

Dr. Caroline Harvey-Smith, Ph.D., N.D.

The Guelph Naturopathic Healthcare Clinic
421 Woolwich Street,
Guelph, ON N1H 3W2
(519) 827-9605

Date _____

Health History Summary

Name _____ Age _____ Birth date D/M/Y _____

Address _____ City _____ Postal _____

Phone (home) _____ Phone (work) _____ Okay to leave message? Y/N E-mail _____

Are you employed? Y/N If so, what do you do? _____

Marital status: Sgl Mar Div Sep Number of children _____

Emergency contact _____ Relation _____

Phone _____ or phone _____

How did you find out about my office? _____

Last physician or health practitioner seen? _____ when? _____

When was your last physical exam? _____ Blood tests done? Yes/No Blood type? _____

Your Current Health Problems

What is your main reason for coming in today?

List in order of importance other health problems that are troubling you:

- 1. _____ & length of time _____
- 2. _____ & length of time _____
- 3. _____ & length of time _____
- 4. _____ & length of time _____

What kind of conventional treatment have you received? _____

Have you seen a: Naturopathic Doctor, Chiropractor, Acupuncturist, Massage therapist, Osteopath?

Other complimentary health care practitioner? _____

What was the therapy and what were the results? _____

Your Health History

The general state of your health is: excellent ___ good ___ avg ___ fair ___ poor ___

What is your current energy level from 1 to 10 (where 10 is the best you have ever felt)?: ___

What is your approximate weight? ___ One year ago? ___ Ideal weight? ___ Height? ___

Please list the 5 most significant, stressful events in your life:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Are any of these situations continuing to impact your life? *Yes/No* Please indicate which ones

Are you currently working with a professional counsellor, psychologist, social worker, pastor, or other therapist?

_____ Have you in the past _____ When? _____

You are currently living with? Spouse ___ partner ___ friends ___ children ___ alone ___

Are you currently in a happy supportive relationship? *Very, Mostly, Somewhat, Not*

Which of the following have you had and indicate “now” (n) or “past” (p):

	n	p		n	p		n	p		n	p
allergies			weight problems			stroke			venereal disease		
asthma			gallstones			cancer			syphilis		
eczema			gout			epilepsy			gonorrhea		
psoriasis			arthritis			migraine			miscarriages		
ear infections			thyroid problems			multiple sclerosis			varicose veins		
strep throat			anemia			pneumonia			broken bones		
hay fever			high blood press			diabetes			numbness/tingling		
measles			rheumatic fever			malaria			cold hands/feet		
mumps			fainting			tuberculosis			visual problems		
chicken pox			poor memory			small pox			warts		
whooping cough			balance problems			polio			mono		
diphtheria			speech problems			gas/bloating			depression		
scarlet fever			ringing in ears			hemorrhoids			child abuse		
sinusitis			jaundice			parasites			physical abuse		
canker sores			hepatitis			rectal bleeding			sexual abuse		
acne			heart disease			herpes			emotional abuse		
tonsillitis			alcoholism			headaches			schizophrenia		

Other: _____

Are there any of these from which you feel you have never been well since? _____

Personal Habits

What do you enjoy most in your life? _____
 What are your main interests or hobbies? _____
 What do you worry about most in your life? _____
 What nurtures you? _____
 Do you exercise? *Yes/ No* If yes, what and how often? _____
 Do you have a religious or spiritual practice? *Yes/ No* _____
 On a scale of 1-10, how would you rate your quality of sleep (10 being great) _____
 Do you have a problem falling asleep? _____ Staying asleep? _____ How much sleep? _____ hours
 How many hours of sleep do you think you need? _____ Do you wake refreshed? _____
 Do you nap or rest horizontally throughout the day? *Yes/ No* For how long? _____
 How is your body temperature compared to others? *Warmer, Cooler, Average* _____
 Do you enjoy your work? *Yes/No* Do you take vacations? *Yes/ No* _____
 How often do you get colds, 'flu, sore throats in a year? _____
 How do you learn? *I read, I listen (lectures), Television, Through stories, Very visual*

Reproductive

Are you sexually active? *Yes/ No* Is this more than one year ago? _____
 Sexual preference: Heterosexual _____ Bisexual _____ Homosexual _____
 Do you use birth control *Yes/ No* What type of birth control? _____

Female

Age of first menses _____ If periods have stopped, at what age did they stop? _____
 Are your periods: *Heavy, medium, light?* What colour is the blood? _____
 Are there any clots? *Yes/ No* Size? _____ Are there any cramps with your period? *Yes/ No*
 Do you have any spotting or bleeding between periods *Yes/ No* Every month? _____
 Do you have any premenstrual symptoms? *water retention, breast tenderness, irritability, depression, headaches, anger, mood swings, crying, bloating, acne, food cravings*
 Other: _____

Number of pregnancies? _____ Number of abortions? _____ Number of miscarriages? _____
 Number of live births? _____ Any problems getting pregnant? _____
 Do you get regular PAP smears? *Yes/ No* Any abnormal PAPs? *Yes/ No*
 Do you do regular breast self exams? *Yes/ No* Have you noticed any breast lumps? *Yes/ No*

Male

How often do you get up at night to urinate? _____ Has this increased recently? *Yes/ No*
 Do you have any problems with impotency? (getting or maintaining an erection) *Yes/ No*
 Do you have any sores on your penis? *Yes/ No* _____
 Do you have any abnormal discharge from the penis? *Yes/ No* _____
 Any venereal diseases? _____
 Any prostate problems? *Yes/ No* Have you had your prostate examined? *Yes/ No* When? _____

Kidneys and Bladder

Have you had a bladder infection? *Yes/ No* How often? _____ How was it treated? _____
 Do you have any burning sensation during or after urination? (*Past, Present, Now*)
 Is your urine (*dark yellow, bright yellow, cloudy, pale or clear, strong odour*)?
 Do you have any difficulty starting or stopping when urinating? *Yes/ No* _____

Perspiration

Do you have any difficulty perspiring? Yes/ No Does you sweat have a strong odour? _____

Do you perspire when exercising? (*lightly, moderately, heavily*)

Do you perspire at times other than when you exercise? Yes/ No When? _____

Digestion and Elimination

Do you have any problems with gas, bloating, or fullness after eating? Yes/ No

How often is this a problem? *Often, sometimes, never* How severe? _____

How often do you have a bowel movement? _____

Do you ever have any (*blood, mucus, undigested food, black stools*)?

Any rectal itching? Yes/ No

Are your stools (*formed or loose*)? Any diarrhea? _____

Ever have alternating constipation and diarrhea? Yes/ No How often? _____

Do you ever have yellow or light coloured stool? Yes/ No

Do you ever have to strain to pass stool Yes/ No How often? _____

Do you pass gas (flatus) frequently? _____ Do you burp frequently? _____

Do your stools have a disagreeable odour? Yes/ No

Have you travelled outside Canada in the last 5 years? Yes/ No If so, where? _____

Have you been camping in the last 5 years? Yes/ No _____

Have you ever fasted? (*Yes/ No juice/water*) _____

Occupational/ household

Is your home damp or moldy at all? Yes/ No

Do you live in the city? Yes/ No

Do you have a specialized air filtration system at home? Yes/ No

Are you currently exposed to second hand smoke? Yes/ No

What do you use for drinking water? (*tap water, bottled water, filtered water, reverse osmosis*)

Is there anything else you feel that I should know about you? _____

*Thank you for taking the time to complete this lengthy questionnaire.
It will be a valuable resource in understanding your health*

Dr. Caroline Harvey-Smith, PhD, N.D.

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DECLARATION AND CONSENT TO TREATMENT

Each person seeking care in this clinic should understand that the practitioner is a naturopath, *not* a medical doctor.

Naturopathy uses non-invasive methods for assessment of bodily dysfunction and a variety of therapeutics for correction. The methods used in this clinic for assessment include laboratory studies, subjective information from the person seeking care as well as objective research. Methods used in this clinic for therapeutics include nutrition and supplementation, homeopathy, botanical medicine, hydrotherapy, detoxification techniques, acupuncture, Bowen therapy and lifestyle modification techniques.

Each person must sign this document
before any treatment will be rendered.

My signature acknowledges that:

1) I understand that:

- I) The treatments that I receive at this office are different from those usually offered by a medical doctor or other licensed health care providers.
- II) I am at liberty to seek or continue to seek medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.
- III) I confirm that Caroline Harvey-Smith, nor anyone else under her control has suggested or recommended that I refrain from seeking or following the advice of other licensed health care provider.

2) I declare that I hereby authorize and consent to treatment.

3) I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, costs of laboratory tests and other fees. I agree to pay the full cost of a visit if I cancel the appointment with less than 24 hours notice. I am aware that these are not covered by OHIP.

I have read, understood and acknowledge the above statements

Date: _____

 (Patient's signature)