Dr. Anita Komonski, B.Sc., ND

Naturopathic Physician

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Health History Questionnaire for Naturopathic Physician (Adult)

Patient Name: _____ Date:_____
PLEASE PRINT (Last) (First) (Middle)

Successful comprehensive health care is only possible when the physician has a complete understanding of the patient's physical, mental and emotional condition and history. Please answer each question completely, marking anything you have a question about. Your time, thoughtfulness and honesty is appreciated and will greatly aid me in evaluating your health needs. All answers are completely confidential.

Address: _____ City: _____ Province: ___ Postal Code: _____
Phone: (home)_____ (work)_____ (cell) _____
Email: _____ Please circle preferred method of contact
Can messages be left confidentially? Y N
Emergency Contact: _____
Name Phone number Relationship

MSP (Care Card) #: _____ Date of Birth: _____
Age: _____ Gender: _____ Occupation: _____

Marital status: ☐ Single ☐ Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Other_____
Live with: ☐ Alone ☐ Partner ☐ Friends ☐ Parents ☐ Children ☐ Relatives ☐ Other_____

How did you hear about Dr. Komonski?_____

Medical doctor and other health care providers:

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
(____)_____	(____)_____	(____)_____

What is your main reason for coming in today?

_____
_____

What are your other health concerns? List as many as you can in order of importance to you, including when they started.

1. _____	onset: _____	6. _____	onset: _____
2. _____	onset: _____	7. _____	onset: _____
3. _____	onset: _____	8. _____	onset: _____
4. _____	onset: _____	9. _____	onset: _____
5. _____	onset: _____	10. _____	onset: _____

What kind of treatment have you received? _____

Do you have any known contagious diseases at this time? N Y: _____

Do you have any known life-threatening allergies? N Y: _____

FAMILY MEDICAL HISTORY: Please indicate if you have a family history of any of the following conditions, specifying whom [mother (M), father (F), sibling (S), child (C), maternal grandparent (MG), paternal grandparent (PG)].

☐ Diabetes	☐ Heart disease	☐ Stroke	☐ Cancer (include type)
☐ Seizures	☐ Asthma	☐ Allergies	☐ High blood pressure
☐ Arthritis	☐ Kidney disease	☐ Depression	☐ Alzheimer's
☐ Lupus	☐ MS	☐ Celiac disease	☐ Other

Current medication (prescription & over the counter), nutritional supplements, natural remedies (please list dosage)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

What hospitalizations, surgeries, major illnesses or injuries have you had?

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

What medical tests (X-Ray, CT Scan, MRI, EEG, ECG, bone density scan, mammogram) have you had?

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

Which childhood illnesses have you had? If you don't know, place a question mark beside it.
☐ Diptheria ☐ Measles ☐ Scarlet Fever ☐ Chicken Pox ☐ Mumps ☐ Rubella ☐ Whooping Cough

Have you been vaccinated? If you don't know, place a question mark beside it.
☐ Diptheria ☐ Measles/Mumps/Rubella ☐ Hepatitis A/B ☐ Flu ☐ Gardasil/HPV
☐ Pertussis ☐ Meningitis ☐ Polio ☐ Chickenpox ☐ Tetanus ☐ Other_____
Any adverse reactions? _____

Are you aware of having any allergies/sensitivities to any of the following? If so, please elaborate.
Drugs _____
Foods _____
Chemicals/perfume _____
Animals _____
Plant/pollen _____

Do you frequently use any of the following? (please list how much, how often)

Pain relievers _____	Sedatives/sleeping pills _____
Laxatives _____	Antibiotics _____
Antacids _____	Cortisone _____
Hormones _____	Birth control pills/implants/injections _____
Alcohol _____	Tobacco _____
Caffeine _____	Recreational drugs (please specify)_____

In your opinion, what is your weakest system (e.g. digestive, immune, cardiovascular, etc.)? _____

Height: _____ Weight: _____ Maximum weight: _____ When? _____

Review of Systems – Please check all current or recurring problems.

GENERAL

☐ Poor appetite	☐ Fatigue	☐ Sleep disturbances
☐ Change in appetite	☐ Night sweats	☐ Weight gain/loss
☐ Cravings	☐ Sweat easily	☐ Sudden energy drop (time?)_____

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

ENDOCRINE

☐ Thyroid problem	☐ Excessive thirst	☐ Seasonal depression
☐ Heat intolerance	☐ Excessive hunger	☐ Hypoglycemia (low blood sugar)
☐ Cold intolerance	☐ Diabetes	

IMMUNE

☐ Swollen glands	☐ Chronic infections	☐ Colds/flu more than once yearly
☐ Slow wound healing	☐ Frequent colds	

NEUROLOGIC

☐ Seizures	☐ Paralysis	☐ Numbness or tingling
☐ Muscle weakness	☐ Loss of memory	☐ Vertigo or dizziness
☐ Loss of balance	☐ Easily stressed	☐ Lack of coordination

MENTAL/EMOTIONAL

☐ Mood swings	☐ Poor concentration	☐ Depression
☐ Anxiety or nervousness	☐ Tension	☐ Quick temper/irritable

Have you ever been treated for emotional problems? _____

Have you ever considered/attempted suicide? _____

HAIR, SKIN & NAILS

☐ Rashes	☐ Eczema	☐ Hives
☐ Itching	☐ Acne	☐ Recent moles/change in moles
☐ Lumps	☐ Hair loss	☐ Change in hair texture
☐ Dandruff	☐ Brittle nails	☐ Change in skin texture

HEAD & NECK

☐ Headaches	☐ Jaw/TMJ Problems	☐ Head injury/concussions
☐ Neck pain	☐ Sinus problems	☐ Postnasal drip

EYES

☐ Eye pain/strain	☐ Tearing	☐ Blurry vision
☐ Using glasses/contacts	☐ Colour blindness	☐ Night blindness
☐ Floaters/spots in vision	☐ Cataracts	☐ Dryness
☐ Double vision	☐ Sensitive to light	☐ Bloodshot/puffy eyes

EARS

☐ Hearing loss	☐ Earaches	☐ Ringing
☐ Sensitivity to noise	☐ Dizziness	☐ Discharge from ears

NOSE, MOUTH & THROAT

☐ Nose bleeds	☐ Hayfever	☐ Nasal congestion/stuffiness
☐ Loss of smell	☐ Mouth ulcers	☐ Dental cavities
☐ Gum problems	☐ Teeth grinding	☐ Copious saliva

□ Sore tongue/lips □ Hoarseness □ Frequent sore throat

RESPIRATORY

□ Difficulty breathing □ Cough □ Spitting up blood
□ Wheezing □ Painful breathing □ Sputum (mucous)
□ Frequent bronchitis □ Shortness of breath □ Shortness of breath lying down

CARDIOVASCULAR

□ High/low blood pressure □ Irregular heartbeat □ Heart disease
□ Heart palpitations □ Chest pain □ Murmurs
□ Blood clots □ Fainting □ Ankle swelling

GASTROINTESTINAL

□ Trouble swallowing □ Nausea/vomiting □ Bad breath
□ Heartburn □ Indigestion □ Abdominal pain/cramps
□ Belching/passing gas □ Constipation □ Diarrhea
□ Black/tarry stools □ Blood in stools □ Jaundice
□ Liver disease □ Gallbladder disease □ Hemorrhoids

Bowel movements: How often? _____ Is this a change?_____

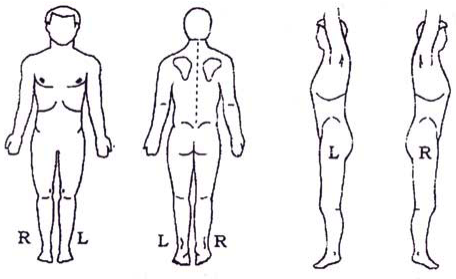
URINARY

□ Pain on urination □ Increased frequency □ Wake to urinate
□ Inability to hold urine □ Frequent infections □ Blood in urine
□ Kidney stones □ Odd smell/colour to urine □ Difficulty starting to urinate

MUSCULOSKELETAL

□ Joint pain/stiffness □ Broken bones □ Muscle weakness
□ Muscle pain □ Muscle spasms/cramps □ Sciatica

Mark areas of pain:



BLOOD/PERIPHERAL VASCULAR

□ Easy bleeding/bruising □ Varicose veins □ Anemia
□ Deep leg pain □ Cold hands/feet □ Fluid retention

MALE REPRODUCTIVE

□ Hernias □ Testicular masses □ Testicular pain
□ Prostate problems □ Erectile dysfunction □ Sexually transmitted infection
□ Premature ejaculation □ Sexually active □ Use birth control (type)_____
□ Low libido □ Discharge/sores □ Do you do testicular self-exams?

FEMALE REPRODUCTIVE

Age of first menses_____ Length of cycle (blood flow to next blood flow)_____
□ Irregular cycles Duration of menses (days of bleeding)_____
□ Painful menses □ Heavy flow □ Light flow
□ Spotting between periods □ Clots □ PMS
Date of last PAP_____ □ Abnormal PAP (when)_____ □ Vaginal discharge

☐ Sexually active	☐ Pain during intercourse	☐ Use of birth control (type)_____
☐ Low libido	☐ Sexually transmitted infection	☐ Menopausal symptoms (type)_____
☐ Difficulty conceiving	☐ Breast pain/tenderness	☐ Breast lumps
☐ Nipple discharge	☐ Recent change in breasts	☐ Do you do breast self-exams?
Number of pregnancies_____	Number of live births_____	Number of miscarriages_____

LIFESTYLE

☐ Exercise regularly (kind)_____ How often? _____
☐ Awake feeling rested ☐ Sleep well How many hours of sleep per night? _____
How often do you consume: Pop: _____ Added salt: _____
Sugar: _____ Artificial sweetener: _____
☐ Cook own meals How often do you eat out? _____
☐ Enjoy your work Any occupational hazards? _____
Have you ever been treated for an addiction? _____
Do you have supportive relationships? _____
Do you have a religious or spiritual practice? _____
What do you LOVE to do? _____

Is there anything else you would like to add or comment on?

CONTEXT OF CARE

Why did you choose to come to *this* clinic?

What expectations do you have of *today's* visit to our clinic?

What *long-term* expectations do you have?

What expectations do you have of me as your naturopathic physician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle habits? Rate from 0-10, where 10 is 100% committed.

0 1 2 3 4 5 6 7 8 9 10

What potential *obstacles* do you foresee in addressing the lifestyle factors that may be undermining your health and adhering to the treatment guidelines we will be sharing with you?

Thank you for your time and effort. We look forward to providing you with the best possible care.

Declaration and Informed Consent to Naturopathic Care

I would like to take this opportunity to welcome you to our clinic. As a naturopathic physician, I will conduct a thorough case history, a physical exam, and may utilize specific blood and/or urinary laboratory reports as part of the treatment work-up. I use supportive therapies such as nutrition counseling, botanical medicine, acupuncture/traditional Chinese medicine, supplementation, hypnotherapy, hydrotherapy, bodywork, homeopathy and lifestyle counseling to assist the body's innate healing capacity and to improve overall health and wellbeing.

Statement of Acknowledgement

Printed name_____

As a patient of Dr. Anita Komonski, I have read the information and understand that the form of medical care is based on **naturopathic** and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information provided is complete, accurate and inclusive of all health concerns including the risk of pregnancy and all medications, including over the counter drugs and supplements. **Slight** health risks of some naturopathic treatments include, but not limited to: temporary aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture, muscle strains and spasms, and disc injuries from spinal manipulations.

I also recognize the following:

- Information revealed during the course of a visit is **strictly confidential**. Exceptions to this confidentiality include disclosure regarding intention to seriously harm myself or others, and where there is reasonable suspicion of emotional, physical and/or sexual abuse of a minor.
- A record will be kept of my visits. This record and the information provided **will not be disclosed** to others without my consent, or unless the law compels or authorizes Dr. Komonski to do so. I understand that I may look at my medical records at any time and can request a copy of them.
- I will be given the opportunity to discuss and ask questions regarding any treatment plan. I have the ability to **accept or reject this care** of my own free will and choice.
- Any treatment or advice provided to me as a patient of Dr. Komonski is **not mutually exclusive** from any treatment I may now be receiving or may in the future receive from another licensed health care provider. I am at liberty to seek or continue medical care from a medical doctor or other licensed healthcare provider. I will inform Dr. Komonski of other treatments that I may be receiving concurrently, or plan to receive while following the treatment plan. I understand that results are not guaranteed.
- I am responsible for **full payment** at the time of each visit for services, cost of supplements/botanicals, lab tests or other fees. I am aware that these fees are not covered by MSP; in the case of premium assistance, I will pay all fees up front and request a reimbursement.
- I am aware that a **minimum of 24 hours notice** must be given for all rescheduled or cancelled appointments. If I cancel an appointment within 24 hours or do not arrive for a scheduled appointment I will be charged a cancellation fee.
- I understand that Dr. Komonski reserves the right to determine which cases fall outside her scope of practice, in which case the **appropriate referral will be recommended**.

I consent to receive naturopathic treatment from Dr. Anita Komonski. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: _____ Date: _____