

Health, Lifestyle and Context of Care

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone # (home): _____ (work): _____

E-mail address: _____

Age: _____ Date of Birth: _____

Education: _____

Married: _____ Separated: _____ Divorced: _____ Widowed: _____ Single: _____

Partnership: _____

Live with: Spouse _____ Partner _____ Parents _____ Children _____ Friends _____

Alone _____

Occupation: _____ Hours per week: _____ Retired: _____

Employer: _____ Alberta Health Care #: _____

Work address: _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

Next of Kin or other to reach in an emergency: _____

Relationship: _____ Phone: _____

Address: _____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) Why did you choose to come to this clinic?

- What do you know about our approach?

2) What three expectations do you have from this visit to our clinic?

- What long term expectations do you have from working with our clinic?
- What expectations do you have of me personally as your physician?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health: (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

- 5) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

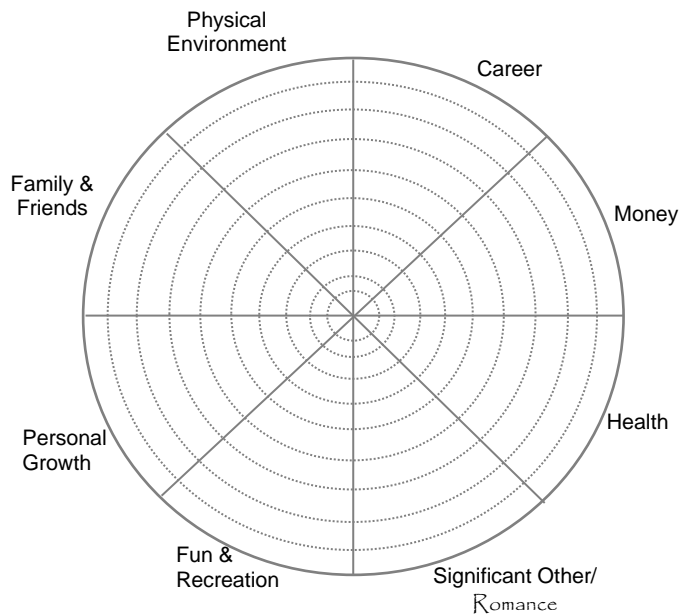
- 6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Wheel of Balance

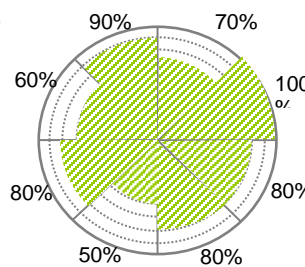
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Example:



Are you currently receiving healthcare? (ie: Medical Doctor, Chiropractor, Acupuncture, Message Therapy, Physiotherapy) Y N

If yes, where and from whom: _____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance and how long they have been an issue:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____

Do you have any known contagious diseases at this time? Y N

If yes, what? _____

Family History

Do you have a family history of any of the following (please circle)?

- | | | | |
|-----------------------|---------------------|---------------|---------------------|
| Cancer | Diabetes | Heart Disease | High Blood Pressure |
| Kidney Disease | Epilepsy | Arthritis | Glaucoma |
| Tuberculosis | Stroke | Anemia | Mental Illness |
| Asthma/Hayfever/Hives | Auto Immune Disease | Addictions | |

Any other relevant family history? _____

What is your heritage: _____

Childhood Illnesses

Please circle whether you had any of these as a child:

- | | | |
|---------------|------------|-----------------|
| Scarlet fever | Diphtheria | Rheumatic fever |
| Mumps | Measles | German measles |

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_____ year: _____ year: _____
 _____ year: _____ year: _____
 _____ year: _____ year: _____

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____
 Any foods? _____
 Any environmental or chemicals? _____

Current Medications

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking and current dosage: (eg: Jamieson D3, 1000iu)

1) _____ 5) _____
 2) _____ 6) _____
 3) _____ 7) _____
 4) _____ 8) _____

General

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.
 Maximum Weight : _____ When: _____
 When during the day is your energy the best? _____ worst? _____

Typical Food Intake

(eg: 1 cup tea, 2 pieces of buttered toast)

Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____
 To drink: _____

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now **N**=Never had **P**=Significant problem in the past

Habits

Main interests and hobbies? _____

Do you exercise? Y N _____

If yes, what kind? _____ How often? _____

Average 6-8 hrs. sleep?	Y N	Enjoy Your work? Y N
Sleep well?	Y N	Take vacations? Y N
Awaken rested?	Y N	Spend time outside? Y N
Problem falling asleep?	Y N	
Problem staying asleep?	Y N	
Have a supportive relationship?	Y N	Watch television? Y N
Have a history of abuse?	Y N	how many hours? _____
Any major traumas?	Y N P	Read? Y N
Use recreational drugs?	Y N P	how many hours? _____
Been treated for drug dependence?	Y N P	
Use alcoholic beverages?	Y N P	Do you eat 3 meals a day? Y N
Treated for alcoholism?	Y N P	Do you go on diets often? Y N
Do you use tobacco?	Y N P	Do you eat out often? Y N
Smoked previously?	Y N P	Do you drink coffee? Y N P
How many years? _____		Drink black/green tea? Y N P
How many packs per day? _____		Do you drink sodas? Y N P
When did you quit? _____		Do you eat refined sugar? Y N P
		Do you add salt? Y N P

Do you have a religious or spiritual practice? Y N

If yes, what? _____

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REVIEW OF SYSTEMS

Mental / Emotional

Treated for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Tension?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P

Immune

Reactions to immunizations?	Y N P	Herpes / Cold Sores?	Y N P
Chronic Fatigue Syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

Endocrine

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Skin

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P
Color Change?	Y N P	Perpetual Hair Loss?	Y N P
Lumps?	Y N P	Night Sweats?	Y N P

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P

Eyes

Spots in Eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

Ears

Impaired hearing?	Y N P	ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P

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Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hayfever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	“ “ “ lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic Fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? _____ Is this a change? _____	
Gall Bladder disease?	Y N P	Black stools?	Y N P
Liver Disease?	Y N P	Blood in stool?	Y N P
Hemorrhoids?	Y N P		
Parasites / Worms?	Y N P		

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Urinary

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Male Reproduction

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Venereal disease?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N P	Chlamydia?	Y N P
Gonorrhea	Y N P		
Impotence?	Y N P	Condyloma?	Y N P
Premature ejaculation?	Y N P	Herpes?	Y N P
Birth control? Type? _____		Syphilis?	Y N P

Female Reproduction / Breasts

Age of first menses? _____	Date of last annual exam/ PAP _____		
Age of last menses? (if menopausal) _____	Are cycles regular?	Y N P	
Length of cycle? _____ days	Bleeding between cycles?	Y N P	
Duration of menses? _____ days	Pain during intercourse?	Y N P	
Painful menses?	Clotting?	Y N P	
Heavy or excessive flow?	Discharge?	Y N P	
PMS?	Birth control?	Y N P	
If yes, what are your symptoms? _____ _____	What type? _____		
	Number of pregnancies: _____		
	Number of live births: _____		
	Number of miscarriages: _____		
	Number of abortions: _____		
Endometriosis?	Y N P	Menopausal symptoms?	Y N P
Ovarian cysts?	Y N P	Abnormal PAP?	Y N P
Difficulty conceiving?	Y N P	Chlamydia?	Y N P
Cervical Dysplasia?	Y N P	Condyloma?	Y N P
Sexual difficulties?	Y N P	Syphilis?	Y N P
Gonorrhea?	Y N P		
Herpes?	Y N P		
Are you sexually active?	Y N P		
Do you do breast self exams	Y N P		
Breast lumps?	Y N P		
Breast pain/tenderness?	Y N P	Nipple discharge?	Y N P

Is there anything else you would like to add or comment on?

Thank you for your time and effort. Our team looks forward to providing you with the best possible care.