

Fredericton Naturopathic Clinic
Drs. Parissa and Judah Bunin, Naturopathic Doctors
288 Union Street, Fredericton, NB E3A 1E5
Ph: 450-9440 Fax: 455-4417

Please complete this form and have it with you for your first visit. It will allow us to use our time together more effectively. All information that you disclose is *confidential and will not be released* without your permission.

Name: _____ Date: _____

Address: _____ Postal Code: _____

Phone: (Home) _____ (Work/Cell) _____ Birth Date: _____

Occupation: _____ Religion: _____

Emergency Contact (Relationship): _____ Telephone: _____

Name of family physician: _____ Telephone: _____

Email (if you would like to receive our newsletters/promotions): _____

How did you hear about this clinic? _____

List reason(s) for your visit in order of importance (include date of onset with each concern):

1. _____
2. _____
3. _____

Are you currently receiving any treatment(s) for these concerns? Have they been effective?

List any medications you are now taking or have taken in the past (include duration, dosage, and frequency): _____

List any vitamin, mineral, or herbal supplements you are taking or have taken in the past (include duration, dosage, and frequency): _____

List any screening tests done recently (bloodwork, x-rays, etc.; include year and results): _____

List any surgeries that you have had: _____

List any hospitalizations, accidents, or serious injuries: _____

List any known allergies or intolerances: _____

Have you ever had any transfusions? Yes No

IMMUNIZATIONS

- | | |
|---|------------------------------------|
| <input type="checkbox"/> Measles, mumps, rubella | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Diphtheria, pertussis, tetanus | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Other _____ | |

Have you had any adverse reactions to any immunizations? Explain: _____

PERSONAL HEALTH HISTORY

General state of health:	Poor	Fair	Good	Excellent
As adult:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As teenager:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As child:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Is there any condition (physical, mental, or emotional) from which you feel that you have not fully recovered? _____

FAMILY HISTORY

Have any family members (including immediate family, grandparents, aunts and uncles) had any of the following conditions:

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Birth Defects |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> Other? _____ |

PAST MEDICAL HISTORY

Have you ever had any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gout | <input type="checkbox"/> Peritonitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Influenza | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Low/High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Venereal Warts |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Yellow Fever |
| <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other? _____ |

LIFESTYLE / ENVIRONMENTAL FACTORS

*Do you consume any of the following **at least once a week**?*

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Artificial Sweeteners | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Carbonated Drinks | <input type="checkbox"/> Distilled Water | <input type="checkbox"/> Fried Foods |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Luncheon Meat | <input type="checkbox"/> Margarine |
| <input type="checkbox"/> Salt (in excess) | <input type="checkbox"/> Tea | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Fast Foods | <input type="checkbox"/> Sweets/Candy |

Do you have any dietary restrictions? Explain. _____

Are you exposed to any chemicals at work or at home? Explain. _____

Are you under excess stress? Explain. _____

How do you relax (include hobbies and leisure activities)? _____

How is your energy level? Rate on a scale of 1 to 10 (1=very low; 10=excellent). _____

Do you exercise regularly (include frequency, duration, and type)? _____

What is your current weight? _____ Maximum? _____ Ideal? _____

Have you ever been physically, sexually, and / or emotionally abused? Explain. _____

Do you use any recreational drugs (include type and frequency)? _____

How old is your residence? _____ Type of heating: _____ Any pets? _____

Type of flooring (hardwood, linoleum, carpets, rugs, etc.): _____

Please use the space below to include any further information regarding your personal health history, family history, past medical history or lifestyle / environmental factors that may be of relevance to your service provider: _____

REVIEW OF SYSTEMS

Please check off any conditions you currently have (indicate with ✓) or have had in the past (indicate with ✕):

General:

- | | |
|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Sleep Difficulties |
| <input type="checkbox"/> Intolerance to heat/cold | <input type="checkbox"/> Fever/Chills |
| <input type="checkbox"/> Fatigue/weakness | <input type="checkbox"/> Significant Weight Change |

Skin:

- | | |
|--|--|
| <input type="checkbox"/> Rash / hives | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Nail Problems/changes | <input type="checkbox"/> Hair problems / changes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Other? _____ | |

Head:

- | | |
|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Ringing/Buzzing in ear(s) |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Frequent Nasal Discharge |
| <input type="checkbox"/> Other? _____ | |

Mouth, throat & neck:

- | | |
|--|---|
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Sore tongue/mouth/gums |
| <input type="checkbox"/> Chronic bad breath | <input type="checkbox"/> Dental cavities |
| <input type="checkbox"/> Speech Difficulties | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Other? _____ |

Respiratory system:

- | | |
|---|---|
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Sputum/phlegm |
| <input type="checkbox"/> Breathing noises (e.g. wheezing) | <input type="checkbox"/> Shortness of breath/difficulty breathing |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Other? _____ | |

Abdomen & gastrointestinal system:

- | | |
|--|--|
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Change in thirst |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Tarry black stool | <input type="checkbox"/> Belching/flatus |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Food Allergies/intolerances | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Change in bowel habit |
| <input type="checkbox"/> Change in stool colour | <input type="checkbox"/> Change in stool odor |
| <input type="checkbox"/> Other? _____ | |

Heart & circulation:

- Murmurs
- Varicose veins
- Swelling of ankles/feet
- Palpitations
- Calf Pain
- Other? _____

Urinary system:

- Urinary frequency
- Sense of urgency
- Dribbling
- Difficulty passing urine
- Frequent infections
- Cloudiness
- Other? _____
- Frequency at night
- Pain
- Hesitancy (difficulty starting)
- Blood in urine
- Change in color
- Retaining water

Female:

Date of first period? _____ Length of full cycle? _____ of bleeding? _____

- Premenstrual Symptoms
- Frequent vaginal infections
- Breast Lumps
- Pregnancies (if so, how many? _____)
- Abortions
- Sexually transmitted infections
- Sexual difficulties/difficulties with libido
- Other gynecological concerns? _____
- Painful periods
- Discharge
- Infertility
- Miscarriages
- Abnormal Pap tests
- Birth Control (if so what type? _____)

Male:

- Infertility
- Sexually transmitted infections
- Rashes
- Varicose veins in scrotum
- Sexual/ libido difficulties
- Discharge
- Pain in genitals
- Other? _____

Musculoskeletal:

- Broken bones
- Joint swelling/pain/stiffness
- Bone pain
- Osteoporosis
- Muscle cramps
- Weakness
- Back pain
- Other? _____

Nervous system:

- Fainting
- Numbness/tingling
- Paralysis
- Other? _____
- Seizures/convulsions
- Loss of balance
- tremors

Signed: _____

Date: _____