Fredericton Naturopathic Clinic
Drs. Parissa and Judah Bunin, Naturopathic Doctors
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Please complete this form and have it with you for your first visit. It will allow us to use our time together more effectively. All information that you disclose is *confidential and will not be released* without your permission.

Name:_____ Date:_____

Address:_____ Postal Code:_____

Phone: (Home)_____ (Work/Cell)_____ Birth Date:_____

Occupation:_____ Religion:_____

Emergency Contact (Relationship):_____ Telephone:_____

Name of family physician: _____ Telephone: _____

Email (if you would like to receive our newsletters/promotions): _____

How did you hear about this clinic?_____

List reason(s) for your visit in order of importance (include date of onset with each concern):

1. _____
2. _____
3. _____

Are you currently receiving any treatment(s) for these concerns? Have they been effective?

_____

_____

List any medications you are now taking or have taken in the past (include duration, dosage, and frequency): _____

_____

List any vitamin, mineral, or herbal supplements you are taking or have taken in the past (include duration, dosage, and frequency): _____

_____

List any screening tests done recently (bloodwork, x-rays, etc.; include year and results): _____

_____

List any surgeries that you have had: _____

_____

List any hospitalizations, accidents, or serious injuries: _____

_____

List any known allergies or intolerances: _____
Have you ever had any transfusions? o Yes o No

IMMUNIZATIONS

- ❑ Measles, mumps, rubella
- ❑ Diphtheria, pertussis, tetanus
- ❑ Polio
- ❑ Other _____
- ❑ Influenza
- ❑ Small Pox
- ❑ Hepatitis

Have you had any adverse reactions to any immunizations? Explain: _____

_____

PERSONAL HEALTH HISTORY

General state of health:	**Poor**	**Fair**	**Good**	**Excellent**
As adult:	o	o	o	o
As teenager:	o	o	o	o
As child:	o	o	o	o

Is there any condition (physical, mental, or emotional) from which you feel that you have not fully recovered? _____

FAMILY HISTORY

Have any family members (including immediate family, grandparents, aunts and uncles) had any of the following conditions:

- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Heart Disease
- ❑ Hypertension
- ❑ Stroke
- ❑ Kidney Disease
- ❑ Headaches
- ❑ Epilepsy
- ❑ Mental Illness
- ❑ Alcoholism
- ❑ Drug Addiction
- ❑ Allergies
- ❑ Cancer
- ❑ Arthritis
- ❑ Asthma
- ❑ Birth Defects
- ❑ Anemia
- ❑ Other?_____

PAST MEDICAL HISTORY

Have you ever had any of the following?

- ❑ Abscesses
- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Cold Sores
- ❑ Depression
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Frequent Colds
- ❑ Gall Stones
- ❑ Genital Herpes
- ❑ Gonorrhea
- ❑ Gout
- ❑ Hayfever
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ HIV
- ❑ Influenza
- ❑ Kidney Disease
- ❑ Leukemia
- ❑ Low/High Blood Pressure
- ❑ Lyme Disease
- ❑ Malaria
- ❑ Measles
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Parasites
- ❑ Peritonitis
- ❑ Pneumonia
- ❑ Pleurisy
- ❑ Pelvic Inflammatory Disease
- ❑ Prostatitis
- ❑ Strep Throat
- ❑ Syphilis
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid
- ❑ Venereal Warts
- ❑ Whooping Cough
- ❑ Worms
- ❑ Yellow Fever
- ❑ Other? _____

LIFESTYLE / ENVIRONMENTAL FACTORS

*Do you consume any of the following **at least once a week**?*

- ❑ Antacids
- ❑ Carbonated Drinks
- ❑ Laxatives
- ❑ Salt (in excess)
- ❑ Coffee
- ❑ Artificial Sweeteners
- ❑ Distilled Water
- ❑ Luncheon Meat
- ❑ Tea
- ❑ Fast Foods
- ❑ Alcohol
- ❑ Fried Foods
- ❑ Margarine
- ❑ Tobacco
- ❑ Sweets/Candy

Do you have any dietary restrictions? Explain. _____

_____

Are you exposed to any chemicals at work or at home? Explain. _____

_____

Are you under excess stress? Explain. _____

_____

How do you relax (include hobbies and leisure activities)? _____

_____

How is your energy level? Rate on a scale of 1 to 10 (1=very low; 10=excellent). _____

Do you exercise regularly (include frequency, duration, and type)? _____

_____

What is your current weight? _____ Maximum? _____ Ideal? _____

Have you ever been physically, sexually, and / or emotionally abused? Explain. _____

_____

Do you use any recreational drugs (include type and frequency)? _____

How old is your residence? _____ Type of heating: _____ Any pets? _____

Type of flooring (hardwood, linoleum, carpets, rugs, etc.): _____

Please use the space below to include any further information regarding your personal health history, family history, past medical history or lifestyle / environmental factors that may be of relevance to your service provider: _____

_____

_____

_____

_____

REVIEW OF SYSTEMS

Please check off any conditions you currently have (indicate with ✓) *or have had in the past* (indicate with ×):

General:

- ❑ Poor appetite
- ❑ Intolerance to heat/cold
- ❑ Fatigue/weakness
- ❑ Sleep Difficulties
- ❑ Fever/Chills
- ❑ Significant Weight Change

Skin:

- ❑ Rash / hives
- ❑ Lumps
- ❑ Nail Problems/changes
- ❑ Eczema
- ❑ Other?_____
- ❑ Easy Bruising
- ❑ Itching
- ❑ Hair problems / changes
- ❑ Jaundice

Head:

- ❑ Headaches
- ❑ Eye problems
- ❑ Ear Infections
- ❑ Earaches
- ❑ Nasal Congestion
- ❑ Other?_____
- ❑ Dizziness
- ❑ Hearing Problems
- ❑ Ringing/Buzzing in ear(s)
- ❑ Nosebleeds
- ❑ Frequent Nasal Discharge

Mouth, throat & neck:

- ❑ Frequent sore throats
- ❑ Chronic bad breath
- ❑ Speech Difficulties
- ❑ Swollen Glands
- ❑ Sore tongue/mouth/gums
- ❑ Dental cavities
- ❑ Cold sores
- ❑ Other? _____

Respiratory system:

- ❑ Chronic cough
- ❑ Breathing noises (e.g. wheezing)
- ❑ Coughing up blood
- ❑ Other?_____
- ❑ Sputum/phlegm
- ❑ Shortness of breath/difficulty breathing
- ❑ Chest pain

Abdomen & gastrointestinal system:

- ❑ Change in appetite
- ❑ Nausea/vomiting
- ❑ Tarry black stool
- ❑ Heartburn
- ❑ Bloating
- ❑ Constipation
- ❑ Food Allergies/intolerances
- ❑ Hepatitis
- ❑ Change in stool colour
- ❑ Other?_____
- ❑ Change in thirst
- ❑ Blood in stool
- ❑ Belching/flatus
- ❑ Indigestion
- ❑ Diarrhea
- ❑ Hernias
- ❑ Abdominal pain
- ❑ Change in bowel habit
- ❑ Change in stool odor

Heart & circulation:

- ❑ Murmurs
- ❑ Varicose veins
- ❑ Swelling of ankles/feet
- ❑ Palpitations
- ❑ Calf Pain
- ❑ Other? _____

Urinary system:

- ❑ Urinary frequency
- ❑ Sense of urgency
- ❑ Dribbling
- ❑ Difficulty passing urine
- ❑ Frequent infections
- ❑ Cloudiness
- ❑ Other? _____
- ❑ Frequency at night
- ❑ Pain
- ❑ Hesitancy (difficulty starting)
- ❑ Blood in urine
- ❑ Change in color
- ❑ Retaining water

Female:

Date of first period? _____ *Length of full cycle?* _____ *of bleeding?*_____

- ❑ Premenstrual Symptoms
- ❑ Frequent vaginal infections
- ❑ Breast Lumps
- ❑ Pregnancies (*if so, how many?*_____)
- ❑ Abortions
- ❑ Sexually transmitted diseases
- ❑ Sexual difficulties/difficulties with libido
- ❑ Other gynecological concerns? _____
- ❑ Painful periods
- ❑ Discharge
- ❑ Infertility
- ❑ Miscarriages
- ❑ Abnormal Pap tests
- ❑ Birth Control (*if so what type?*_____)

Male:

- ❑ Infertility
- ❑ Sexually transmitted diseases
- ❑ Rashes
- ❑ Varicose veins in scrotum
- ❑ Sexual/ libido difficulties
- ❑ Discharge
- ❑ Pain in genitals
- ❑ Other? _____

Musculoskeletal:

- ❑ Broken bones
- ❑ Joint swelling/pain/stiffness
- ❑ Bone pain
- ❑ Osteoporosis
- ❑ Muscle cramps
- ❑ Weakness
- ❑ Back pain
- ❑ Other? _____

Nervous system:

- ❑ Fainting
- ❑ Numbness/tingling
- ❑ Paralysis
- ❑ Other? _____
- ❑ Seizures/convulsions
- ❑ Loss of balance
- ❑ tremors

Signed:_____ Date:_____