtheria, Pertussis, Tetanus (DPT) _____

Small Pox _____

Haemophilus Influenzae type B (Hib) _____

Hepatitis A _____

Hepatitis B _____

Varicella (Chicken pox) _____

Other: _____

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Mental Emotional Health:

Have you had in the past or have now, any of the following conditions (indicate n for now, and p for past):

Schizophrenia ____ Manic Depression ____ Major Depression ____ Minor Depression ____ Chronic Anxiety ____ Panic Attacks ____
 Post Traumatic Stress Disorder ____ Dysthymic Disorder (chronic low level depression) ____ Obsessive-Compulsive Disorder ____
 Other (please name) _____

Family History:

Please list ages, health problems and if deceased, cause of death:

	Living (age)?	Health Problems	Died(age)?	Cause
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
<u>Maternal:</u>				
Grandfather	_____	_____	_____	_____
Grandmother	_____	_____	_____	_____
<u>Paternal:</u>				
Grandfather	_____	_____	_____	_____
Grandmother	_____	_____	_____	_____

What is your ethnicity? _____

Do you have children? _____ How many? _____ Do they have any health problems? _____

Do you have any blood relatives who suffers from or has suffered from the following (circle):

- | | | | | | | | |
|---------------|-----------|-----------------|-----------------|--------------|--------------|------------------|-----------|
| allergies | arthritis | asthma | cancer | diabetes | anemia | Alzheimer's | syphilis |
| depression | eczema | heart disease | genetic disease | hypertension | stroke | bipolar disorder | gonorrhea |
| schizophrenia | cataracts | thyroid disease | hypoglycemia | seizures | sickle cells | tuberculosis | ulcers |

What is your weakest organ system and why? _____

Your Lifestyle:

Describe your current living arrangements. _____

Describe the emotional environment at home. _____

Are you (circle): married separated divorced widowed single in a supportive relationship in a same sex relationship, or other _____

What do you enjoy most in your life? _____

What are your main interests and hobbies? _____

What do you worry about most in your life? _____

How often do you exercise per week? _____ What kind and for how long? _____

ACACIA Integrative Health Clinic

Do you have a religious or spiritual practice and what is it? _____

Do you have dietary restrictions, religious or ethical? _____

Do you meditate? _____ Do you enjoy your work? YES NO Do you take vacations? YES NO

What is your level of education? _____ Are you happy with this? _____

Female Reproduction:

Age of first period _____ Age at menopause _____ Length of cycles _____

Length of bleeds _____ Are they: heavy medium light clotted dark light color

Do you have spotting or bleeding between periods and since when? _____

Do you have PMS? ____ (circle all that apply) bloating, breast tenderness, irritability, depression, headaches, mood swings, food cravings

Number of pregnancies _____ Number of abortions _____ Number of live births _____ Number of miscarriages _____

Have you had difficulty conceiving? (Please describe) _____

Date and results of last PAP smear _____ Mammogram _____ Self breast exam _____

Have you ever had an abnormal pap/mammogram? YES NO If yes, when? _____

Are you sexually active? YES NO If you use birth control, what kind? _____

Have you ever been or are now physically or sexually abused? _____

Male Reproduction:

Any problems with impotency? YES NO Any sores on your penis? YES NO Any discharge? YES NO

Any problems urinating? YES NO Any known prostate problems? (if so describe) _____

Date of last prostate examination _____ Date of last self testicular examination _____

Are you sexually active? YES NO If you use birth control, what kind? _____

Have you ever been or are now physically or sexually abused? _____

Your Work and Home Environment:

How long have you lived at your present address? _____ Where have you lived previously? _____

Is your home damp or moldy? YES NO How is your home heated? _____

Can you open windows where you work? YES NO Is their air filtration systems at work? YES NO

Does your work expose you to toxic chemicals and fumes? YES NO Describe _____

Do any of your hobbies expose you to toxic chemicals? YES NO Are you exposed to second hand smoke? YES NO

Thank you for taking the time to fill out this form.

Please return this form to your Doctor:

Dr. E. Pamela Hutchinson, B.Sc., N.D.

Dr. Amy Gilchrist, B.A., N.D.

Dr. Jaime de Melo, B.Sc, N.D.

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Confidentiality Agreement and Informed Consent to Treatment Naturopathic Treatment

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors (NDs) assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history and conduct a screening physical examination. This may include a breast exam, gynaecological, rectal, prostate, and blood and urine samples as required. Treatment may involve such interventions as Botanical Medicine, Traditional Chinese Medicine, Bony manipulations, Massage, Hydrotherapy, Nutrition, Lifestyle Counselling, Psychological counselling, and Homeopathy.

I understand that I must inform the Naturopathic Doctor immediately of any disease process that I may be suffering from, if I am on any medication or over the counter drugs, if I am pregnant, suspect I may be pregnant or am breast-feeding.

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that the physicians at this clinic are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests.

I understand that 24 hours notice is required for appointment cancellation; otherwise I will be responsible for the cancellation fee.

I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of treatment with this Naturopathic Doctor. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient/Guardian Name: (Please Print) _____

Signature of Patient (or Guardian): _____

Date: _____

Optional Consent (please initial box)

To provide me with truly integrated medical care I hereby give my consent to share my file and/or my medical history and current treatment plan options with any other practitioner that I am currently seeing (or may be referred to see in the future) at Acacia Integrative Health Clinic for the sole purpose of improving my current health condition and/or to discuss current and/or future treatment options.

Naturopathic Doctor Signature: _____

Date: _____