gaia

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
Father			
Mother			
Sibling	M F		
	M F		
	M F		
	M F		
	M F		
	M F		
Children	M F		
	M F		
	M F		
	M F		
Grandmother Maternal			
Grandfather Maternal			
Grandmother Paternal			
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 ________________________