Comprehensive Patient Questionaire

Last Name: First Name: Initials: Age:

Street Address: DOB: / / dd mm yy

City: Province: Postal Code:

Home: ( ) Bus. ( ) Mobile: ( )

Email (OPTIONAL):

Marital Status: Single Married Divorced Common Law

First Name of Partner/Significant Other:

Children: Y N Ages & Sex:

Occupation: Place of Employment:

Emergency Contact: Phone: ( )

REFERRAL: Self Physician Other:

Physician: Phone: ( )

Dentist: Phone: ( )

AHC #:

List any health professionals you currently see:		**Reason**
Name:	Practice:	
Name:	Practice:	
Name:	Practice:	
Name:	Practice:	

Current health conditions you desire improvement in **and** length of time they have been a concern to you, placed in order of importance:

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

To what extent do these areas interfere with your daily activities (work, sleep, etc.)?

Have you been given a diagnosis for this problem -- if so, what?

Family History

Check the box if there is a family history for the following health problems. If the health condition resulted in a family member death, please mark the third column with DC.

				Abbreviation LEGEND
Allergies/Hay Fever				
Alcoholism				MGM: maternal grand mother
Anemia				PGM: paternal grand father
Arthritis				MGF: maternal grand father
Asthma				PGF: paternal grand father
Cancer				F: father
Diabetes				M: mother
Digestive Illness				B: brother
Epilepsy				S: sister
Glaucoma				Sp: spouse
Headaches				C: children
Heart Disease				DC: deceased
High Cholesterol				
High Blood Pressure				
Kidney Disease				
Mental Illness				
Obesity				
Stroke				
Syphilis				
Thyroid Condition				
Tuberculosis				
Other				

Past Medical

Hospitalization (year, reason):

Surgeries (year, reason):

Serious Illnesses/injuries/accidents (year, cause/injury):

Childhood Illnesses:

Health as a child (1: poor to 10: excellent): If less than 8, explain:

Rheumatic Fever German Measles Polio Allergies Chicken Pox
Frequent Colds/Flus Mumps Ear Infection Skin Conditions (eczema,psoriasis)

Vacinations:

Type, year, adverse reactions:

Allergies: (list all known)

Allergy	Items	Reaction
Drugs		
Foods		
Other		

Pets:

What Kind	How Many

Medications:(prescription & over-the-counter)

Medications	Dose	How Long?	For What?

Supplements: (non-prescription, herbal, nutrional, any over-the-counter items)

Supplement	Dose	How Long?

Have you ever had general anesthetic? Yes No If yes, when? ______________________________

Antibiotic Use? Yes No if yes, when? ____

Dental:
To the best of your knowledge please list all dental work/treatments you have undergone. Include fillings (specify type), pulled teeth, root canals, bridges, crowns, dentures, braces, retainer/splints, accidents/injuries or any other type of dental/jaw surgery.

Date	Treatment

Describe any current dental concerns or symptoms:

Are you aware of any grinding of your teeth or clenching your jaw? Yes No

If yes, when? day night both

Chemicals:
Please list any current or past exposures to solvents, chemicals, cleaning agents, insecticides, herbicides, pesticides, chemical/metal vapors, dry cleaning agents

Item	When	How Long?	Work or Home

Travel: (list back country & third world trips)

Item	When	Illness or trauma

Lifestyle
Enjoy Work? Yes No If No Why?

What have been your previous occupations?

Please indicate on the line below where you feel your current balance between work and play is:

All Work 0 - - - - -1 - - 2 - - - - - 3 - - - - 4 - - - - - 5 - - - - - 6 - - - - - 7 - - - - - 8 - - - - - 9 - - 10 **All Play**

Physical Fitness
Exercise Regularly? Yes No Describe your program:

Hobbies
Please list your hobbies or recreational interests:

Support, Stressors & Personal Growth

Do you get along with your family? Yes No

Please list the stressors that affect you the most:	Please list the people/areas that support you the most:
1.	1.
2.	2.
3.	3.

Do you currently follow a (religious/spiritual) belief system?

Do you feel supported and comfortable with this belief system?

Do you: Meditate Pray Use Visualization Use Relaxation Techniques

Use other Techniques? Describe:

How might you finish this statement in regards to suggestions/programs for your health......I:

can follow the plans/programs start programs then let things slide

prefer choosing from options am easily overwhelmed

How will you know when you are feeling better:

How might things look for you when your life is very good?

Do you have any concerns or reservations in pursuing complementary & alternative therapies?

Smoking:

	How Often	How Long?	Quit - When
Cigarettes			
Cigars			
Pipe			
Marijuana			

Drinking:

	How Often	How Long?	Quit - When
Liquor			
Beer			
Wine			
Coffee			
Soft Drinks			

Diet: (for each 'yes' list type, serving size & frequency)

	Yes	No	
Vegetarian			If yes, what kind? Lacto Ovo Lacto-Ovo Pesco Vegan
Meat			
Fish			
Fowl			
Dairy			
Eggs			
Beans/Legumes			
Fruits			
Vegetables			
Grains/Bread/Pasta/Cereal			

Meal	**Time**	**Food/Drink**
Breakfast		
Lunch		
Dinner		
Snacks/Dessert		
Drinks	N/A	
Cravings	N/A	
Aversions	N/A	

What kind of water do you drink and how much?

Please mention any foods or drinks that aggravate your symptoms or that you find hard to digest:

Diet Continued:

How long have you been following this diet?

Do you eat or use any of the following:

Margerine   Processed/Deli Meats   Alumninum Pots/Utensils   Lard
Sugar   Microwave   Crystal/Packaged Drinks   Candy
Shortening   Artificial Sweeteners   Fried Foods

Part B - Review of Symptoms

Please complete the following section as thoroughly as you can. For every question that you answer "yes" or " past", please explain your answer further on the accompanying line.

General:

Weight		Height	
Weight 1 Year Ago		Date of Last Physical	
Maximum Weight		Date of Last Blood Work	
When			

Energy: 1 (poor) - 10 (great): ______________ Does your energy vary within a day? Yes No

If Yes, circle & label the time(s) of day you feel is/are best (B) or (W) for you:

Midnight 1 2 3 4 5 6 7 8 9 10 11 noon 1 2 3 4 5 6 7 8 9 10 11 Midnight

What makes your energy better?

What makes your energy worse?

Sleep:

	Yes	No	Explanation
Sleep Well?			If No please specify
Insomnia			
Sleepy during the day?			
Wake up at night?			
Wake early in the morning?			
Restless?			
Nightmares/Dreams			
Wake to use washroom?			
Wake Rested?			If No please specify:
Grains/Bread/Pasta/Cereal			
Average Hours of Sleep per night			

Sweating:

	Yes	No	Past	Explanation
Night Sweats				
Perspire Profusely				
Perspire very little				
Do not perspire				
Sweat with high fever				

Skin:

	Yes	No	Past	Explanation
Eczema				
Psoriasis				
Rashes				
Hives				
Inflamation				
Infection				
Growths				
Changes in hair				
Change in nails				

Eyes:

	Yes	No	Past	Explanation
Glasses/Contacts				
Impaired Vision				
Eye Pain				
Tearing or or Dryness				
Red, Itching, Painful				
Double Vision				
Change in nails				

Ears:

	Yes	No	Past	Explanation
Hearing Loss				
Impaired Hearing				
Ringing				
Earache/Itch				

Nose & Sinuses:

	Yes	No	Past	Explanation
Frequent Colds/Year				
Nose Bleeds				
Stuffiness				
Sinus Problems				
Post Nasal Drip				

Mouth & Throat:

	Yes	No	Past	Explanation
Frequent Sore Throats				
Sore Tongue				
Sores in Mouth/On Lips				
Gum Problems/Bleeding				
Hoarseness				
Jaw Pain				
Dental Problems				

Respiratory/Chest:

	Yes	No	Past	Explanation
Cough				If Yes or Past: dry little phlegm much phlegm
Wheezing				
Spitting up Blood				
Difficulty Breathing				
Pain on Breathing				
Shortness of Breath				
Shortness on Lying Down				
Shortness at Night				
Positive Tuberculosis Test				
Asthma				
Hay Fever				
Pain				If Yes or Past please describe: sides central chest burning prickling distending dull other:

Heart:

	Yes	No	Past	Explanation
Chest Pain				If yes or past please describe below:
Is the pain... burning prickling fullness tightness Distending Dull Other:				
Heart Disease				
High Blood Pressure				
Rheumatic Fever				
Swelling in Legs/Ankles				
Palpitation/Fluttering				

Digestion/Abdomen:

	Yes	No	Past	Explanation
Stomach/Abdominal Pain				If yes or past please describe below:
Is the pain... cramping prickling fullness Distending Dull Other: ______ Pain is relieved by: pressure hot cold bowel movement				
Trouble Swallowing				
Heartburn				
Change in Thirst				
Do you prefer	hot	cold	not thirsty	
Change in appetite				If yes or past please describe below:
Describe the change as... abnormal overeating under eating hungry yet cannot eat				
Taste/Feeling in Mouth	bland sour salty hot sweet bitter sticky metallic			
Nausea				
Vomiting				
Belching/gas/bloating				
Do these symptoms occur... during meals 1 hour after meals 2-3 hours after meals				
Heaviness from foods				
Liver/gall bladder disease				
Gall stones				
High Cholesterol				
Diabetes				
Mononucleosis				
Ulcers				
Pain before eating				
Pain after eating				
Low Blood Sugar/Hypoglycemia				
Irritable before meals				
Tired after eating				
Distress from fats/greasy foods (nausea, dizziness, headaches)				
Rapid Weight Change				
Hiccups				

Bowel Function:

Frequency of Bowel Movements	# times per day week			
Usual time of Bowel Movements				
Consistency of Bowel Movements				
	Yes	No	Past	Explanation
Diarrhea				
Constipation				
Alternate diarrhea & constipation				
Loose/Broken Stools				
Stool Hard to Pass				
Blood/Mucus in stools				
Undigested Food in Stool				

Urinary:

	Yes	No	Past	Explanation
Pain on Urination				
Burning on Urination				
Increase in Frequency				
Frequency at Night				
Change in Colour				
Change in Odor				
Unable to Hold Urine				
Incomplete Urination				
Bladder Infections				
Kidney Stones				

Circulation:

	Yes	No	Past	Explanation
Deep Leg Pain				
Cold Hands/Feet				
Varicose Veins				
Hemorrhoids				
Anemia				
Easy Bleeding/Bruising				

Neurological:

	Yes	No	Past	Explanation
Fainting				
Seizures				
Paralysis				
Muscle Weakness				
Memory Loss				

Sexual Function:

	Yes	No	Past	Explanation
Change in Libido				
Loss of Libido				
Infertility				
Veneral Disease				

Female Reproduction:

	Yes	No	Past	Explanation
Age Menses Began				
Date of Last Menstruation				
No. of days of Menstrual Flow				
Length of Complete Cycle				
Regular Self Breast Exam				
Date & Results of last PAP				
Abnormal PAP's				
No. of Pregnancies				
No. of Live Births				
No. of Miscarriages				
No. of Abortions				
Sexually Active?				
Birth Control				
Spotting Between Periods				
Are cycles regular?				If No, please describe: early delayed irregular
Pain During Intercourse				
Cramps				
Abnormal Vaginal Discharge	yellow white thick strong odor			
Vaginal Infections				
Menstrual Flow	normal heavy light			
Colour of Flow	normal bright red dark red light red			
Consistency of Flow	thick thin clots			
PMS	breast tenderness moods water retention headaches craving back ache acne bloating other: ____________			
Ovarian Cysts				
Uterine Fibroids				
Difficulty Concieving				
Menopausal Symptoms				

Male Reproduction:

	Yes	No	Past	Explanation
Date and results of most recent rectal exam for an enlarge prosteate exam.				
Impotence				
Premature Ejaculation				
Noctural Emissions				
Hernias				
Testicular Masses				
Testicular Pain				
Are you Sexually Active?				
Sexual Difficulties				
Any prostate problems?				
Discharge/Sores				

Difficulty starting/stopping urination				
Birth Control				

Risk of Infection:

	Yes	No	Details
HIV			
Hepatitis B			
Hepatitis C			

Emotional:

	Yes	No	Past	Explanation
Mood Swings				
Depression				
Anger/Resentment				
Anxiety/Nervousness				
Fear				
Apathy				

Musculoskeletal:

	Yes	No	Past	Explanation
Joint Pain/Stiffness				
Muscle Pain/Stiffness				
Muscle Spasms/Cramps				
Low Back Pain				
Numbness/Tingling				
Arthritis				
Broken Bones				

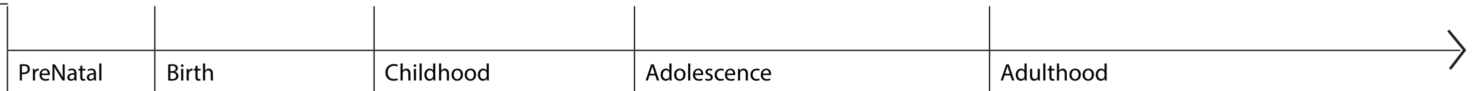
Miscellaneous:

	Yes	No	Past	Explanation
Thyroid Problems				
Heat Intolerance				
Cold Intolerance				
Fever				
Chills				
Alternating Chills & Fever				
Body Feels Cold				
Easy Weight Gain				
Rapid Weight Change				
Dizzy Upon Standing/Bending				
Fluoride Toothpaste				
Drink Tap Water				

Part C: STRESSORS & SYMPTOMS

Using the timeline below, list the stressors (surgery, accidents/injury, change in work/residence/relationships, births, loss, mental/emotional stress etc.) and symptoms (pain, digestive concerns, fatigue, headaches, allergies, menstrual changes, behavior/mood changes, etc.)

STRESSORS:



SYMPTOMS:

In the questionnaire that follows, read each statement and score it in the margin as follows:

- 0 - points ifthis statement is not true at or does not apply to you.
- 1 - point if the statement is true a lot of the time and/or is affecting the quality of your life.
- Please respond to all questions as though you were not taking any medications or supplements.

SECTION 1: Type - S

#	Question	Pts
1.	Do you have a tendancy to be negative or have dark pessimistic thoughts?	
2.	Are you often worried or anxious?	
3.	Do you have feelings of low self-esteem and/or lack of confidence?	
4.	Are you self-critical and feel guilty over small issues?	
5.	Do you have obsessive, repetitive, angry, useless thoughts that you are unable to turn off? Do they happen when you are trying to fall asleep?	
6.	Can your behaviour become obsessive? This can show up as difficulty making transitions, being inflexible, a perfectionist, controling? Computer, TV or work addict?	
7.	Do you suffer from seasonal affective disorder? Tend to get blue in the winter months? Symptoms of this are a tendancy to gain weight, fatigue, depression, and sleepig problems during the winter.	
8.	Are you apt to be irritalbe, impatient, edgy or angry?	
9.	Are you shy or fearful? Can you be nervous or panicky about heights, flying, enclosed spaces, public performances, bugs, crowds, leaving house etc.?	
10.	Do you have anxiety or panic attacks?	
11.	Do you suffer from PMS or menopausal moodiness (tears, anger and/or depression)?	
12.	Do you dislike hot weather?	
13.	Do you find it hard to get to sleep?	
14.	Do you wake up at night, have restless or light sleep, or wake to early in morning?	
15.	Do you find relief from the above symptoms through exercise?	
16.	Do you crave sweet or starchy snacks, wine, or marijuana in the afternoons, evenings or in the middle of the night?	
17.	Do you or have fibromyalgia, TMJ?	
18.	Have you had suicidal thoughts or plans?	
19.	Do you have gastrointestinal disorders such as irritable bowel, gas and/or bloating?	
20.	Do you suffer from general fatigue?	
	TOTAL	

SECTION 2: Type - D

#	Question	Pts
1.	Do you feel flat and bored a lot of the time?	
2.	Do you like to sleep more than normal and are slow to get out of bed?	
3.	Do you crave or use stimulants like coffee, recreational drugs, alcohol and chocolate, diet soda, ephedra and cocaine to get high?	
4.	Do you lack libido, a reduced sex drive?	
5.	Do you feel that you have reduced feelings of satisfaction, and assertiveness.	
6.	Has your short term memory, concentration and ability to learn changed for the worse?	
7.	Do you lack appetite?	
8.	Do you tend to have muscle stiffness?	
9.	Do you crave pleasurable experiences?	
10.	Have you been under a lot of stress in your life from traumatic experiences?	
11.	Do you get more accomplished under high stress environments?	
12.	Are you a procrastinator, waiting until the last minute to accomplish tasks?	
13.	Do you tend to be low on physical or mental energy?	
14.	Do you have to push yourself to exercise?	
15.	Is your drive, enthusiasm, and motivation on the low side?	
16.	Do you have difficulty focusing and concentrating?	
17.	Are you easily chilled, cold hands and feet?	
18.	Do you tend to put on weight easily?	
19.	Do you often wish that you were more alert and motivated?	
20.	Do you often have spontaneous muscle twitches, restless leg syndrome?	
	TOTAL	

SECTION 3: Type - T

#	Question	Pts
1.	Low energy and/or lethargy.	
2.	Require lots of sleep, and have trouble getting up in the morning.	
3.	Suffer from depression this may also include post partum.	
4.	A tendency to feel cold, especially in your hands and feet.	
5.	Poor concentration, mental sluggishness, and/or poor memory.	
6.	A family history of thyroid problems?	
7.	Weight gain that began with: The onset of menstruation, after a miscarriage, abortion, birth, and/or menopause.	
8.	Chubby or overweight since childhood.	
9.	Tendency to excessive weight gain or inability to lose weight despite normal eating.	
10.	Hoarseness and/or gravelly voice.	
11.	Low blood pressure, and/or hear rate.	
12.	Menstrual problems, excessive bleeding, severe cramping, irregular menses, PMS, scanty flow, late or early menarchy (before 12) premenopausal cessation of menstruation.	
13.	Reduced sex drive.	
14.	Swollen eyelids and face, general water retention.	
15.	Thinning or loss of outside eyebrow hair.	

16.	Tendency to have low blood pressure.	
17.	Headaches (including migraines)	
18.	High cholesterol, atherosclerosis, and/or high homocysteine.	
19.	Lump in throat and/or trouble swallowing pills.	
20.	Slow body movement or speech.	
21.	Change in hair or skin (thinning/loss/ dryness)	
22.	Weak brittle nails	
23.	Constipation	
24.	Tight tendons, muscle stiffness/ tension.	
	TOTAL	

SECTION 4: Type - A

#	Question	Pts
1.	Do you often feel overworked, pressured or dead-lined?	
2.	Trouble relaxing, or loosening up	
3.	Body tending to be stiff, uptight, tense?	
4.	Easily upset, frustrated, or snappy under stress?	
5.	Often feel overwhelmed or as though you just cant get it all done?	
6.	Weak, shaky at times?	
7.	Sensitive to bright light, noise, or chemical fumes? Need to wear dark glasses?	
8.	Feel significantly worse if you skip meals or go too long without eating?	
9.	Use drugs or food to relax and calm down?	
10.	Have type II diabetes, hypoglycemia?	
11.	Tend to gain weight around the middle?	
12.	Do you dislike hot weather?	
13.	Reduced sex drive.	
14.	Chronically fatigued: a tiredness that is not usually relieved by sleep?	
15.	Feeling unwell a lot of the time, tend to have colds and flu's that hang on?	
16.	Decreased tolerance to cold, feeling cold a lot?	
17.	Small irregular brown spots have appeared on skin?	
18.	Hands and legs get restless-experience meaningless body movements?	
19.	Often become hungry, confused, shaky, or somewhat paralyzed under stress?	
20.	Water retention, bloating, digestive problems?	
21.	Feeling “wired” yet “tired at the same time.	
	TOTAL	

Declaration and Informed Consent to treatment:

This form is designed to present benefits and risks of the therapies offered by Urgent Care Chiropractic and must be signed before treatment is rendered. Ask your doctor if you have any questions or concerns regarding your consent to treat prior to signing this Informed Consent form.

Treatments may include one or a combination of the following:

- Dietary and nutritional counselling
- Nutritional and other supplementations, either orally, topically or as injection/IV therapy such as vitamins, minerals, enzymes, amino acids, essential fatty acids, homeopathic remedies, homotoxicological preparations and others.
- Nutritional or other IV therapy, chelation (detox) therapy, and more.
- Injection therapies (neural therapy, prolotherapy, trigger point & neuralprolotherapy and more)
- Counselling & Energy therapies.

Caution must be taken in physiological conditions such as pregnancy and lactation, in very young children, persons with diabetes, heart, liver or kidney impairment and/or in persons taking multiple medications.

It is important that you inform your Naturopathic Doctor immediately of:

- Any disease process from which you currently suffer
- If you are on any medications either prescribed or over-the-counter
- If you are pregnant, suspect you are pregnant, planning to become pregnant or are currently breast feeding.

I am seeking medical health care services, including alternative medical therapies with Dr. Eric Arrata. I hereby request and consent to the performance of naturopathic procedures (including but not limited to examination, diagnostic testing and the use of natural substances such as vitamins, minerals, and botanical medicines) on me (or on the patient named, for whom I am legally responsible) by Dr. Eric Arrata.

I understand and am informed that results from treatments may vary and are not guaranteed. In addition, I understand that my compliance with diet recommendations, supplements, prescribed medications, prescribed exercises and lifestyle modification will increase the effectiveness of my care and enhance or maintain the results.

I understand a referral to another physician or specialist may be necessary due to the nature of my condition and limitations in the scope of practice of Naturopathic Medicine.

I acknowledge that the scope of practice of a Naturopathic Physician in Alberta has limitations including at this time no prescription privileges and lack of hospital privileges. Consequently, a referral to a specialist or emergency room may be deemed necessary under certain circumstances and is in my best interest.

I understand that this medical practice uses diagnostic and treatment methods that are known as investigational, complementary, alternative, holistic, nutritional and herbal oriented. Some of these methods have not been accepted by consensus mainstream medicine.

I understand that it is not recommended that any medical test be purchased without a medical consultation. If I purchase a medical test without a consultation it is done so at my own risk.

I understand that I am in no way obligated to purchase the products or run labs recommended by Urgent Care Chiropractic I am free to purchase these products from any source that I may choose.

I do not expect the doctor to be able to anticipate and explain all the risks and complications that could possibly happen during or because of treatment and wish to rely on the doctor to be able to exercise judgment during the course of the procedure based upon the facts known at that time.

I understand and am informed that, as in the practice of medicine, in the practice of Naturopathic medicine, in the practice of intravenous therapy, in the practice of nutritional and other supplementation, in the practice of hormone therapy, in the practice of any treatment we administer or order there are some risks.

These include but are not limited to:

• Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms.
When this occurs, the duration is usually short.
• Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
• Pain, bruising or injury from intra-muscular injections, venipuncture or acupuncture.

Below is a more in-depth explanation of some of the various therapeutic modalities used by Urgent Care Chiro.
A Naturopathic physician is trained as a general family practitioner. Naturopathic physicians combine modern laboratory and physical diagnostic tools with natural, nontoxic therapies that encourage the body's inherent healing abilities. Some of the treatments may include nutrition, herbal medicine, homeopathy, counselling, physiotherapy, hormone replacement therapy, hormone reduction therapy, electrotherapy, natural supplementation and other natural remedies.
Nutritional and herbal supplements. At times, your organ systems and tissues may need nutritional and/or herbal support. Make sure to tell your doctor about any medications you are currently taking so that drug/herb/supplement interactions are minimized. Potential side effects of any herb/supplement recommended to you will be discussed your doctor.

All Medical Tests, supplements, and consults are non-refundable. At the discretion of the doctor labs that have not been completed may be returned with a 25% discount from the cost of the lab. All supplements are non-returnable.

All clients must give 48 hours' notice for cancelled appointments. Missed appointments will be billed to the client at 100% the cost of the visit.

Patient's Full name (please print): ____
First Middle Last

Date of Consent: ____
Day Month Year

X____
Signature of Patient (or legal guardian)