Port Moody Naturopathic Clinic
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Dr. Kira Frketich N.D.

Health History Intake Questionnaire

By completely filling out this form you will help us to help you. All answers will be absolutely confidential. If you have any questions, please ask. Thank-you.

Name_____ Age____ M □ F □
Occupation_____ Date_____
Birth date_____
Address_____ Phone (H)_____
_____ (W)_____
_____ Email_____
Spouse's name_____ Children(s)(name/age)_____

Emergency Contact_____ Relation _____ Phone_____

Who referred you to the clinic?_____

Your Main Health Concern

What has brought you to the clinic today?

When did your problem(s) begin (please be specific)?

Your Past Medical History (Please check and date)

□ Cancer □ Diabetes □ Venereal Disease
□ High Blood Pressure □ Seizures □ Surgeries
□ Heart Disease □ Hepatitis/Kidney disease □ Anemia
□ High Cholesterol □ Thyroid Disease □ Rheumatic Fever
□ Significant Trauma (auto accidents, falls, other) □ Other major illness
□ Allergies (drugs, chemicals, foods) Specify_____
Specify_____ _____
_____ _____

Your Family Medical History (list any health concerns experienced by your family)

Mother _____ Father _____
Grandmother_____ Grandmother_____
Grandfather_____ Grandfather_____

PORT MOODY
NATUROPATHIC CLINIC

Please check all symptoms that apply to you now (check) or in the past (mark with P)

General

□ Poor appetite
□ Poor sleep
□ Fatigue
□ Chills
□ Cravings_____
□ Night sweats
□ Sweat easily
□ Change in appetite
□ Bleed or bruise easily
□ Strong thirst
□ Weight gain
□ Weight loss
□ Sudden energy drop (time?)
□ Peculiar tastes or smells
□ Fevers

Skin and Hair

□ Rashes
□ Itching
□ Eczema
□ Other hair or skin problems?
□ Change in hair or skin texture
□ Loss of hair
□ Dandruff
□ Recent moles
□ Ulcerations
□ Pimples

Head, Eyes, Ears, Nose and Throat

□ Headaches
□ Neck pain
□ Concussions
□ Eye pain
□ Eyestrain
□ Blurry vision
□ Using glasses
□ Night blindness
□ Colour blindness
□ Cataracts
□ Earaches
□ Poor hearing
□ Ringing in ears
□ Facial pain
□ Sinus problems
□ Nose bleeds
□ Jaw clicks or pain
□ Tooth pain
□ Mercury tooth fillings
□ Recurrent sore throats
□ Sore on lips or tongue

Heart and Circulation

□ High blood pressure
□ Low blood pressure
□ Irregular heart beat
□ Dizziness
□ Fainting
□ Chest pain
□ Varicose veins
□ Blood clots
□ Cold hands or feet
□ Swelling of hands
□ Swelling of feet

Lungs and Breathing

□ Difficulty breathing
□ Cough
□ Bronchitis
□ Asthma
□ Pain with a deep breath
□ Production of phlegm (color?)
□ Coughing blood
□ Pneumonia
□ Other problems

Digestion and Elimination

□ Indigestion
□ Gas
□ Bloating
□ Constipation
□ Bad breath
□ Abdominal pain and cramps
□ Nausea
□ Vomiting
□ Chronic laxative use
□ Rectal pain
□ Hemorrhoids
□ Blood in stool
□ Diarrhea

PORT MOODY
NATUROPATHIC CLINIC

Women

____ Age of first menses
____ Duration of menses
____ Days between menses
____ Date of start of last menses
____ Date of last PAP exam

□ Unusual menses
□ Heavy
□ Light
□ Clots
□ Breast lumps

□ Irregular periods
□ Painful periods
□ Vaginal discharge
□ Vaginal sores

□ Do you perform a monthly self-breast exam?
□ Changes in your body or emotions prior to menstruation?_____
□ Do you practice birth control? What type and for how long?_____
___Number of pregnancies ____Number of births____ Miscarriages____Abortions

Muscle, Joints and Bones

□ Neck pain
□ Back pain
□ Hip pain
□ Knee pain
□ Foot/ankle pain
□ Shoulder pain
□ Muscle pain
□ Hand/wrist pain
□ Other joint or bone problems?

Brain, Nerve and Emotions

□ Loss of balance
□ Quick temper
□ Poor memory
□ Anxiety
□ Depression
□ Susceptible to stress
□ Dizziness
□ Lack of coordination
□ Concussion
□ Seizures
□ Areas of numbness

□ Have you ever been treated for emotional problems?
□ Have you ever considered or attempted suicide?
□ Any other neurological or psychological problems?

Occupational Stress (chemical, physical, psychological)

Describe your weekly stressors:

□ How many cigarettes or marijuana joints do you smoke in a day?_____
□ How much do you ingest/week? ___ Coffee/tea ___ Pop ___ Alcohol
□ Do you use recreational drugs?

Current Medicines

List all prescriptions, over-the-counter drugs you are currently taking or have taken for long periods of time in the past (we will discuss vitamin and herbal supplements together).