



Inspired Health Naturopathic Clinic

385 Lagoon Road Colwood, BC V9C 1T5 Phone: (250)478-4734

Dr. Trevorrow and her staff are delighted to welcome you to our clinic! Please fill out the following personal information and health history to better help us assist you in meeting your health goals.

Personal Information (please print):

Name: _____ Gender: M F Date of First Visit: _____

Address: _____

City: _____ Province/State: _____ Postal code: _____

Phone (home): _____ (work): _____

Email address: _____ May we correspond with you at this address? Y N

Date of Birth: _____ BC Health Plan # : _____

Occupation: _____ Employer: _____

Are there other family members seen here? _____

Emergency contact person: _____ Work phone no.: _____

Relationship to patient: _____ Home phone no.: _____

How did you hear about our clinic? _____

Health Overview:

Current General Practitioner (MD): _____ none at present

GP address/phone: _____

When was your last visit to your GP?: _____

What was the reason? _____

Are you seeing a medical specialist? Yes _____ No _____

If yes, for what reason? _____

Name/address/phone of specialist: _____

What is the main reason for your visit today? _____

What are your most important health concerns? List as many as you can in order of importance:

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

What questions do you have that you would like answered? _____

What kind of help would you like to be provided? _____

I hereby consent to treatment by the practitioners of Inspired Health Clinic. I understand that I am responsible for any treatment and pharmacy costs at the time of my visit. I also understand that I am responsible for paying a \$25.00 fee if I do not give 24 hours' notice of cancellation.

Signature: _____ Today's date: _____

(Parent or guardian if a minor)

Health History Questionnaire:

Note: this is a confidential record of your medical history and will be kept secured in our office. Information contained here will not be related to any person except when you have authorized us in writing to do so. Please complete this questionnaire as thoroughly as possible. Thank you.

General:

Height: _____ Weight _____ lbs/kg. Has this changed recently? Y N

If so, has it increased or decreased in the last year? _____ By how much? _____

When during the day is your energy the best? _____ The worst? _____

Allergies/sensitivities:

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental chemicals, smoke, perfume etc.? _____

Are there any foods/food groups that you avoid? Yes _____ No _____

If 'yes', which ones? _____

Current medications: please list any prescription medications (from your doctor) or over the counter medications (such as aspirin, cold medicines, antacids) you are taking:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Please list any supplements (vitamins/minerals/herbs etc) you are taking currently:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Hospitalizations, surgeries, imaging:

What hospitalizations or surgeries, x-rays, CT or MRI scans, EEG or EKG's have you had?

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

Diet: Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	Usual Breakfast	Ö		Usual Lunch	Ö		Usual Dinner	Ö
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	

s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of black tea/hot chocolate	
f.	Cups of decaffeinated coffee/tea	
h.	Sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	

Are you on a special diet? Yes ___ No ___

___ ovo-lacto

___ vegetarian

___ other (describe):

___ diabetic

___ vegan

___ dairy restricted

___ blood type diet

Is there anything special about your diet that we should know?

Yes ___ No ___

If yes, please explain: _____

Do you feel much worse when you eat a lot of :

- | | |
|-------------------------------------------------------------|---------------------------------|
| _____ high fat foods | _____ refined sugar (junk food) |
| _____ high protein foods | _____ fried foods |
| _____ high carbohydrate foods
(breads, pastas, potatoes) | _____ 1 or 2 alcoholic drinks |
| | _____ other _____ |

Do you feel much better when you eat a lot of :

- | | |
|-------------------------------------------------------------|---------------------------------|
| _____ high fat foods | _____ refined sugar (junk food) |
| _____ high protein foods | _____ fried foods |
| _____ high carbohydrate foods
(breads, pastas, potatoes) | _____ 1 or 2 alcoholic drinks |
| | _____ other _____ |

Does skipping a meal greatly affect your symptoms? Yes____ No____

Have you ever had a food that you craved or really "binged" on over a period of time?
Food craving may be an indicator that you may be allergic to that food. Yes____ No____

If yes, what food(s)? _____

Lifestyle:

Have you or your family recently experienced any major life changes? Yes____ No____

If yes, please comment: _____

Have you experienced any major losses in life? Yes____ No____

If so, please comment: _____

Have you ever used alcohol? Yes____ No____

- If yes, how often do you now drink alcohol?
- ___ No longer drinking alcohol
 - ___ Average 1-3 drinks per week
 - ___ Average 4-6 drinks per week
 - ___ Average 7-10 drinks per week
 - ___ Average >10 drinks per week

Have you ever had a problem with alcohol? Yes____ No____

If yes, please indicate time period (month/year): from _____ to _____.

Have you ever used recreational drugs? Yes____ No____

Have you ever used tobacco? Yes____ No____

If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.

How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your spouse/partner					
h. With your children					
i. With your parents					

Hobbies and leisure activities: _____

Exercise: Do you exercise regularly? Yes____ No____

If so, how many times a week?

When you exercise, how long is each session?

1. ____ 1x

1. ____ ≤15 min

2. ____ 2x

2. ____ 16-30 min

3. ____ 3x

3. ____ 31-45 min

4. ____ 4x or more

4. ____ > 45 min

What type of exercise is it? _____

Medical history--please circle conditions you have had in the past:

ILLNESS/CONDITION	WHEN?	DESCRIBE:
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Depression/mood disorder		
Diabetes		
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
Gout		
Heart attack/Angina		
Heart failure		
Hepatitis		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel		
Kidney stones		
Mononucleosis		
Pneumonia		

Rheumatic fever		
Sinusitis		
Sleep apnea		
Stroke		
Thyroid disease		
Other (describe)		

Family Medical History:

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

Cancer	Diabetes	Heart disease
Kidney disease	Epilepsy	High blood pressure
Tuberculosis	Stroke	High cholesterol
Asthma/hay fever/hives	Arthritis	anemia
Mood problems	Ulcers	Crohn's disease/ulcerative colitis

Any other relevant family history? _____

Thank you for taking the time to fill out this form.

--Dr. Marianne