Theresa MacLean ND
Doctor of Naturopathic Medicine
River Valley Partners in Health

Thank you for taking the time to fill out this form. This information is confidential and important in the assessment of your case.

Date:_____
Full Name:_____
Address:_____ City:_____
Province:_____ Postal code:_____
Phone (H):_____(W):_____
Age:_____ Date of Birth:_____Place of birth_____
Occupation:_____Past occupation:_____
Martial Status:_____ Number of Children: _____
Family Physician:_____ Phone:_____
What are your main health concerns:_____

Medical History:

General:
Date of last physical exam:_____ Weight:_____
Height:_____Maximum weight:_____
Energy Level (scale 1-10, 10 highest) _____
Blood Type:_____ Do you wake refreshed? _____
Do you smoke? Yes (Presently)_____ Yes, in the past _____No never _____
Do you drink alcohol? Yes_____ No _____Number of drinks per week _____
Do you exercise? Yes _____ No _____
Type of exercise and times per week _____
Allergies? No_____ Yes_____ Please list _____
Current medications:_____
Past Medications:_____
Current vitamins and supplements _____
Other treatments tried in the past_____

Review of Systems:
Please circle any of the following conditions you are experiencing now or have had in the past.

Skin: rashes, boils, lumps, hives, itching, dry skin, acne, eczema, night sweats,
other:_____

Head: headache, dizziness, head injury, migraine, other_____

Ears: discharge**,** earache, ringing, excessive wax, itching, decreased hearing,
other _____

Eyes: glasses/contacts, impaired vision, double vision, redness, discharge, tearing, dryness, cataracts, blurring, light sensitivity, blind spots, difficulty with night vision, glaucoma, itching, other_____

Nose and Sinuses: nose bleeds, obstructions, hay fever, allergies, frequent colds, nose/sinus injury, sinus problems, colds per year_____
other_____
_____

Mouth and throat: hoariness, dry mouth, many sore throats, sores, dental cavities, gum problems, loss of taste,
other:_____

Neck: Stiffness, lumps, goiter, swollen glands, pain,
other:_____

Respiratory: Wheezing, sputum, chest pain, pleurisy, asthma, difficult breathing, pneumonia, emphysema, bronchitis, cough,
other_____

Breasts: Lumps, tenderness, pain,
other:_____

Cardiovascular: Heart disease, ankle swelling, murmurs, chest pain, high blood pressure, angina, palpitations, rheumatics,
others:_____

Gastrointestinal: indigestion, heartburn, belching/gas, bloating, hiatal hernia, difficulty swallowing, change in appetite, jaundice, nausea, vomiting, hemorrhoids, diarrhea, constipation, rectal bleeding, number of bowel movements per day_____
Other:_____

Urinary: pain on urination, increased frequency, blood in urine, bladder infection, kidney stones, inability to urinate,
other:_____

Musculoskeletal: Joint pain or stiffness, muscle spasm or cramps, weakness, numbness/tingling, broken bones, arthritis, backache,
other:_____

Peripheral Vascular: cold hands, cold feet, varicose veins, deep leg pain, thrombplebitis,
other:_____

Neurological: Fainting, loss of memory, seizures, loss of balance, paralysis, speech problems, muscle weakness, involuntary movements, other:_____

Endocrine: Thyroid disease, diabetes, hormone therapy, low blood sugar, other:_____

Blood/Lymphatic: Anemia, lymph node swelling, easy bruising/bleeding, blood transfusion, other_____

Reproductive: history of venereal disease, sexual difficulties**,** sexually active**,** type of birth control?_____
Other:_____

Males: Prostate disease, premature ejaculation, impotent,
other:_____

Female: Regular menses, number of days of menstrual cycle_____, menopause, if yes what age?_____**,** menopause symptoms_____
, Age of first menstruation _____, number of pregnancies?_____ Miscarriages?_____
Abortions?_____

Premenstrual syndrome symptoms: Depression, irritability, mood swings, cravings, breast tenderness, weight gain, increased appetite, other_____

Psyco/social: depression, mood swings, emotional/physical abuse, anxiety/nervousness, phobias, alcohol/drug problems, sleep problems, other_____
Have you ever had psychiatric/psychological counseling?_____
How content are you with your life? (1-10, 10 very content)_____
What would you like to change in your life?_____
Do you express your emotions easily?_____

Environment: Do you live in a recently constructed house?_____ Have you been exposed to any chemicals or toxins?_____ Do you have any chemical sensitivities?_____

Family history: Please circle:
cancer, heart disease, high blood pressure, diabetes, arthritis, osteoporosis, asthma, kidney disease, mental illness, thyroid disease, other_____

Childhood diseases: Please circle: Measles, rheumatic fever, diphtheria, mumps, chickenpox, polio, whooping cough? Other:_____
Have you had a bad reaction to a vaccination? Explain_____

Health History: Please list hospitalizations, surgeries, diseases, major accidents, trauma's, etc...
Age:_____
Age:_____
Age:_____
Age:_____
Age:_____

Age:_____
Is there anything else you feel I should know about?_____

Diet Diary: Please record what you have ate and drank for 7 days**,** including snacks**.**

Day one
Breakfast _____
Lunch_____
Supper _____

Day two
Breakfast _____
Lunch_____
Supper _____

Day three
Breakfast _____
Lunch_____
Supper _____

Day four
Breakfast _____
Lunch_____
Supper _____

Day five
Breakfast _____
Lunch_____
Supper _____

Day six
Breakfast _____
Lunch_____
Supper _____

Day seven
Breakfast _____
Lunch_____
Supper _____