NATUROPATH

COLONIC

INNER HEALTH

NATUROPATHIC QUESTIONNAIRE

Date _____

Name _____

Address _____

City _____ **Province** _____ **Postal code** _____

Home phone _____ **Work** _____ **Mobile phone** _____

Email _____

Date of birth _____ **Present age** _____ **Blood type** _____

Where did you hear from us : ❒ newspapers ❒ internet ❒ website ❒ email ❒ friends ❒ others

What is your present height _____ **Weight** _____

Date of latest measurement _____

Has your weight changed over the past year? **Yes** ❒ **No** ❒

If yes please offer an explanation _____

_____

_____

What is your reason for attending this clinic? Please be prepared to describe your condition in great detail during your naturopathic medical interview. Make note of symptoms you typically experience, other people's observation, and any factors which may have contributed to the condition's onset /development?

_____

_____

_____

_____

_____

_____

_____

_____

If this is a chronic illness, how long have you had this condition ?_____

_____

_____

Who diagnosed your illness? _____

_____

_____

When was this diagnosis made ? _____

_____

_____

What specialists have seen and when ?_____

_____

_____

How has this illness been treated until now, and what results have been obtained to date ?_____

What other objectives do you have as far as your health is concerned? If these objectives are related to specific health conditions, then also advise as to how long these conditions have existed. _____

_____

_____

_____

_____

_____

_____

_____

How long has it been since you were totally well ?_____

_____

_____

_____

Are you currently working with a professional counselor, psychologist, social worker, or other therapist ? Please provide details _____

_____

_____

_____

_____

_____

Have you had naturopathic treatment before ? Please provide details_____

_____

_____

_____

_____

_____

Each line below represents a year in your life. Please draw a timeline of all major events in your life. This will enable your naturopath to assess your present health problem. Please indicate in chronological order all accidents, illnesses, hospitalizations, surgery, injuries, traumatic and emotional events, major changes in your life up to this point in time. Also please include when you had vaccinations, you started school, changes schools, graduated, failed, got married, children, separated, divorced, etc.…we want to know about all MAJOR TRAUMAS which may have impacted on your life at a MENTAL,EMOTIONAL, or PHYSICAL level

Please circle the top 5 stressful events.

Age 1 _____

Age 2 _____

Age 3 _____

Age 4 _____

Age 5 _____

Age 6 _____

Age 7 _____

Age 8 _____

Age 9 _____

Age 10 _____

Age 11 _____

Age 12 _____

Age 13 _____

Age 14 _____

Age 15 _____

Age 16 _____

Age 17 _____

Age 18 _____

Age 19 _____

Age 20 _____

Age 21 _____

Age 22 _____

Age 23 _____

Age 24 _____

Age 25 _____

Age 26 _____

Age 27 _____

Age 28 _____

Age 29 _____

Age 30 _____

Age 31 _____

Age 32 _____

Age 33 _____

Age 34 _____

Age 35 _____

Age 36 _____

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Age 38 _____

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Age 40 _____

Age 41 _____

Age 42 _____

Age 43 _____

Age 44 _____

Age 45 _____

Age 46 _____

Age 47 _____

Age 48 _____

Age 49 _____

Age 50 _____

Age 51 _____

Age 52 _____

Age 53 _____

Age 54 _____

Age 55 _____

Age 56 _____

Age 57 _____

Age 58 _____

Age 59 _____

Age 60 _____

Age 61 _____

Age 62 _____

Age 63 _____

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Age 66 _____

Age 67 _____

Age 68 _____

Age 69 _____

Age 70 _____

Age 71 _____

Age 72 _____

Age 73 _____

Age 74 _____

Age 75 _____

Age 76 _____

Age 77 _____

Age 78 _____

Age 79 _____

Age 80 _____

Age 81 _____

Age 82 _____

Age 83 _____

Age 74 _____

Age 85 _____

Age 86 _____

Age 87 _____

Age 88 _____

Age 89 _____

Age 90 _____

Family health history

INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER AILMENTS, HAVE AFFECTED YOUR RELATIVES

Alcoholism	Asthma	Digestives disorders	Hay fever	Mental illness
Skin disease	Allergies	Cancer	Epilepsy	Heart disease paralysis syphilis
Alzheimer's	Depression	Gonorrhea	Hypertension	Parkinson's
Thyroid disorder	Arthritis	Diabetes	Gout	Kidney disease
Pneumonia	Tuberculosis			

Relative	Age if alive	Age of death	Ailments
Mother			
Father			
Brothers			
Sisters			
Maternal grandmother			
Maternal grandfather			
Maternal aunts/uncles			
Paternal grandmother			
Paternal grandfather			
Paternal aunts/uncles			

Review of symptoms

Please circle “y” if you have the the condition now and “p” if you had it in the past

Skin

Rashes Y P
Hives Y P
Acne Y P
Boils Y P
Eczema Y P
Psoriasis Y P
Dry skin Y P
Itching Y P
Lumps Y P
Night sweats Y P
How often Y P
Other _____

Mouth and throat

Hoarseness Y P
Gum problems Y P
Dental cavities Y P
Sores Y P
Mouth dryness Y P
Sore throats Y P
Lose taste Y P
Other _____ Y P
Y P

Gastrointestinal

Heartburn Y P
Difficult swallow Y P
Thirst changes Y P
Appetite changes Y P
Nausea Y P
Gas /flatulence Y P
Constipation
Diarrhea Y P
Rectal bleeding Y P
Hemorrhoids Y P
Jaundice Y P
Hernias Y P
Other _____
Y P
Y P

Jaundice Y P
Hernias Y P
Diarrhea Y P
No. BM/day Y P
Y P

Head

Headaches Y P
Migraine Y P
Dizziness Y P
Injuries Y P
Other _____

Respiratory

Wheezing Y P
Coughing Y P
Short of breath Y P
Difficult breath Y P
Chest pain Y P
Bloody sputum Y P
Emphysema Y P
Asthma Y P
Breath painful Y P
Bronchitis Y P
Pneumonia Y P
Pleurisy Y P
Last chest xray Y P
Last TB test Y P
Other _____

Neck

Pain Y P
Swollen glands Y P
Lumps Y P
Goiter Y P
Stiffness
Other _____ Y P
Y P

Noses and sinuses

Bleeding	Y	P
Stuffiness	Y	P
Hay fever	Y	P
Injures	Y	P
Colds	Y	P
Allergies	Y	P
Obstruction	Y	P
Sinus problems	Y	P

Other _____

Urinary

Pain urinating	Y	P
More frequent	Y	P
Reduced flow	Y	P
Kidney stones	Y	P
Blood in urine	Y	P
Infections	Y	P
Incontinence	Y	P

Other _____

Ears

Discharge	Y	P
Itching	Y	P
Excess wax	Y	P
Infection	Y	P
Ringing (tinnitus)	Y	P
Earache	Y	P
Hearing loss	Y	P

Other _____

Breasts

Lumps	Y	P
Tenderness	Y	P
Self-examine ?	Y	P

Other _____

Peripheral vascular

Cold hands/feet	Y	P
Deep leg pain	Y	P
Varicose veins	Y	P
Thrombophlebitis	Y	P

Other _____

Menses

Cycle regular	Y	P
Length of cycle	Y	P
Bleeding between periods	Y	P
Painful menses	Y	P

Cardiovascular

Heart disease	Y	P
Angina	Y	P
High blood pressure	Y	P
Murmurs	Y	P
Chest pain	Y	P
Palpitations	Y	P
Ankle swelling	Y	P
Rheumatic fever	Y	P
Last ECG test	Y	P

Other _____

Eyes

Impaired vision	Y	P
Pain	Y	P
Redness	Y	P
Double vision	Y	P
Cataracts	Y	P
Light sensitive	Y	P
Discharge	Y	P
Tearing	Y	P
Dryness	Y	P
Itching	Y	P
Blurring	Y	P
Glaucoma	Y	P
Blind spot(s)	Y	P
Contact lenses	Y	P

Other _____

Musculoskeletal

Joint paint arthritis		
Broken bones	Y	P
Numbness	Y	P
Tingling	Y	P
Muscle spasms	Y	P
Weakness	Y	P
Backache	Y	P

Other _____

Females

Age of first menses	Y	P
Menopause symptoms	Y	P
Age	Y	P
Type of birth control how long	Y	P
Last pap	Y	P
Vaginal discharge	Y	P
Itching	Y	P

Other _____

Excessive flow Y P
N° of pregnancies Y P
Age Y P
N°of miscarriages Y P
N° of abortions Y P
Other _____

Reproductive
Sexual difficulties Y P
Venereal disease Y P
Other _____

Male
Prostate symptoms Y P
Impotence Y P
Testicular masses Y P
Hernia Y P
Urgency of urination Y P
Incomplete urination dribbling Y P
Decreased sexual desire Y P
Other _____

Endocrine (hormones)
Thyroid problems Y P
Diabetes hypoglycemia Y P
Hormone therapy Y P
Other _____

Psycho/social
Depression Y P
Tension Y P
Mood swings Y P
Phobias Y P
Sleep problems Y P
Anxiety Y P
Nervousness Y P
Alcohol or drug abuse Y P
Other _____

Thyroid
Loss of hair Y P
Weight gain Y P
Dry skin Y P
Loss of outer part of eyebrows Y P
Menstrual disorders Y P
Stubborn constipation Y P
Goiter Y P
Low or high blood cholestero Y P
Feeling very cold Y P
Other _____

PMS symptoms
Depression Y P
Bloating Y P
Increased appetite Y P
Weight gain Y P
Breast tenderness Y P
Pain Y P
Other _____

Blood/lymphatic
Anemia Y P
Swollen lymphs Y P
Easy bleeding Y P
Bruising Y P
Transfusions Y P
Clotting Y P
Other _____

Neurological
Fainting Y P
Seizures convulsions Y P
Paralysis Y P
Muscles weakness Y P
Memory loss Y P
Involuntary movements Y P
Loss of balance Y P
Speech problems Y P
Other _____

Adrenal
Fatigue, apathy Y P
Allergies Y P
Delayed wound healing Y P
Low blood pressure Y P
Dizziness when standing up Y P
Frequent urination Y P
Urination at night Y P
Muscular weakness Y P
Nervousness Y P
Low back pain Y P
Knee pain Y P
Ringing in the ears Y P
Other _____

Liver
Anemia Y P
Hypertension Y P
Elevated blood cholesterol Y P
Low energy before eating Y P

Pancreas

Food allergies	Y	P
Blood sugar abnormalities	Y	P
Maldigestion	Y	P
Undigested food in stool	Y	P
Bowel gas	Y	P
Stool floats	Y	P
Other _____	Y	P

Parathyroid

Osteoporosis	Y	P
Joint pain	Y	P
Gum/tooth disease	Y	P
Kidney stones	Y	P
Other _____		

Decreased drug or alcohol	Y	P
Tolerance	Y	P
Premenstrual tension	Y	P
Endometriosis	Y	P
Heavy menses	Y	P
Frequent headaches	Y	P
Skin problems	Y	P
Constipation	Y	P
Gall bladder problems	Y	P
Chronic muscle tension	Y	P
Eye problems	Y	P
Difficulty digesting fatty foods	Y	P
Other _____		