purewellness group

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To help us serve your health needs, please take 20-30 minutes to complete the following questionnaire as accurately as possible. All of your answers will be held ***absolutely confidential***. If you have any questions, please ask. Thank you!

GENERAL INFORMATION

Date:

Name: Health Card #:

Date of Birth: Gender: Blood Type

Address:

Home Phone: Work Phone:

Cell Phone: E-mail Address:

Marital Status:

Emergency Contact: Relationship:

Phone:

Physician: Phone:

Chiropractor: Phone:

Naturopath: Phone:

Specialist(s): Phone:

Phone:

How did you hear about us?

ALLERGIES/SENSITIVITIES

COMPLAINTS/CONCERNS

Please state your reason for attending our clinic:

Did something trigger your change in health?

What aggravates it?

What improves it?

Have you been given a diagnosis?

Please list current and ongoing problems in order of severity:

Describe Problem(s)	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair

Dr. Allan Price ND #934 & Dr. Tara O'Brien ND #1725

Members in Good Standing with the Canadian Association of Naturopathic Doctors and the Ontario Association of Naturopathic Doctors
Pure Wellness Group is located at 1933 Regent St. Unit#10, Sudbury, ON P3E5R2

MEDICAL HISTORY

Please check the appropriate box and provide the date of onset
P = Past Condition **O = Ongoing Condition**

DISEASES/DIAGNOSES

P	O	GASTROINTESTINAL
○	○	Irritable Bowel Syndrome
○	○	Crohn's
○	○	Ulcerative Colitis
○	○	Gastric or Peptic Ulcer Disease
○	○	GERD (reflux)
○	○	Celiac Disease
○	○	Gallstones
○	○	

P	O	GENITAL & URINARY SYSTEMS
○	○	Kidney Stones
○	○	Gout
○	○	Interstitial Cystitis
○	○	Frequent Urinary Tract Infections
○	○	Frequent Yeast Infections
○	○	Erectile Dysfunction or Sexual Dysfunction
○	○	

P	O	CARDIOVASCULAR
○	○	Heart Attack
○	○	Other Heart Disease
○	○	Stroke
○	○	Elevated Cholesterol
○	○	Arrhythmia (irregular heart rate)
○	○	Hypertension (high blood pressure)
○	○	Rheumatic Fever
○	○	Mitral Valve Prolapse
○	○	

P	O	CANCER
○	○	Lung Cancer
○	○	Breast Cancer
○	○	Colon Cancer
○	○	Ovarian Cancer
○	○	Prostate Cancer
○	○	Skin Cancer
○	○	

METABOLIC/ENDOCRINE

P	O	
○	○	Type 1 Diabetes
○	○	Type 2 Diabetes
○	○	Hypoglycemia
○	○	Metabolic Syndrome (insulin resistance or Pre-Diabetes)
○	○	Hypothyroidism (low thyroid)
○	○	Hyperthyroidism (overactive thyroid)
○	○	Endocrine Problems
○	○	Polycystic Ovarian Syndrome (PCOS)
○	○	Infertility
○	○	Weight Gain
○	○	Weight Loss
○	○	Eating Disorder (specify)
○	○	

INFLAMMATION/AUTOIMMUNE

P	O	
○	○	Chronic Fatigue Syndrome
○	○	Autoimmune Disease
○	○	Rheumatoid Arthritis
○	○	Lupus SLE
○	○	Immune Deficiency Disease
○	○	Herpes (Genital)
○	○	Severe Infectious Disease
○	○	Poor Immune Function (frequent infections)
○	○	Food Allergies
○	○	Environmental Allergies
○	○	Multiple Chemical Sensitivities
○	○	

MUSCULOSKELETAL/PAIN

P	O	
○	○	Osteoarthritis
○	○	Fibromyalgia
○	○	Chronic Pain
○	○	

SKIN DISEASES

P	O	
○	○	Eczema
○	○	Psoriasis
○	○	Acne
○	○	Melanoma
○	○	Skin Cancer
○	○	

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P O NEUROLOGIC/MOOD

- Depression
- Anxiety
- Bipolar Disorder
- Schizophrenia
- Headaches
- Migraines
- ADD/ADHD
- Autism
- Mild Cognitive Impairment
- Memory Problems
- Parkinson's Disease
- Multiple Sclerosis
- ALS
- Seizures
-

P O RESPIRATORY DISEASES

- Asthma
- Chronic Sinusitis
- Bronchitis
- Emphysema
- Pneumonia
- Tuberculosis
- Sleep Apnea
-

PREVENTATIVE TESTS

Check box if yes and provide date of last test

- Full Physical Exam Date:
- Bone Density Date:
- Colonoscopy Date:
- Cardiac Stress Test Date:
- EKG Date:
- Hemoccult Test (blood in stool) Date:
- MRI Date:
- CT Scan Date:
- Upper Endoscopy Date:
- Ultrasound Date:

SURGERIES

Check box if yes and provide date of surgery

- Appendectomy Date:
- Hysterectomy +/- Ovaries Date:
- Gall Bladder Date:
- Hernia Date:
- Tonsillectomy Date:
- Dental Surgery Date:
- Joint Replacement Date:
- Angioplasty or Stent Date:
- Pacemaker Date:
- None Date:

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HOSPITALIZATIONS/INJURIES

Date Reason/Event

COMMENTS

GYNECOLOGIC HISTORY (for women only)

Check circle and provide number of if applicable

OBSTETRIC HISTORY

◯ Pregnancies ____ ◯ Caesarean ____ ◯ Miscarriages ____ ◯ Abortions ____

◯ Vaginal Deliveries ____ ◯ Living Children ____ ◯ Postpartum Depression ◯ Toxemia

◯ Gestational Diabetes ◯ Breastfeeding ____ *If so, for how long?* ____

MENSTRUAL HISTORY

Age at first period: Frequency: Length: Pain: ◯ Yes ◯ No Clotting: ◯ Yes ◯ No

Have you ever skipped a cycle? *If so, for how long?*

First day of last menstrual period: Days between menses:

Do you use hormonal contraception? ◯ Yes ◯ No *If so what type?:* *For how long?:*

Do you use contraception? ◯ Yes ◯ No *If so what type?:* ◯ Condom ◯ Diaphragm ◯ Partner Vasectomy ◯ IUD ◯ Tubal Ligation ◯

WOMEN'S DISORDERS/HORMONAL IMBALANCES

◯ Fibrocystic Breasts ◯ Endometriosis ◯ Fibroids ◯ Infertility ◯ Painful Periods ◯ Heavy Periods

◯ PMS ◯ Spotting ◯ Vaginal Discharge ◯ Low Sex Drive

Last Mammogram: Last Breast Biopsy: Last Self Breast Exam:

Last PAP Test: Results: ◯ Normal ◯ Abnormal

Last Bone Density Test: Results: ◯ High ◯ Low ◯ Within Normal Range

Describe any changes to body/psyche prior to menses:

Are you in menopause?: ◯ Yes ◯ No Age at menopause: _____

Symptoms

◯ Hot Flashes ◯ Mood Swings ◯ Concentration/Memory Problems ◯ Loss of Bladder Control

◯ Heavy Bleeding ◯ Joint Pain ◯ Headaches ◯ Weight Gain ◯ Vaginal Dryness ◯ Low Sex Drive

◯ Palpitations ◯ Use of Hormone Replacement Therapy *If so, for how long?:* _____

MEN'S HISTORY (for men only)

Have you had a PSA done?: ◯ Yes ◯ No Level: ◯ 0-2 ◯ 2-4 ◯ 4-10 ◯ >10

◯ Prostate Enlargement ◯ Prostate Infection ◯ Change in Libido ◯ Impotence ◯ Difficulty Obtaining Erection

◯ Difficulty Maintaining Erection ◯ Nocturia (urination at night) *If so, how many times a night?:* _____

◯ Urgency/Hesitancy/Change in Urinary Stream ◯ Loss of Bladder Control

Last Prostate Exam: _____ Last Self-Testicular Exam: _____

GASTROINTESTINAL HISTORY

Foreign Travel?: ◯ Yes ◯ No *If so, where?* _____

Wilderness Camping? ◯ Yes ◯ No *If so, where?* _____

Have you ever had severe: ◯ Gastroenteritis ◯ Diarrhea

Do you feel like you digest all your food well?: ◯ Yes ◯ No Do you feel bloated after meals?: ◯ Yes ◯ No

PATIENT BIRTH HISTORY

◯ Term ◯ Premature Pregnancy Complications:

Birth Complications:

Did you eat a lot of candy or sugar as a child?: ◯ Yes ◯ No

DENTAL HISTORY

DENTAL SURGERY

◯ **Silver/Mercury Fillings** *If so, how many?:* _____ ◯ **Gold Fillings** ◯ **Root Canals** ◯ **Implants**

◯ **Tooth Pain** ◯ **Bleeding Gums** ◯ **Gingivitis** ◯ **Problems Chewing**

Do you floss regularly?: ◯ **Yes** ◯ **No** *How many days per week?:* _____

MEDICATIONS

CURRENT MEDICATIONS *(or attach pharmacist print out)*

MEDICATION	DOSE	FREQUENCY	START DATE	REASON FOR USE

PAST MEDICATIONS *(last 10 years, fill in to the best of your ability)*

MEDICATION	DOSE	FREQUENCY	START DATE	REASON FOR USE

NUTRITIONAL SUPPLEMENTS *(vitamins, minerals, herbs, homeopathy)*

SUPPLEMENT OR BRAND	DOSE	FREQUENCY	START DATE	REASON FOR USE

Have medications or supplements ever caused you unusual side effects or problems?: ◯ Yes ◯ No

If so, please describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.) Motrin, or Aspirin?: ◯ Yes ◯ No

Have you had prolonged or regular use of Tylenol?: ◯ Yes ◯ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)?: ◯ Yes ◯ No

Frequent antibiotic use (>3 times/year)? ◯ Yes ◯ No Long-term antibiotic use?: ◯ Yes ◯ No

Use of steroids (prednisone, nasal allergy inhalers) in the past?: ◯ Yes ◯ No

Use of oral contraceptives?: ◯ Yes ◯ No

FAMILY HISTORY

Check family members that apply

	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts/Uncles	Details
Age *(if alive)*											
Age at death *(if deceased)*											
Cancer *(breast, colon, leukemia, etc.)*											
Heart Disease											
Obesity											
Diabetes											
Stroke											
Arthritis											
Inflammatory Bowel Disease											
Autoimmune Disease *(Lupus, MS, etc.)*											
Gastrointestinal Issues *(IBS, Celiac, Crohn's, etc.)*											
Allergy/Skin Issues *(Eczema, Asthma, Environmental Sensitivities, etc.)*											
Parkinson's											
ALS or Motor Neuron Diseases											
Genetic Disorders											
Mental Health Issues *(substance abuse, psychiatric disorders, depression, schizophrenia, ADHD, Autism, Bipolar, Dementia, etc.)*											

SOCIAL HISTORY

NUTRITION HISTORY *(Describe your typical daily diet)*

BREAKFAST	DINNER

LUNCH	SNACKS

Have you ever had a nutritional consultation?: ◯ **Yes** ◯ **No**

Have you made any changes to your eating habits because of your health?: ◯ **Yes** ◯ **No** *Describe:* _____

Do you currently follow a special diet or nutritional program?: ◯ **Yes** ◯ **No** *Describe:* _____

Do you have cravings for a specific item(s)? ◯ **Yes** ◯ **No** *to what?* _____

Height: Weight: Usual Weight Range (+/- 5lbs):

Desired Weight Range (+/- 5lbs): Highest Adult Weight: Lowest Adult Weight:

Weight Fluctuations (>10lbs): ◯ **Yes** ◯ **No** Body Fat % _____

How often do you weigh yourself?: ◯ **Daily** ◯ **Weekly** ◯ **Monthly** ◯ **Rarely** ◯ **Never**

Do you grocery shop? ◯ **Yes** ◯ **No** *if no, who does the cooking?* _____

Do you read food labels? ◯ **Yes** ◯ **No** *if yes, what are you looking for?* _____

Do you cook?: ◯ **Yes** ◯ **No** *if no, who does the shopping?* _____

Check all the factors that apply to your current lifestyle and eating habits:

◯ **Fast eater** ◯ **Erratic eating pattern** ◯ **Eat too much** ◯ **Late night eating** ◯ **Dislike healthy food**

◯ **Time constraints** ◯ **Eat more than 50% of meals away from home** ◯ **Travel frequently**

◯ **Non-availability of healthy food** ◯ **Do not plan meals or menus** ◯ **Reliance on convenience items**

◯ **Poor snack choices** ◯ **Significant other or family members do not like healthy foods**

◯ **Significant other or family members have special dietary needs or preferences** ◯ **Eat in the middle of the night**

◯ **Struggle with eating issues** ◯ **Emotional eater** ***(eat when sad, lonely depress or bored)*** ◯ **Eat too much under stress**

◯ **Eat too little under stress** ◯ **Don't care to cook** ◯ **Confused about nutrition advice**

◯ **Love to eat** ◯ **Eat because I have to** ◯ **Have a negative relationship with food**

SMOKING

Currently Smoking? ◯ Yes ◯ No *if so, for how many years* _____ *how many packs per day* _____

# of Attempts to Quit: Previous Smoking?: *for how many years* _____ *how many packs per day* _____

Second Hand Smoke Exposure?:

ALCOHOL INTAKE

How many drinks do you currently have per week? 1 drink= 5 ounces of wine, 12 ounces of beer, 1.5 ounces of spirits

◯ None ◯ 1-3 ◯ 4-6 ◯ 7-10 ◯ >10

OTHER SUBSTANCES

Caffeine?: ◯ Yes ◯ No *Coffee cups/day:* ◯ 1 ◯ 2-4 ◯ >4 *Black Tea cups/day:* ◯ 1 ◯ 2-4 ◯ >4

Caffeinated Soda or Diet Soda?: ◯ Yes ◯ No *12 ounce can or bottle/day:* ◯ 1 ◯ 2-4 ◯ >4

Are you currently using any recreational drugs?: ◯ Yes ◯ No *if so, what type?* _____

EXERCISE

Current Exercise Program: (Describe your weekly exercise regime, including sports, leisure activities, stretching, etc.)

Rate your level of motivation for including exercise in your life: ◯ Low ◯ Medium ◯ High

Do you have any problems that limit activity?: ◯ Yes ◯ No *if so, describe?* _____

Do you feel unusually fatigued after exercise?: ◯ Yes ◯ No Do you usually sweat when exercising?: ◯ Yes ◯ No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago?: ◯ Yes ◯ No Are you happy?: ◯ Yes ◯ No

Do you believe stress is presently reducing your quality of life?: ◯ Yes ◯ No

Do you like the work you do?: ◯ Yes ◯ No Have you ever experienced major losses in your life?: ◯ Yes ◯ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations?: ◯ Yes ◯ No

Would you describe your experience as a child in your family as happy and secure?: ◯ Yes ◯ No

STRESS/COPING

Have you ever sought counseling?: ◯ Yes ◯ No

Are you currently in therapy?: ◯ Yes ◯ No *if so, decribe?* _____

Do you have an excessive amount of stress in your life?: ◯ Yes ◯ No

Do you feel you can easily handle the stress in your life?: ◯ Yes ◯ No

Daily Stressors: *(rate on a scale of 1-10, 10 being the worst)*

Work ____ **Family** ____ **Social** ____ **Finances** ____ **Health** ____ **Other** ____

Do you practice meditation or relaxation techniques?: ◯ Yes ◯ No *if yes, check all that apply*

◯ Yoga ◯ Meditation ◯ Imagery ◯ Tai Chi ◯ Prayer ◯ Other _____

Have you ever been the victim of a crime, experienced significant trauma, or been physically, sexually or emotionally abused?:

◯ Yes ◯ No

SLEEP/REST

Average number of hours you sleep per night: ◯ >10 ◯ 8-10 ◯ 6-8 ◯ <6

Do you have trouble falling asleep?: ◯ Yes ◯ No Do you feel rested upon awakening?: ◯ Yes ◯ No

Do you have problems with insomnia?: ◯ Yes ◯ No Do you snore?: ◯ Yes ◯ No

Do you use sleeping aids?: ◯ Yes ◯ No

ROLES/RELATIONSHIPS

Children: *(if applicable)*

AGE	GENDER

AGE	GENDER

Who is living in the household?: *Number of people:* _____ *Names:* _____

Resources for emotional support? *check all that apply*

◯ Spouse ◯ Family ◯ Friends ◯ Religious/Spiritual ◯ Pet(s) ◯ Other _____

Are you satisfied with your sex life?: ◯ Yes ◯ No

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions, sensitivities, or allergies?: ◯ Yes ◯ No

If yes, describe symptoms: _____

List all known: _____

When you drink caffeine, do you feel: ◯ Irritable or Wired ◯ Aches & Pains

Which of these significantly affect you?: *check all that apply*

◯ Cigarette Smoke ◯ Perfumes/Colognes ◯ Auto Exhaust Fumes ◯ Other _____

In your work or home environment, are you exposed to: ◯ Chemicals ◯ Electromagnetic Radiation ◯ Mold

Do you have a known history of significant exposure to any harmful chemicals such as the following:

◯ Herbicides ◯ Insecticides *(frequent visits by exterminator)* ◯ Pesticides ◯ Organic Solvents

◯ Heavy Metals ◯ Other _____

Chemical Name, Date & Length of Exposure: _____

Do you dry clean your clothes frequently?: ◯ Yes ◯ No Do you have any pets or farm animals?: ◯ Yes ◯ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure?: ◯ Yes ◯ No

SYMPTOM REVIEW

Please check all current symptoms occurring or present

GENERAL

◯ Poor appetite ◯ Poor sleep ◯ Fatigue ◯ Fevers ◯ Chills ◯ Night sweats ◯ Sweat easily

◯ Tremors ◯ Cravings ◯ Localized weakness ◯ Poor Balance ◯ Change in appetite

◯ Bleed or bruise easily ◯ Peculiar tastes or smells ◯ Strong thirst *(cold or hot drinks)*

◯ Chronic infections ◯ Sudden energy drop *what time of day?:* _____

SKIN AND HAIR

◯ Rashes ◯ Ulcerations ◯ Hives ◯ Itching ◯ Pimples ◯ Dandruff ◯ Loss of hair

◯ Recent moles ◯ Change in hair or skin texture

◯ Any other hair or skin problems? *describe:* _____

HEAD, EYES, EARS, NOSE AND THROAT

◯ Dizziness ◯ Loss of balance ◯ Areas of numbness ◯ Lack of coordination ◯ Poor memory

◯ Concussion ◯ Quick temper/irritable ◯ Easily susceptible to stress ◯ Panic attacks

◯ Have you ever received treatment for emotional problems?

◯ Have you ever considered or attempted suicide?

◯ Any other neurological or psychological problems? *describe:* _____

MUSCULO-SKELETAL

◯ Joint pain ◯ Stiffness ◯ Lack of flexibility ◯ Radiating pain ◯ Headaches/Migraines

◯ Low back pain ◯ Foot pain ◯ Neck pain ◯ Trauma *(ie. MVA, slip, fall)* ◯ Joint pain

◯ Jaw clicks ◯ Any other head or neck problems? *describe:* _____

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:

Significantly modify your diet _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Take several nutritional supplements each day _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Keep a record of everything you eat each day _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Modify your lifestyle *(e.g., work demands, sleep habits)* _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Practice a relaxation technique _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Engage in regular exercise _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Have periodic lab tests to assess your progress _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1

Comments

_____

_____

_____

_____

Rate on a scale of 5 (very confident) to 1 (not confident at all)

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

◯ 5 ◯ 4 ◯ 3 ◯ 2 ◯ 1

Comments

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact)

How much on-going support and contact (e.g. telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?

◯ 5 ◯ 4 ◯ 3 ◯ 2 ◯ 1

Comments