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GAIA HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Who referred you to our clinic?			
Name:	☐ **M** ☐ **F**	**Date of Birth:**	**Age:**
Address:		**City:**	**Province:**
Postal Code:	**Email:**	**Tel:**	
Emergency Contact:	**Relation:**	**Tel:**	
Current Occupation:	**Years:**	**Previous:**	
Marital status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**			
# of Children & their ages:			
Name of Medical Doctor:	**Date of last physical exam:**		

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles	☐ Mumps	☐ Rubella	☐ Chickenpox	☐ Rheumatic Fever	☐ Polio
Blood Type	☐ A	☐ B	☐ O	☐ AB	☐ Don't Know	
Immunizations/Complications	☐ Tetanus			☐ Pneumonia		
	☐ Hepatitis			☐ Chickenpox		
	☐ Influenza			☐ MMR Measles, Mumps, Rubella		

Please List your primary health concerns/reason for visit:

List any medical problems that other doctors have diagnosed:

Surgeries and other hospitalizations:

Year	Reason

List your prescribed drugs and over-the-counter drugs, vitamins and other supplements

Name the Drug/Supplement	Strength/Dosage	Frequency Taken

Please list any allergies you have and what kind of reaction occurs:	
Name the Drug	Reaction You Had

HEALTH HABITS				
Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting? ☐ Yes ☐ No		Name of Diet?	
Are there any foods that you avoid or restrict?				
Which foods do you crave?				
Please describe your average daily diet:				
Breakfast:				
Lunch:				
Dinner:				
Snacks:				
Drinks:				
Weight	Current Weight?	Current Height?	Ideal Weight?	
Energy	What would you rate your energy (1-10, 10 being highest)		When is your energy highest?	Lowest?
Sleep	How many hours of sleep do you get per night?		Do you wake-up feeling refreshed? ☐ Yes ☐ No	
Water	Number of litres of water you drink per day?		Type? ☐ Filtered ☐ Reverse Osmosis ☐ Spring	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	If yes, what kind?			
	How many drinks per week?			
Tobacco	Do you use tobacco?		☐ Yes ☐ No	
	Cigarettes - pks./day	Chew - #/day	Pipe - #/day	Cigars - #/day
	# of years	Or year quit		
Drugs	Do you currently use recreational or street drugs?			☐ Yes ☐ No
Sex	Are you sexually active?			☐ Yes ☐ No
	If yes, are you trying for a pregnancy?			☐ Yes ☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:			
	Any discomfort with intercourse?			☐ Yes ☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** Maternal		
	☐ M ☐ F		**Grandfather** Maternal		
	☐ M ☐ F		**Grandmother** Paternal		
	☐ M ☐ F		**Grandfather** Paternal		

MENTAL HEALTH

Do you feel often stressed?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Are you overwhelmed by stress?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
What activities help you relieve stress?		

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Do you wake in the night to urinate? ☐ Yes ☐ No	If yes, # of times _____	
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No

Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

OTHER HEALTH CONCERNS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	Recent changes in:
☐ Head/Neck	☐ Back/Joints	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

INFORMED CONSENT

I would like to take this opportunity to welcome you to Gaia Health Care. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supporting therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. If you are working with a naturopathic doctor a physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

As a patient of this clinic I have read the information and understand that the form of medical care is based on Naturopathic and other supporting principles and practices. As Gaia Health Care is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

PRINTED NAME _____ DATE _____