CROSSROADSCLINICS
NATUROPATHIC
MEDICINE

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Please complete the following form as thoroughly as possible. All information is confidential.

Name: _____ Today's Date: _____

Address:_____ City: _____

Province: _____ Postal Code: _____

Phone: (h)_____ Phone: (cell) _____

E-mail: _____ Date of Birth: _____

Care Card / Personal Health Number:_____

Do you have an extended health care plan? Y_____ N_____

Occupation: _____ Employer: _____

Emergency Contact:_____ Phone: _____

Name(s) of other health care providers: _____

Doctor's address / phone: _____

Date of last visit to Doctor: _____

Are you under the care of a medical specialist? Y_____ N_____

Most Important Health Concerns – Please list:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Do you have any life threatening allergies? Y_____ N_____

Please list any medications and/or vitamins that you are currently taking (include dosage)

_____ _____

_____ _____

_____ _____

What are your goals for this visit?

_____

_____

How did you hear about our clinic (if internet, please specify website)?

_____

Would you like to receive our email newsletters (you can opt out any time)? Y____ N____

Medical History

Please check if you have had any concerns within the last year or of significance in the past.

MUSCULOSKELETAL

Joint Pain	_____	Osteoarthritis	_____
Muscle Pain	_____	Rheumatoid Arthritis	_____
Headaches	_____	Broken Bones	_____

SKIN

Acne	_____	Psoriasis	_____
Eczema	_____	Hives	_____
Moles change	_____	Sunburn	_____
Itching	_____	Rash	_____
Sores	_____	Excessive dryness	_____

EYES

Impaired Vision	_____	Diabetes	_____
Glaucoma	_____	Blurred vision	_____
Macular degeneration	_____	Laser Surgery	_____

EARS

Impaired hearing	_____	Ringing in ears	_____
Earache	_____	History of frequent ear infections	_____

NOSE AND SINUSES

Sinus infections	_____	Nosebleeds	_____
Stuffiness	_____	Hay fever	_____
Sinus pain	_____	Sinus congestion	_____

MOUTH AND THROAT

Sore throat	_____	Trouble swallowing	_____
Gum problems	_____	Strep throat	_____
Tooth pain	_____	Canker sores	_____
Cold sores	_____	Cracked lips	_____

NEUROLOGICAL

Fainting	_____	Seizures	_____
Dizziness	_____	Headaches	_____
Numbness/tingling	_____	Memory Loss	_____

RESPIRATORY

Shortness of breath	_____	Wheezing	_____
Chest congestion	_____	Cough	_____
Sputum	_____	Asthma	_____

CARDIOVASCULAR SYSTEM

High blood pressure	_____	High cholesterol	_____
Angina/Chest Pain	_____	Murmurs	_____
Heart Disease	_____	Heart attack	_____
Heart palpitations	_____	Cold Hands/Feet	_____

History of heart disease in family _____

DIGESTIVE SYSTEM

Difficulty swallowing	_____	Heartburn	_____
Stomach pain	_____	Change in appetite	_____
Nausea	_____	Vomiting	_____
Gas pain	_____	Ulcers	_____

Bowel movements How often? _____/day

Do you have blood in your stool? _____

Constipation	_____	Colitis	_____
Diarrhea	_____	IBS	_____
Crohn's	_____	Gall bladder removal	_____

URINARY

Pain on urination	_____	Increased frequency	_____
Urgency	_____	Inability to hold urine	_____
Frequent infections	_____	Kidney stones	_____

ENDOCRINE

Thyroid problems	_____	Hot flashes	_____
Sugar Cravings	_____	Weight Loss	_____
Weight Gain	_____	Hair Loss	_____

IMMUNE SYSTEM

Frequent colds/flu's	_____	Allergies	_____
Cancer	_____	Auto-Immune Disease	_____

FEMALE REPRODUCTIVE

Irregular cycles	_____	PMS	_____
Breast tenderness	_____	Fatigue with menses	_____
Cramps	_____	Heavy periods	_____
Skipped cycles	_____	Emotional changes	_____

Length of period (number of days) _____ Do you bleed between periods?_____

Frequency of cycle (how many days apart are your cycles?) _____

Have you reached menopause? _____ If yes, at what age? _____

Menopausal Symptoms?

Have you had a mammogram? _____ If yes, when? _____

Are you currently pregnant? _____ No. of pregnancies _____

No. of live births _____ No. of miscarriages _____

No. of abortions _____ Difficulty conceiving _____

Are you currently sexually active? _____ Sexual difficulties _____

History of STD's _____

Abnormal Pap smear _____ if yes, when _____

Date of last PAP smear _____

MALE REPRODUCTIVE

Hernias _____ Testicular masses/pain _____
Sexually active _____ Sexual difficulties _____
History of STD's _____ Discharge or sores _____
Prostate problems _____

MENTAL/EMOTIONAL

Depression _____ Mood swings _____
Anxiety _____ Anger/frustration _____
Insomnia _____ Phobias _____
Change in appetite _____ Panic Attacks _____

Have you ever been treated for any of these?_____

LIFESTYLE

What are your main interests and hobbies?

_____ _____

_____ _____

Do you eat 3 meals a day? _____ How often do you exercise? _____

Do you stay asleep through night? _____ Hours of sleep/night? _____

Do you wake up feeling rested? _____ Do you enjoy your work? _____

MISCELLANEOUS

When was your last treatment with antibiotics? _____

Have you/ do you ever use recreational drugs? _____

Do you drink alcohol? _____ How many drinks/week? _____

Do you smoke? _____ How many cigarettes/day?_____

Drink coffee or tea? _____ How many cups/day? _____

Any other health concerns or symptoms that you would like to mention: