FALL RIVER
COLLABORATIVE HEALTH CARE

Naturopath Initial form

Name:_____
Last name First name Middle initial Pronoun (He/she/They)

DOB:_____
Year Month Day Height Weight

Address:_____
Street City Postal Code

Phone Number:_____
Home Cell Work

Email Address: _____

Occupation:_____Employer:_____

Medical Doctor:_____Health Card Number:_____

What is your major complaint today?_____

_____

How long have you had this condition?_____

Describe the onset of this condition:_____

_____

Current weight:____Weight a year ago:____Maximum weight:____Current height:____

Please list any allergies or sensitivities, including medications, environmental and foods:

_____

_____

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Medical History: Please list any serious conditions, illnesses, and injuries along with dates:

_____

_____

Family History: Indicate if your close relatives suffer from any of the following.

( ) Allergies ( ) Asthma ( ) Autoimmune conditions (Psoriasis, Crohn's/Colitis, Lupus, RA, MS etc)
( ) Depression ( ) Cancer ( ) Heart Disease ( ) High Blood Pressure ( ) High Cholesterol ( ) Kidney Disease
( ) Digestive issues ( ) Mental Illness ( ) Substance Abuse ( ) Stroke

Naturopathic History

Have you seen a Naturopathic Doctor before?

( ) Yes ( ) No

If yes, how long has it been since your last treatment?_____

If yes, who did you see?_____

General Health

Please list any surgeries and/or hospitalizations and approximate dates:

_____

_____

_____

List any current medications (including birth control) and doses in possible:

_____

_____

_____

List any current supplements:

_____

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Do you frequently take any of the following:

( ) Aspirin ( ) Tylenol ( ) Advil ( ) Naproxen/Aleve ( ) Muscle relaxants ( ) Laxatives ( ) Antiacids
( ) Cough Remedies ( ) Asthma Inhaler ( ) Diet Pills

If you Smoke (including marijuana and cigars), indicate quantity:_____

If you drink alcohol, indicate quantity:_____

If you consume caffeine, indicate quantity:_____

Are you currently experiencing any of the following:

( ) Pain that wakes you from sleep ( ) Recent fever/infection ( ) Night sweats ( ) Unexplainable weight loss
( ) Unexplainable weight gain ( ) extreme fatigue ( ) Fainting/Dizziness ( ) Numbness into face
( ) shortness of breath ( ) Rashes or skin issues ( ) swollen glands

Environmental Factors

What are your hobbies?_____

_____

_____

Please list the most significant stressful events in your life, from most recent to most distant. Do any of these still affect your life now?
_____

_____

_____

Are you regularly exposed to smoke?

( ) Yes ( ) No

Do you receive any type of mental Health services (Counselling, Psychiatric services etc?)

( ) Yes ( ) No

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Check if you have had any of the following:

Skin/Allergies

( ) Allergies ( ) Bruise easily ( ) psoriasis ( ) Eczema ( ) Rashes, Hives or irritation ( ) Shingles
( ) Fungal infection ( ) skin sensitivities ( ) Cancer ( ) Acne ( ) Itching ( ) Colour changes
( ) Temperature changes ( ) Lumps

Neuromuscular skeletal

( ) Headaches/Migraines ( ) Grinding/clenching teeth ( ) Stiff neck ( ) Back Pain ( ) Swollen joints
( ) Numbness/Tingling ( ) Tremors ( ) Scoliosis ( ) Osteo Arthritis ( ) Rheumatoid Arthritis
( ) Psoriatic Arthritis ( ) Osteoporosis ( ) Carpal Tunnel ( ) Muscle/cramps/Spasms
( ) Excessively cold hands/feet

Cardiovascular

( ) Heart attack ( ) High blood pressure ( ) Low blood pressure ( ) High Cholesterol ( ) Angina ( ) Stroke
( ) TIA ( ) Blood Clots ( ) Varicose veins ( ) Irregular heart beat/murmur ( ) Heart Palpitations
( ) Bypass Surgery ( ) Clotting issues ( ) Pacemaker ( ) Chest pain ( ) Swelling in ankles ( ) Hemophilia
( ) Rheumatic fever ( ) Past Transfusions

Respiratory

( ) Asthma ( ) Bronchitis ( ) Chronic cough ( ) Cough up mucus/blood ( ) COPD ( ) Emphysema
( ) Difficulty/pain with breathing ( ) Chest pain ( ) Wheezing ( ) Pneumonia ( ) Tuberculosis
( ) Shortness of breath

Abdomen and Gastrointestinal

( ) IBS ( ) Crohn's ( ) Colitis ( ) Diverticulitis ( ) Reflux/Indigestion/Heartburn ( ) Ulcers ( ) Food sensitivities
( ) Celiac ( ) Hernia ( ) Gall stones ( ) Constipation ( ) Gas or bloating ( ) Diarrhea ( ) Nausea/vomiting

Urinary

( ) Frequent urination ( ) Inability to control urination ( ) Inability to fully void ( ) Urgency ( ) Hesitancy ( ) Strong smell to urine ( ) Regular bladder/kidney infections ( ) Kidney stones ( ) Blood in urine ( ) Pain with urinating ( ) Other

Mental Health

( ) Depression ( ) Anxiety ( ) OCD ( ) Seasonal Affective Disorder ( ) Personality Disorder ( ) Suicidal
( )Schizophrenic ( )Other

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Ear Nose and Throat

( ) Allergies ( ) Hayfever ( ) Ear Infections ( ) Trouble swallowing ( ) Sinus problems ( ) Loss of smell
( )Loss of hearing ( )Strep throat ( )Impaired Hearing ( )Vertigo ( )Frequent colds ( )Nose bleeds ( )Swollen glands

Eyes

( ) Cataracts ( ) Discharge ( ) Double Vision ( ) Dryness ( ) Eye pain ( )Glasses/contacts ( )Glaucoma
( )Impaired vision

Endocrine

( ) Cold/hot intolerance ( ) Excessive thirst/hunger ( ) Hormone therapy ( ) Hyper/Hypoglycemia
( ) Thyroid disfunction

Male reproductive

( ) Enlarged prostate ( ) Hernias ( ) Testicular pain ( ) Infertility

Breasts

( ) Fibrocystic Breasts ( ) Lumps ( ) Nipple discharge ( ) Pain Tenderness

Female Reproduction

( ) Pregnant ( ) Miscarriage ( ) C-section ( ) Irregular or painful periods ( ) Pre, peri, or post menopausal
( ) Infertility ( ) Pain with intercourse ( ) Endometriosis ( ) PCOS ( ) Vaginal discharge ( ) Excessive flow

Privacy Policy

We are committed to protecting the privacy of all individuals providing personal and medical information to us.

Signed:_____Date:_____