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Thank you for taking the time to fill out this form. This information is confidential and important in the assessment of your case.

Date: _____
Full Name: _____
Address: _____ City: _____
Province: _____ Postal code: _____
Phone (H): _____ (W): _____
Age: _____ Date of Birth: _____ Place of birth _____
Occupation: _____ Past occupation: _____
Marital Status: _____ Number of Children: _____
Family Physician: _____ Phone: _____
What are your main health concerns: _____

Medical History:

General:

Date of last physical exam: _____ Weight: _____
Height: _____ Maximum weight: _____
Energy Level (scale 1-10, 10 highest) _____
Blood Type: _____ Do you wake refreshed? _____
Do you smoke? Yes (Presently) _____ Yes, in the past _____ No never _____
Do you drink alcohol? Yes _____ No _____ Number of drinks per week _____
Do you exercise? Yes _____ No _____
Type of exercise and times per week _____
Allergies? No _____ Yes _____ Please list _____
Current medications: _____
Past Medications: _____
Current vitamins and supplements _____
Other treatments tried in the past _____

Review of Systems:

Please circle any of the following conditions you are experiencing now or have had in the past.

Skin: rashes, boils, lumps, hives, itching, dry skin, acne, eczema, night sweats,
other: _____

Head: headache, dizziness, head injury, migraine, other _____

Ears: discharge, earache, ringing, excessive wax, itching, decreased hearing,
other _____

Eyes: glasses/contacts, impaired vision, double vision, redness, discharge, tearing, dryness, cataracts, blurring, light sensitivity, blind spots, difficulty with night vision, glaucoma, itching, other _____

Nose and Sinuses: nose bleeds, obstructions, hay fever, allergies, frequent colds, nose/sinus injury, sinus problems, colds per year _____
other _____

Mouth and throat: hoariness, dry mouth, many sore throats, sores, dental cavities, gum problems, loss of taste,
other: _____

Neck: Stiffness, lumps, goiter, swollen glands, pain,
other: _____

Respiratory: Wheezing, sputum, chest pain, pleurisy, asthma, difficult breathing, pneumonia, emphysema, bronchitis, cough,
other _____

Breasts: Lumps, tenderness, pain,
other: _____

Cardiovascular: Heart disease, ankle swelling, murmurs, chest pain, high blood pressure, angina, palpitations, rheumatics,
others: _____

Gastrointestinal: indigestion, heartburn, belching/gas, bloating, hiatal hernia, difficulty swallowing, change in appetite, jaundice, nausea, vomiting, hemorrhoids, diarrhea, constipation, rectal bleeding, number of bowel movements per day _____
Other: _____

Urinary: pain on urination, increased frequency, blood in urine, bladder infection, kidney stones, inability to urinate,
other: _____

Musculoskeletal: Joint pain or stiffness, muscle spasm or cramps, weakness, numbness/tingling, broken bones, arthritis, backache,
other: _____

Peripheral Vascular: cold hands, cold feet, varicose veins, deep leg pain, thrombophlebitis,
other: _____

Neurological: Fainting, loss of memory, seizures, loss of balance, paralysis, speech problems, muscle weakness, involuntary movements, other: _____

Endocrine: Thyroid disease, diabetes, hormone therapy, low blood sugar, other: _____

Blood/Lymphatic: Anemia, lymph node swelling, easy bruising/bleeding, blood transfusion, other _____

Reproductive: history of venereal disease, sexual difficulties, sexually active, type of birth control? _____
Other: _____

Males: Prostate disease, premature ejaculation, impotent, other: _____

Female: Regular menses, number of days of menstrual cycle _____, menopause, if yes what age? _____, menopause symptoms _____, Age of first menstruation _____, number of pregnancies? _____ Miscarriages? _____ Abortions? _____

Premenstrual syndrome symptoms: Depression, irritability, mood swings, cravings, breast tenderness, weight gain, increased appetite, other _____

Psyco/social: depression, mood swings, emotional/physical abuse, anxiety/nervousness, phobias, alcohol/drug problems, sleep problems, other _____
Have you ever had psychiatric/psychological counseling? _____
How content are you with your life? (1-10, 10 very content) _____
What would you like to change in your life? _____
Do you express your emotions easily? _____

Environment: Do you live in a recently constructed house? _____ Have you been exposed to any chemicals or toxins? _____ Do you have any chemical sensitivities? _____

Family history: Please circle:
cancer, heart disease, high blood pressure, diabetes, arthritis, osteoporosis, asthma, kidney disease, mental illness, thyroid disease, other _____

Childhood diseases: Please circle: Measles, rheumatic fever, diphtheria, mumps, chickenpox, polio, whooping cough? Other: _____
Have you had a bad reaction to a vaccination? Explain _____

Health History: Please list hospitalizations, surgeries, diseases, major accidents, trauma's, etc...
Age: _____
Age: _____
Age: _____
Age: _____
Age: _____

Age: _____

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

Diet Diary: Please record what you have ate and drank for 7 days, including snacks.

Day one

Breakfast _____

Lunch _____

Supper _____

Day two

Breakfast _____

Lunch _____

Supper _____

Day three

Breakfast _____

Lunch _____

Supper _____

Day four

Breakfast _____

Lunch _____

Supper _____

Day five

Breakfast _____

Lunch _____

Supper _____

Day six

Breakfast _____

Lunch _____

Supper _____

Day seven

Breakfast _____

Lunch _____

Supper _____