



Foundation for Integrated Health

PATIENT HEALTH HISTORY

Date: _____

Patient's Name: _____
First Middle Last

Integrative natural medicine is most effective when your practitioner(s) completely understand your health challenges. The information you provide is therefore essential to assist you reach your health goals. Our objectives are, firstly, to help with the symptoms you are experiencing, and secondly, to offer you the opportunity to improve your health and quality of life. On a daily basis, everyone experiences physical, chemical, electromagnetic and emotional stresses that can accumulate and result in loss of health and also in chronic disease. For most, this manifests as a subtle but cumulative decrease in vitality and an increase in symptoms. The information you are about to share help us identify your needs based on your specific response patterns. Thank you very much for taking the time to fill in the form so we can serve you better. Please share as much as you feel comfortable, as everything is potentially important – and feel free to ask questions.

Personal Contact Information

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Numbers: home _____ work/cell _____

(Preferred # for appointment reminders and other messages — no health information will be disclosed)

Birth date: _____ Age: _____ Gender: M F Number of children you have: _____

Occupation: _____ Employer: _____ Employer address: _____

Marital status: Single Married Partnership Separated Divorced
With whom do you live? Spouse Partner Parents Friends Children Alone

Do you wish to receive our health email? Y N Email: _____

Physician/Emergency Contact Information

Do you see a medical doctor? Y N

Name: _____ Telephone: _____ Fax: _____

Emergency Contact: _____ Relationship: _____ Telephone: _____

Foundation for Integrated Health

#109-267 West Esplanade, North Vancouver, British Columbia V7M 1A5 Tel: (604) 988-7080 Fax: (604) 988-7077

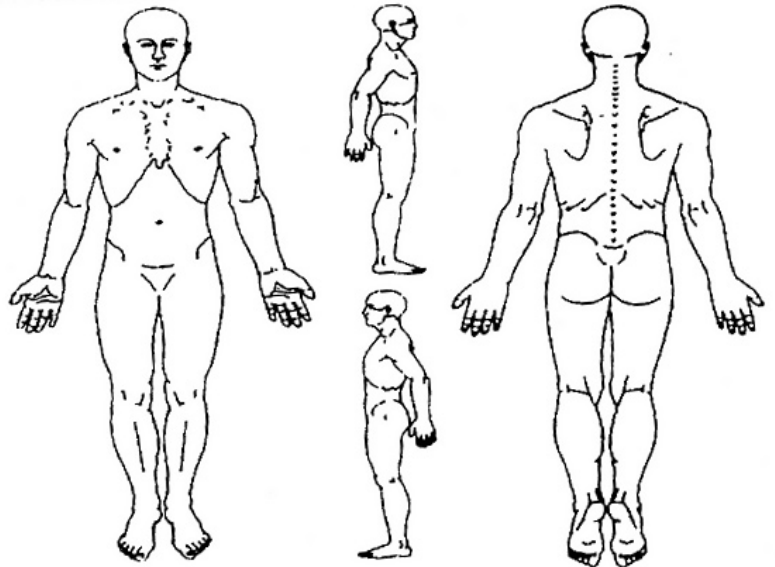
In order to serve you better, you may wish to fax this information to us prior to your appointment.

Chief Complaint

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A = Ache **O** = Other
B = Burning **P** = Pins & Needles
N = Numbness **S** = Stabbing

Please provide any further details.



Medical History

Have you been treated for any conditions in the last year? Y N

If yes, please describe: _____

Date of last physical exam: _____ Is there a chance that you are pregnant? Y N

Have you had any of the following taken? MRI X-rays If yes, where? _____

CT Scans Date: _____

Have you had any of the following tests done? Blood Urine Bone scan Other: _____

Most Recent - Date: _____

Immunizations: Tetanus Pertussis Diphtheria German Measles Measles Mumps Polio

Any reactions to the immunizations? _____

Childhood Illnesses:

Measles Mumps Chickenpox Tuberculosis Rheumatic Fever
 Diabetes Cancer Scarlet Fever German Measles Ear/Throat Infections

Hospitalizations & Surgeries: If you have ever been hospitalized, list reason, and dates.

Adult Illnesses/Injuries: List all serious diseases & injuries for which you have not been hospitalized, including approximate dates.

_____ / ____ / ____

_____ / ____ / ____

Habits:	None	Light	Moderate	Heavy	Symptoms	Yes	No
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience pain every day?	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your symptoms interfere with daily life?	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does pain wake you up at night?	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your symptoms worse during certain times of the day?	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do changes in weather affect your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear orthotics?	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take vitamin supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Activities aggravate symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	eg. _____		
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	eg. _____		
Sweet Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Medications: List all medications that you are or have taken on a regular basis in the last 6 months (include home remedies).

A) _____ B) _____ C) _____

D) _____ E) _____ F) _____

Medications to which you are allergic:

A) _____ B) _____ C) _____

D) _____ E) _____ F) _____

Family History: Do you have a family history of any of the following?

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hayfever/hives	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gall bladder disease	<input type="checkbox"/> Autoimmune diseases	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Goiter	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Polio

Is your father still living? Y: His Age _____ N: Age at time of death _____ Cause of death _____

Is your mother still living? Y: Her Age _____ N: Age at time of death _____ Cause of death _____

Is your sibling still living? Y: Age _____ N: Age at time of death _____ Cause of death _____

Is your sibling still living? Y: Age _____ N: Age at time of death _____ Cause of death _____

Review of Systems

Y = Yes, Present Condition N = No, Never had the Condition P = Problem of the Past

Habits

Alcoholism	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	Anorexia/Bulimia	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Overeating	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	Over the Counter Drugs	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Smoking	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	Recreational Drugs	eg. _____		

Head

Headaches Y P N
Head Injury Y P N

Ears

ringing Y P N
Earaches Y P N

Neck

Lumps Y P N
Goiter Y P N

Skin

Rashes Y P N
Lumps Y P N
Itching Y P N
Eczema/Hives Y P N
Psoriasis Y P N

Musculoskeletal

Joint Pain Y P N
Weakness Y P N
Arthritis Y P N
Poor Posture Y P N
Back Pain Y P N

Eyes

Blurred Vision Y P N
Glasses/Contacts Y P N
Glaucoma Y P N
Spots in Eyes Y P N
Double Vision Y P N

Nose/Sinuses

Stiffness Y P N
Sinus Problems Y P N
Nose Bleeds Y P N

Mouth/Throat

Hoarseness Y P N
Frequent Sore Throat Y P N
Dental Cavities Y P N
Loss of Taste Y P N

Respiratory

Asthma Y P N
Coughing up Blood Y P N
Bronchitis Y P N
Sputum Y P N
Pain with Breathing Y P N
Pleurisy Y P N
Tuberculosis Y P N

Migraine Headaches Y P N
Jaw/TMJ Problems Y P N

Dizziness Y P N
Impaired Hearing Y P N

Swollen Glands Y P N
Pain or Stiffness Y P N

Psoriasis Y P N
Acne/Boils Y P N
Loss of Hair Y P N
Color Changes Y P N
Bruise Easily Y P N

Muscle Spasms Y P N
Sciatica Y P N
Broken Bones Y P N
Spinal Curvatures Y P N
Knee/Foot Y P N

Cataracts Y P N
Eye Pain/Strain Y P N
Tearing/Dryness Y P N
Color Blind Y P N
Dizziness Y P N

Loss of Smell Y P N
Hayfever Y P N
Frequent Colds Y P N

Gum Problems Y P N
Jaw Clicks Y P N
Sore Lips/Tongue Y P N

Wheezing Y P N
Cough Y P N
Difficulty Breathing Y P N
Pneumonia Y P N
Emphysema Y P N
Shortness of Breath Y P N
.....Lying Down Y P N
.....At Night Y P N

Cardiovascular

Angina	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Blood Clots	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Heart Disease	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Fainting	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Irregular Heart Beat	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Chest Pain	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Gastrointestinal

Diarrhea	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Changes in Thirst	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Black Stool	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Jaundice	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Gallbladder Disease	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Abdominal Pain	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Liver Disease	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Urinary

Incontinence	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Painful Urination	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Frequency at Night	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Blood/Peripheral Vascular

Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Thrombophlebitis	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Easy Bruising	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Neurological

Fainting	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Numbness	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Seizures	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Muscle Weakness	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Emotional

Mood Swings	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Tension/Stress	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Depression	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Endocrine

Hypothyroid	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Excessive Thirst	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Cold Intolerance	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Male Reproductive

Hernias	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Discharge or Sores	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Sexual Difficulty	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Venereal Disease	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Testicular Pain	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Arteriosclerosis	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Rheumatic Fever	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Ankle Swelling	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Low Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Pacemaker	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Constipation	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Ulcers	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Spitting up Blood	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Hemorrhoids	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Heartburn	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Blood in Stool	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
How many bowel movements per day? _____			

Frequent Infections	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Kidney Stones	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Cloudy/Smelly	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Cold Hands/Feet	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Leg Pain	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Varicose Veins	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Paralysis	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Tingling	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Loss of Memory	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Loss of Balance	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Fatigue	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Anxiety	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Sleep Problems/Insomnia	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Hyperthyroid	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Excessive Hunger	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Hot Flashes	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Testicular Masses	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Prostate Problems	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Frequent Urination at Night	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N
Premature Ejaculation	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N

Female Reproductive

Age of First Menses _____ Age of Last Menses (if menopausal) _____ Length of Cycle _____
Duration of Menses _____ Date of Last Annual Exam _____

Painful Menses Y P N

Night Sweats Y P N

Ovarian Cysts Y P N

Fertility Issues Y P N

Breasts Tender Y P N

Sexually Active Y P N

Sexual Difficulty Y P N

PMS Y P N

Nipple Discharge Y P N

Do Self Breast Exams Y P N

Endometriosis Y P N

Heavy Flow Y P N

Cervical Dysplasia Y P N

Venereal Disease Y P N

Bleeding between Cycles Y P N

Abnormal Pap Y P N

Breast Lump(s) Y P N

Irregular Cycle Y P N

Birth Control Y P N

If yes, what type? _____

Number of Pregnancies: _____ Number of Live Births: _____ Number of Miscarriages: _____

Number of Abortions: _____

What is your personal definition of Optimal Health?

In terms of your health, what goal(s) do you wish to achieve by coming to our clinic for treatment?

Insurance Information

Extended health insurance? Y N Name of Company: _____

Provider #: _____

Unless specified by a check mark, all information is available to all practitioners in the office.

Chiropractor Acupuncturist Massage Therapist Counsellor Naturopath

Other: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Further more, I understand that this office will complete any necessary forms to assist me in making collection from my insurance carrier and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I also give this office power of attorney to endorse insurance cheques made out to me, to be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also understand that 24 hours notice is needed for cancellation of appointments and that the full fee may be charged and paid for prior to your next appointment.

Patient Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____