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Adult Patient Health History Questionnaire

Natural medicine health care works best when the physician completely understands the person's physical, mental, and emotional conditions. The information you provide helps us understand your needs and how to help you reach your health goals. Please write legibly, and mark anything you may have questions about.

Thank you for your time and thoroughness, and welcome to your journey to better health!

Name: _____Date: _____
Address:_____
City: _____Province: _____ Postal Code: _____
Phone (home, cell, work): _____
Do we have your permission to leave confidential messages on your voicemail?:_____
E-mail: _____Age: ____ Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____
Relationship of emergency contact person to you: _____
If the patient is a minor (under the age of 18), please provide the name(s) and signature(s) of parent(s)/legal guardian(s):_____
Occupation & employer: _____
Employer's address _____Hours per week: _____
Live with: □Spouse □Partner □Parents □Children □Friends □ Alone
□ Other (pets, etc) _____
How did you hear about our clinic?_____
Who can we thank for referring you to us (name and phone number if applicable)? _____
_____
When was your last visit to a clinic or hospital? Why? _____
_____
What are your most important health concerns currently? _____
_____
_____
To what extent do these health issues interfere with your daily activities (work, sleep, eating, physical movement, etc)? _____
_____
Are there others in your family with the same or similar conditions? _____
What are your long-term health goals (physically, mentally, emotionally, spiritually)? _____
_____
_____
What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Please circle):

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support and strengthen your health? _____

_____

_____

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? _____

_____

_____

_____

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to therapy and guidance provided here? _____

_____

_____

What do you believe to be the root cause(s) of your health condition(s)? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify having caused or aggravated your health problems? _____

_____

_____

Have you previously sought other forms of healthcare for your health problems (MD, DO, acupuncture, chiropractic, naturopathy, homeopathy, massage, etc)? How was your experience?

_____

_____

What hospitalization or surgeries have you had? When and why? _____

_____

_____

Do you have allergies to drugs, food, airborne (dust, mold, pollen), or other allergens? What happens when you have a reaction? _____

_____

Do you smoke/use tobacco? How much/how long/when did you quit?_____

_____

Do you use any other drugs (alcohol, marijuana, etc)? _____

Family history:

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

alcoholism allergies anemia arthritis asthma cancer cataracts

diabetes epilepsy gallbladder disease glaucoma goiter hayfever/hives

heart disease high blood pressure HIV/AIDS kidney disease liver disease

mental illness stroke tuberculosis

Father's health status, age, (or cause/age of death):_____

Mother's health status, age, (or cause/age of death):_____

Siblings health status, age(s):_____

Childhood Health:
Please circle if you have/had any of the following conditions as a child/adolescent:
chicken pox diphtheria measles mumps pertussis rubella polio

Please list any vaccinations/immunizations you have had: _____
_____
_____

Past medical history:
Please circle any of the following conditions you have had **in the past:**

Appendicitis alcoholism arthritis anemia malaria epilepsy cancer
Tuberculosis diabetes heart disease high cholesterol mental illness pleurisy
Pneumonia sexually transmitted infections goiter low back pain rheumatic fever
Influenza mononucleosis chronic viral infections chronic pain or fatigue eczema
Hepatitis others _____

Review of systems:
Please circle any of the following issues or conditions that you **currently have:**

headaches/migraines head injury TMJ/jaw pain ringing in the ears dizziness earaches
ear infections impaired hearing goiter swollen lymph nodes or glands neck pain/stiffness
blurred vision eye strain cataracts glaucoma color-blindness prescriptive lenses
nasal congestion hayfever or allergies sinus infections loss of smell frequent colds
sore throats dental cavities vocal hoarseness gum disease coldsores
Asthma cough shortness of breath coughing up blood or sputum difficulty breathing
chest pain heart palpitations blood clots murmur fainting high/low blood pressure
skin rashes itching acne hair loss eczema hives night sweats
joint pains muscle spasms arthritis muscle weakness sciatica fractures
diarrhea constipation ulcers jaundice heartburn gas/bloating hemorrhoids
appetite changes urinary incontinence kidney stones painful urination
frequent urination discharge anemia cold hands/feet easy bruising
varicose veins intolerance to temperature extremes seizures memory loss
numbness/tingling anxiety depression mood swings hernias
prostate issues sexual difficulties breast tenderness or lumps menstrual pain PMS

MEDICATION / SUPPLEMENT LIST

If you are currently taking any medications (prescriptive or over-the-counter), supplements, herbs, vitamins, birth control pills, nasal sprays, acid blockers, etc, please list each item, dosages, and adverse reactions.

Pharmacy name, phone number _____
Drug allergies? _____

Start date	End date	Medication name	Dosage	Frequency	Adverse effects

Consent for Naturopathic Treatment

A naturopathic doctor, Dr. Erica Volk, will conduct a detailed case history and physical exam, as well as utilize various blood, salivary and/or urinary laboratory reports as part of the treatment work-up. Treatments that may be prescribed include but are not limited to: nutrition, herbs, homeopathy, naturopathic manipulation, hydrotherapy, lifestyle counselling, and injection therapies. All patients agree to inform the practitioner of all health conditions and changes, as well as new conditions throughout treatment. All female patients must alert the health care practitioner if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

As a patient of Dr. Erica Volk, ND, I have read the information and understand that the form of medical care is based on naturopathic principles and practices. I also recognize the potential risks that include, but are not limited to, depending on the treatments administered: aggravation of pre-existing symptoms; allergic reactions to supplements, herbs, or injectables; pain; fainting, dizziness, itching, numbness, infection, soreness or bruising from venipuncture or injections; muscle strains and sprains from spinal manipulations; inconvenience of lifestyle changes; scar or wound enlargement, keloid formation, temporary or permanent alteration in sensation, discolouration, the need for additional surgery, embolism, injury to nerves, pneumothorax (air on the outside of the lung), or paralysis from injection therapies; no benefit from treatments; or other serious or debilitating injuries. I also recognize that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may or could arise from the Treatments. *NB: every effort is made to minimize these risks. I understand that the results are not guaranteed.

I understand that selected elements of treatments are undergoing research and evaluation within the scientific and medical community, and are not considered conventional care or treatment. I understand that the treatments are needed to be followed as recommended. Also, no promises or guarantees have been made regarding anticipated outcome of any tests or procedures.

I have read and understood the above statement, accept the risk and thereby consent to treatment. I also confirm that I have the ability to accept or reject this care of my own free will and choice at any time. I also verify that I am not an agent of any private, local, county, provincial, or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

Name:_____Date: _____

Signature: _____

Policies

Privacy and Sharing of Information: I authorize Dr. Erica Volk to collect my personal and medical information for the purpose of providing naturopathic medical treatment. I understand that a record will be kept of the health services provided to me. I authorize the clinic to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission or as required by law. I have read and agree with the above statement. _____ (Initial)

Cancellation Policy: I am required to provide 24 hours notice if I need to change or cancel my appointment. If I provide less than 24 hours notice, or miss my appointment, I will be charged a cancellation fee which may be any fee up to but not exceeding the full appointment cost. Unforeseen circumstances and emergencies will be considered on a case by case basis. _____ (Initial)

Payment Policy: I agree to pay for any fees for services, cost of supplements and medicines, cost of laboratory tests, or other fees out of pocket at the time of the visit. It is my responsibility to ask about fees for service before or during my first appointment. I understand that the terms of this office are to pay the balance within 30 days of the most recent statement. Balances not paid within 30 days may be charged a rebilling fee. If a balance is not paid within 90 days, and my account is not sent to a collection agency, I understand that I am responsible for any additional collection and/or attorney fees related to my delinquency, and I hereby authorize my provider(s) to release information necessary to secure payment. Discounts and/or payment extension plans are only offered on an individual basis, based on financial need, and it is my responsibility to request any discounts. Payments for office visits, procedures, medicinary items, etc., can be made using cash, Visa, Mastercard, American Express, Discover, or debit. When possible, the staff at Momentum Health will assist me with direct billing, but it may be my responsibility to submit my receipts for reimbursement. _____ (Initial)

Medicinary/Pharmacy Policy: It is my full responsibility to pay for any medicines or pharmacy items that I choose to purchase at the time of the visit or at the time of pick up. I understand that items purchased cannot be returned or refunded unless the item is expired or defective. If I have an adverse reaction to, or simply cannot tolerate, a particular medicine recommended or prescribed to me, it is my responsibility to notify my provider(s) as soon as possible, so the treatment can be re-evaluated. _____ (Initial)

Minor Policy: The minor patient's parent(s) or legal guardian(s) is/are fully responsible for payments of fees for services, costs of supplements and medicines, cost of laboratory tests, or other fees out of pocket at the time of the visit. All minors must be accompanied by their parent(s) or legal guardian(s) during the full office visit or appointment, unless otherwise agreed upon by the provider(s), the patient(s), and their parents/guardians. _____ (Initial)

I have read, understood, and am in agreement with the above statements.

Name: _____ Date: _____

Signature:_____