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Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_  
 Number of Children and their ages: \_\_\_\_\_  
 Occupation(s): \_\_\_\_\_ Religion/Spiritual Path: \_\_\_\_\_

Please fill in the following pages of questions as best as you can. Put an "X" beside ones you wish to discuss.  
 If you need more room, please use the other side or additional sheets of paper.

A. Primary Problem: \_\_\_\_\_  
 This will be discussed in detail during your first visit.

B. Medical History:

Prenatal influences (if known, e.g. alcohol, coffee, cigarettes, drugs, stress): \_\_\_\_\_  
 Nature of Birth (if known, e.g. trauma, forceps, drugs, natural, etc.): \_\_\_\_\_  
 Breast Fed: \_\_\_\_\_ mos. Health as an infant (colic, earaches, development, etc): \_\_\_\_\_  
 Vaccinations: \_\_\_\_\_ Reactions: \_\_\_\_\_  
 Normal Childhood diseases (mumps, measles, chicken pox): \_\_\_\_\_  
 Any complications? \_\_\_\_\_  
 Chronic problems as a child (lungs, stomach, throat, other): \_\_\_\_\_  
 \_\_\_\_\_  
 Tonsils out? \_\_\_\_\_ Age: \_\_\_\_\_ Complications?: \_\_\_\_\_  
 Specific teenage problems (e.g. acne, weight, development, mono, other): \_\_\_\_\_  
 \_\_\_\_\_

Adult Illnesses	Age:	How severe (hospitalized?)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications taken (including prescription and over-the-counter dugs, excluding supplements). List what, when, for what, for how long and any reactions experienced.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had a nervous breakdown? \_\_\_\_\_  
 If so, when, how severe and what treatment did you receive?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**C. Family History**

Appearance of parents (build, colouring, hair texture, glasses, eye colour)

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Which side of the family do you take after in physical appearance?

Health problems of mother: \_\_\_\_\_

father: \_\_\_\_\_

Check any diseases which have occurred in your family, who had them and at what age. Specify side of family.

\_\_\_ Cancer \_\_\_\_\_

\_\_\_ Diabetes \_\_\_\_\_

\_\_\_ Heart Disease \_\_\_\_\_

\_\_\_ Mental Illness \_\_\_\_\_

\_\_\_ Tuberculosis \_\_\_\_\_

\_\_\_ High Blood Pressure \_\_\_\_\_

\_\_\_ Stroke \_\_\_\_\_

\_\_\_ Thyroid Problems \_\_\_\_\_

\_\_\_ Kidney Disease \_\_\_\_\_

\_\_\_ Arthritis \_\_\_\_\_

\_\_\_ Anemia \_\_\_\_\_

\_\_\_ Headaches \_\_\_\_\_

\_\_\_ Alcoholism \_\_\_\_\_

\_\_\_ Ulcers \_\_\_\_\_

\_\_\_ Anything similar to your symptoms \_\_\_\_\_

**D. Habits**

Diet: normal, junk food, vegetarian, other: \_\_\_\_\_

What is an average day's food intake? Include beverages.

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Do you eat quickly? \_\_\_ Standing up? \_\_\_ On the run? \_\_\_  
at restaurants often? \_\_\_, and if so, what type of restaurants? \_\_\_\_\_

Supplements taken (vitamins, minerals, herbs, etc.) \_\_\_\_\_

Exercise: Type: \_\_\_\_\_ Amount: \_\_\_\_\_

Drugs: Do you use recreational drugs? \_\_\_  
If so, what and how often? \_\_\_\_\_

Cigarettes \_\_\_ How many per day? \_\_\_\_\_

Alcohol \_\_\_ How much per week Beer \_\_\_\_\_

Liquor \_\_\_\_\_

Wine \_\_\_\_\_

Sleep: What are your regular sleeping hours? From \_\_\_\_\_ To \_\_\_\_\_

Do you wake refreshed? \_\_\_ In what mood do you awaken? \_\_\_\_\_

Relaxation: What do you do to relax? \_\_\_\_\_

Have you learned any specific relaxation exercises? \_\_\_\_\_

**E. Ecology**

Type of home: \_\_\_\_\_ Type of heating: \_\_\_\_\_

Any polluting industries near home? \_\_\_

Describe workplace: Windows open? \_\_\_ Chemicals present? \_\_\_ Air Conditioner? \_\_\_

What kind of fabrics do you use? Natural \_\_\_\_\_

Synthetic \_\_\_\_\_

If you have a garden, do you use pesticides? \_\_\_ Herbicides? \_\_\_

Has your home or office recently been painted / varnished, etc.? \_\_\_\_\_

Have you done any travelling recently? \_\_\_ Where? \_\_\_\_\_

Any hobbies using chemicals? \_\_\_\_\_

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Review of symptoms. Check those that apply now or in the past (p). Add any not listed. Use back of page if necessary.

- |   |   |  |  |
|---|---|--|--|
| <p><u>General</u><br/> height ___ weight ___<br/> changes in wt ___<br/> energy level<br/>   hi med low<br/> daily fluctuations ___<br/> fatigue ___<br/> fever ___<br/> <u>Skin</u><br/> rash ___ lumps ___<br/> itching ___ dryness ___<br/> colour change ___<br/> change in hair ___<br/>           nails ___<br/> eczema ___<br/> <u>Blood:</u><br/> abnormal blood<br/>   test ___<br/> bleed / bruise easily ___<br/> anemia ___<br/> allergies ___<br/> <u>Head:</u><br/> headache ___<br/> head injury ___<br/> long labour/forceps at<br/>   birth ___<br/> <u>Eyes:</u><br/> poor vision ___<br/> glasses / contacts ___<br/> sensitive to light ___<br/> last eye exam ___<br/> pain ___<br/> redness ___<br/> discharge ___<br/> excess tearing ___<br/> double vision ___<br/> glaucoma ___<br/> cataracts ___<br/> infections ___<br/> <u>Ears:</u><br/> poor hearing ___<br/> ringing in ears ___<br/> dizziness ___<br/> earaches ___<br/> infection ___<br/> discharge ___<br/> excess ear wax ___<br/> <u>Nose / Sinuses:</u><br/> frequent colds ___<br/> nasal stuffiness ___<br/> hay fever ___<br/> nose bleeds ___<br/> sinus trouble ___</p> | <p><u>Mouth / Throat</u><br/> cavities/root canals ___<br/> poor gums ___<br/> sore tongue ___<br/> cold/canker sores ___<br/> last dental exam ___<br/> coated tongue ___<br/> hoarseness ___<br/> frequent sore throat ___<br/> bitter taste in mouth ___<br/> <u>Nodes:</u><br/> neck/underarms/groin<br/> lumps ___ pain ___<br/> <u>Breasts:</u><br/> lumps ___ pain ___<br/> nipple discharge ___<br/> self exam ___<br/> <u>Lungs:</u><br/> cough ___<br/> sputum ___<br/> wheezing ___<br/> shortness of breath ___<br/> last chest x-ray? ___<br/> difficulty breathing ___<br/>   at night ___<br/> <u>Heart:</u><br/> heart problems ___<br/> high blood pressure ___<br/> rheumatic fever ___<br/> heart murmurs ___<br/> swollen ankles ___<br/> chest pain ___<br/> palpitations ___<br/> last ECG or other tests ___<br/> cholesterol hi/low ___<br/> <u>Urinary:</u><br/> urinations per day ___<br/> urination at night ___<br/> pain ___<br/> blood in urine ___<br/> urgency ___<br/> kidney trouble ___<br/> incontinence ___<br/> infections ___<br/> stones ___<br/> dribbling ___<br/> <u>Endocrine:</u><br/> thyroid trouble ___<br/> heat ___ cold ___<br/>   intolerance<br/> excessive sweating ___<br/> diabetes ___<br/> excessive thirst/hunger<br/>   /urination ___</p> | <p><u>Musculoskeletal</u><br/> joint pains ___<br/> stiffness ___<br/> arthritis ___<br/> bad posture ___<br/> gout ___<br/> backache ___<br/> muscle pain or cramps ___<br/> <u>Circulation:</u><br/> pain in calves after<br/>   exercise ___<br/> leg cramps ___<br/> varicose veins ___<br/> cold extremities ___<br/> thrombophlebitis ___<br/> <u>Digestion:</u><br/> trouble swallowing ___<br/> heartburn ___<br/> nausea ___<br/> appetite up or down ___<br/> vomiting ___ with blood ___<br/> indigestion ___<br/> bowel movements/day ___<br/> rectal bleeding ___<br/> change in bowel<br/>   movements ___<br/> stools pale ___ black ___<br/>   with undigested food ___<br/> small ___ or thin ___<br/> constipation ___<br/> diarrhea ___<br/> abdominal pain ___<br/> difficulty skipping a<br/>   meal ___<br/> food intolerance(s) ___<br/>   cravings ___<br/> excessive belching ___<br/>   bloating ___<br/>   passing gas ___<br/> haemorrhoids ___<br/> jaundice ___<br/> liver or gall bladder<br/>   trouble ___<br/> hepatitis ___<br/> <u>Nervous System:</u><br/> fainting ___<br/> blackouts ___<br/> seizures ___<br/> paralysis ___<br/> local weakness ___<br/> numbness ___<br/> tingling ___<br/> tremors ___<br/> memory ___<br/> strokes ___</p> | <p><u>Female</u><br/> age at first period ___<br/> length of cycle ___<br/> duration of periods ___<br/>   regular? ___<br/> last menstrual period ___<br/> amount of bleeding ___<br/>   between periods ___<br/>   after intercourse ___<br/> painful periods ___<br/> age of menopause ___<br/> symptoms ___<br/> post menopausal ___<br/>   bleeding ___<br/>   discharge ___<br/>   itching ___<br/>   infections ___<br/>   treatment ___<br/>   last pap smear ___<br/>   # of pregnancies ___<br/>   # of deliveries ___<br/>   # of abortions ___<br/>   complications of<br/>    pregnancy ___<br/>   _____<br/> birth control ___<br/> frequency of<br/>   intercourse ___<br/>   sex drive ___<br/>   sexual difficulties ___<br/> <u>Male:</u><br/> discharge from penis ___<br/> sores on penis ___<br/> hernias ___<br/> testicular pains ___<br/> venereal disease ___<br/>   treatment ___<br/> masses ___<br/> prostate problems ___<br/> frequency of<br/>   intercourse ___<br/>   sex drive ___<br/>   sexual difficulties ___<br/> <u>Mind:</u><br/> nervousness ___<br/> tension ___<br/> mood swings ___<br/> depression ___<br/> lack of concentration ___<br/> fuzziness ___<br/> <u>Emotions:</u><br/> excess anger / sadness /<br/>   frustration / mania /<br/>   difficulty feeling or<br/>   expressing emotions<br/>   _____<br/>   _____<br/>   _____</p> |
|---|---|--|--|

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**F. Psychosocial History**

List any important life experiences, in chronological order, especially traumatic events.

Age	Event	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly outline a typical week day. What do you do from waking to sleeping?

Time	Activity	Time	Activity
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who are the most significant others in your life and what are the challenges in each relationship:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Religious or spiritual beliefs \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is your view of the present and your outlook for the future? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How do you feel about yourself? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**G. Summary**

Do you have a preference for the type of naturopathic treatments used?

Are there any treatments you are presently aware of which you would rather not have?

Do you have a supportive environment (home / work) for making lifestyle changes?