Natural Terrain
naturopathic clinic

Dr. Bjorndal ¤ Dr. Haarsma ¤ Dr. Mason-Wood

200-6650 177th St NW, Edmonton, AB, T5T 4J5
Phone: 587-521-3595 Fax: 855-541-0837
www.naturalterrain.com

CONFIDENTIAL HEALTH QUESTIONNAIRE

Name: _____Alberta Health Care #: _____
Address: _____
Telephone: (home) [____] _____ (work) [____] _____ (cell) [____] _____
E-mail: _____ Age: _____ Birth Date: _____ Occupation: _____
Sex: Male ____ Female ____ Marital Status: *S M D W Sep* Number of Children: _____
Other Health Care Providers? 1)_____ 2)_____
Tel: _____ Tel: _____
How did you find out about our clinic or who can we thank for referring you?
Name: _____ *Internet (please list website):* _____
Have you been treated by a Naturopathic Doctor before? *Y or N* *By who?* _____
Emergency Contact: _____ _____ [____] _____
Full name Relation Telephone

List your health concerns and how long they have been occurring, in order of importance:

1._____
2._____
3._____
4._____
5._____
6._____

MEDICATIONS / SUPPLEMENTS

How many times have you been treated with antibiotics? _____ When was the last time? _____

Medication	Date started [m/y]	Dose	Effectiveness
1)			
2)			
3)			
4)			
5)			
Supplement / Vitamin (Brand Name)	**Date started [m/y]**	**Dose**	**Effectiveness**
1)			
2)			
3)			
4)			
5)			
6)			

Are you sensitive or allergic to:

Drugs? _____ Chemicals? (Multiple Chemical Sensitivity) _____
Foods? _____ Environmentals? _____
Please indicate any serious conditions, illnesses, injuries, surgeries, x-rays, CT scans, MRIs and/or hospitalizations that you have had. Include approximate dates. _____
_____
_____

What is your level of commitment to address your health concerns?

Rate from 1 to 10: (0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

Please explain why your commitment level is not 100%: _____

What do you feel is causing any health problems you may have? _____

_____

What expectations do you have of me personally as your physician? _____

_____

What behaviours or lifestyle habits currently support your health? _____

_____

What behaviours / lifestyle habits currently inhibit your health or are obstacles to your health?

_____

Immunizations: Regular childhood vaccinations? *Y or N* Do you get an annual flu shot? *Y or N*

Please indicate any adverse reactions you have experienced from an immunization. _____

_____

Family History:	Father	Mother	Brothers			Sisters			Spouse	Child		
Age (if living)												
Health (G=Good; P=Poor)												
Age at death (if deceased)												
Check (√) those applicable												
Allergies/Hay fever												
Arthritis												
Asthma												
Cancer (Type?)												
Diabetes Type 1 or 2												
Drug abuse/alcoholism												
High Blood Pressure												
Mental Illness												
Other												
Cause of Death												

Illnesses: Which of the following conditions have you had?

	Alcoholism		Cold sores		Gout		Mononucleosis		Strep throat
	Cancer		Eating Disorder		Hepatitis		Parasites		Tonsillitis
	Chicken pox		Fatty Liver Disease		Herpes		Shingles		Warts

Lifestyle: Do you exercise regularly? *Y or N* How often? _____

What level of stress are you experiencing right now? *Minimal Average Considerable Unbearable*

Main stressor(s): *Financial; Work; Marriage; Health; Family; Spiritual; Unfulfilled expectations*

Are / were you a smoker? *Y or N* How long? _____ If you quit, when? _____

Do you have regular sleeping habits? *Y or N* How many hours? _____

Circle if any apply to you: *Early riser; Difficulty falling asleep; Wake in middle of night; Nightmares*

What are your main interests and hobbies? _____

Do you have a religious or spiritual practice? If yes, what? _____

For the following, **circle "Y" for yes, "N" for no, or "P" for in the past**

Do you wake rested	Y N	Do you use a microwave oven	Y N
Do you eat organic	Y N	Do you eat out often	Y N P
Do you have a supportive relationship	Y N	Do you eat refined sugar	Y N P
Do you enjoy your work	Y N	Do you use recreational drugs	Y N P
Do you take vacations	Y N	Do you have a history of abuse	Y N
Do you spend time outdoors	Y N	Do you have a TV in your bedroom	Y N

Diet: Describe a typical day's diet.

Breakfast_____

Lunch_____

Supper_____

Snacks_____

Do you have any dietary restrictions (religious, vegetarian, vegan, etc.)? _____

Weight? _____ lbs Height? _____inches Time of day energy is: Best? _____ ↳Worst? _____

How many cups/bottles/glasses do you drink on average per day?

Beverage	**Amount**	**Beverage**	**Amount**	**Beverage**	**Amount**
Water		Fruit juice		Coffee	
Milk (Type?)		Vegetable juice		Beer	
Soft drinks regular		Herbal Tea		Wine	
Soft drinks diet		Black Tea		Liquor	

Review of Systems

Additional Comments

Skin

Rashes?	Y N P	Dryness?	Y N P
Eczema, hives?	Y N P	Night sweats?	Y N P
Acne, boils?	Y N P	Change in a mole?	Y N P
Itching?	Y N P	Skin cancer?	Y N P
Colour change?	Y N P	Nail changes?	Y N P

Head

Headaches or Migraines?	Y N P	Head Injury?	Y N P
Hair loss?	Y N P	Jaw / TMJ problems?	Y N P

Eyes

Impaired vision?	Y N P	Blurred vision?	Y N P
Eye pain?	Y N P	Itching / redness?	Y N P
Dry eyes?	Y N P	Discharge?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches or Discharge?	Y N P	Infections?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose bleeds?	Y N P
Stuffiness / Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Loss of taste?	Y N P
Teeth grinding?	Y N P	Sore tongue/mouth?	Y N P
Gum problems?	Y N P	Metallic taste?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Difficulty / Pain on breathing?	Y N P
Spitting up blood?	Y N P	Wheezing?	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Emphysema?	Y N P
Shortness of breath?	Y N P	Shortness of breath at night?	Y N P

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High / low blood pressure?	Y N P	Fainting?	Y N P
Blood clots?	Y N P	Palpitations / fluttering?	Y N P
Swelling in ankles?	Y N P	Chest pain?	Y N P

Gastrointestinal

Trouble swallowing?	Y N P	Change in thirst?	Y N P
Nausea?	Y N P	Change in appetite?	Y N P
Vomiting?	Y N P	Indigestion / Heartburn?	Y N P
Blood in stool?	Y N P	Constipation?	Y N P
Abdominal pain or cramps?	Y N P	Diarrhea?	Y N P
Belching or passing gas?	Y N P	Gallstones?	Y N P
Black, tarry stools?	Y N P	Ulcer?	Y N P
Change in bowel movements?	Y N P	Hemorrhoids / fissures?	Y N P
Bowel movements – how often?		Hernia?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency – day or night?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P
Urgency or hesitancy?	Y N P	Blood in urine?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P
Joint / extremity swelling?	Y N P	Backache?	Y N P

Blood/Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands / feet?	Y N P
Varicose veins?	Y N P	Slow wound healing?	Y N P

Neurologic

Seizures / convulsions?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Vertigo or dizziness?	Y N P	Speech problems?	Y N P
Fainting?	Y N P	Involuntary movement?	Y N P

Endocrine / Immune

Hypothyroid?	Y N P	Diabetes Type 1 or 2?	Y N P
Hyperthyroid?	Y N P	Heat or cold intolerance?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P
Chronic fatigue syndrome?	Y N P	Hypoglycemia?	Y N P
Excessive thirst?	Y N P	Excessive sweating?	Y N P
Excessive hunger?	Y N P	Hormone therapy?	Y N P
Excessive urination?	Y N P	Chronic infections?	Y N P

Mental/Emotional

Treated for emotional problems?	Y N P	Memory problems?	Y N P
Mood swings?	Y N P	Anxiety or nervousness?	Y N P
Poor concentration?	Y N P	Depression?	Y N P
Tension and / or stress?	Y N P	Considered / attempted suicide?	Y N P
Phobias?	Y N P	Insomnia?	Y N P

Male Reproduction

Hernias?	Y N P	Testicular pain or masses?	Y N P
Are you sexually active?	Y N P	Impotence?	Y N P
Premature ejaculation?	Y N P	Prostate enlargement or disease?	Y N P
Do you use birth control? ↳What type?	Y N P	Sexually Transmitted Disease? ↳ What type?	Y N P
Sexual preference: *Heterosexual* *Bisexual* *Homosexual*			

Is there anything else that you would like to add or comment on? _____

_____

For Women Only: Please circle all that apply

Age of first menses? ____ Are your menses regular? *Y or N* Average number of days? _____

Length of cycle? _____ Last menstrual period? _____ Age of cessation of menses? _____

The blood flow during the menses is: *Not at all; Spotting; Moderate; Heavy; Heavy and clots*

Do you have bleeding between periods? *Y N P* Any pain during intercourse? _____

Pain with the menses? *Not at all; Slight; Moderate; Severe; Incapacitating*

PMS Questionnaire: Rate each of the following symptoms of your last menstrual cycle only

0 if not experienced
1 if mild [present but does not interfere with activities]
2 if moderate [present and interferes with activities but not disabling]
3 if severe [disabling; unable to function]

SYMPTOMS	0, 1, 2, 3	SYMPTOMS	0, 1, 2, 3	SYMPTOMS	0, 1, 2, 3
Abdominal bloating		Anxiety / Nervous tension		Breast tenderness / lumps	
Craving for sweets		Crying		Dizziness or faintness	
Increased appetite		Depression		Fatigue	
Weight gain		Forgetfulness		Headache	
Irritability		Mood swings		Insomnia	

Are you now on or have you ever taken birth control pills? *Y N P* How long? _____ What type? ____

Are you now or have you ever used any hormone-modulating medications (pills, patches, or creams of estrogen, progesterone or testosterone)? *Y N P* If yes, please list the type, dosage and frequency:

_____

For the following, **circle "Y" for yes, "N" for no, or "P" for in the past**

Fibrocystic breast disease?	Y N	Endometriosis?	Y N P
Do you do self-breast exams?	Y N	Uterine fibroids?	Y N P
Ovarian cysts?	Y N	Cervical dysplasia?	Y N P
Vaginal discharge?	Y N P	Vaginal itching?	Y N P
Yeast infections?	Y N P		
Sexually Transmitted Disease?	Y N P	What type?	
Are you sexually active?	Y N	Any sexual difficulties?	
Recurring vaginal infections? *Never; Rarely; Frequently; More than 3x/year*			
Sexual preference? *Heterosexual; Bisexual; Homosexual*			
Difficulty conceiving?	Y N	Last Pap Smear?	

Number of pregnancies? _____ Deliveries? _____ Miscarriages? _____ Abortions? _____

Were there any complications associated with the above? _____

_____

CONSENT FORM

Welcome to the Natural Terrain Naturopathic Clinic! This clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body, mind and spirit in its own inherent healing power. Our practitioners will take a full case history and may perform a complaint oriented physical exam, as well as blood, urinary or saliva testing to assist in diagnosis and treatment. Please **read and initial** the following statements:

_____ Initials
A confidential record will be kept of health services provided. This record will not be released to others unless directed by yourself or unless law requires it. You understand that you may look at your medical record at anytime and can request a copy of it by paying the document fee of $25. You understand that information from your medical record may be analyzed for research purposes and that your identity will be protected and kept confidential.

_____ Initials
Treatment results are not guaranteed and we will answer questions as best as we can. You do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, you voluntarily consent to diagnostic and therapeutic procedures, except for (please list any exceptions): _____

_____ Initials
You intend this consent form to cover the entire course of treatment for you or your child's chief health concerns. You confirm that you have free will and choice regarding suggested care. You acknowledge that you are not representing an agency (private, governmental or otherwise) attempting to gather information without so stating.

_____ Initials
All fees are due at the time of the visit (ie consultation, prescriptions and lab testing). The clinic does not direct bill but a receipt is provided to submit your claim to insurance providers.

_____ Initials
You will be charged for the first appointment if it is missed or if you cancel with less than 2 business days notice. For follow-up visits a missed appointment fee of $50 will be charged for any appointments that are missed or late cancellations (less than 2 business days).

_____ Initials
Please refrain from wearing scents/perfume due to the sensitivity of other clients.

_____ Initials
There may be times when you may be required to wait as we are providing needed attention to a current patient – we appreciate your cooperation, patience and understanding.

_____ Initials
I agree to receive newsletters, health information handouts and updates from the clinic by email. I am aware I can withdraw my consent at any time.

Patient Name: (Please Print) _____ Date: _____

Patient Signature (parent/guardian if patient under 18 years of age): _____

Name of parent/guardian if patient is under 18 years old (please print): _____