**Raven Naturopathic Health Services**
508 – 2250 Bovaird Drive East, Brampton, ON, L6R 0W3
(905) 216-8730 * www.RavenNaturopathic.ca

# PATIENT HISTORY FORM

*The purpose of this form is to help us get to know you before your first appointment. Please fill it in to the best of your ability, and return it to us prior to your first appointment. The more information you provide, the better we are able to help.*

## Health Concerns

Please list your main health concerns, in order of importance for you:

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

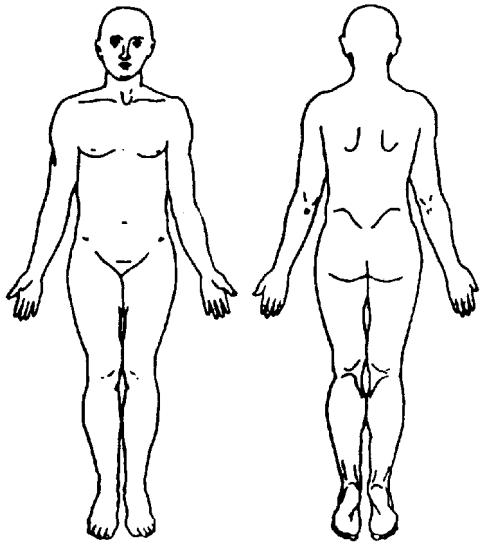
## Health Goals

Please list your top three health goals (ie, how can we help?):

1. _____
2. _____
3. _____

## Pain

Draw any areas of pain here:
(You can describe your pain or make your own legend below, if you wish)



_____
_____
_____
_____
_____
_____
_____
_____

## Questions

Do you have any questions you would like us to help you answer? _____

_____
_____
_____
_____
_____

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**Medical History**

Please list any medical conditions that you may currently have:

Heart / Blood: _____

Lungs / Breathing: _____

Eyes, Ears, Nose and Throat: _____

Skin: _____

Stomach / Intestines: _____

Liver / Gallbladder: _____

Kidney / Urinary Bladder: _____

Male Genitalia / Prostate: _____

Female Genital / Uterus / Ovaries / Menstural Concerns: _____

_____

Endocrine / Diabetes / Thyroid: _____

Autoimmune: _____

Neurological / Brain: _____

Mental Health Concerns: _____

Muscles / Bones: _____

Cancer: Type: _____ Stage: _____ Grade: _____

O Just Diagnosed O Active Treatment O Finished Treatment

O Recurrence O Palliative

Please list any surgeries or hospitalizations that you might have had: _____

_____

Please list any allerges or sensitivities that you might have: _____

_____

Please list any medications, natural supplements and any other remedy you may be taking:

| Medication / Supplement | How much are you taking? | How often? | When did you Start? | Why are you taking it? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

*Need more space? You can simply write the rest on a separate piece of paper and hand them in together with this form.*

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**Dietary & Lifestyle**

Do you follow a restricted diet? (eg. Vegetarian, Halal, Kosher, DASH; please describe)

_____

What do you eat in a typical day? _____

_____

_____

What exercise do you get in a typical week? _____

_____

Describe your sleep: _____

_____

**Social History**

What do you do? _____

_____

Relationship status (and partner's name): _____

Any children (names and ages)?: _____

_____

Any pets (names, ages and types)?: _____

_____

Do you drink alcohol? ____ How much / how often: _____

Do you smoke? ____ How much / how long: _____

Do you use recreational drugs? ____

What type: _____ How much / how often: _____

What type: _____ How much / how often: _____

What type: _____ How much / how often: _____

**Family History**

Please tell us who in your family, if anyone, has had any of the following conditons:

Allergies / Asthma: _____

Autoimmune: _____

Heart Disease: _____

Hyptertension: _____

Diabetes: _____

Thyroid Disease: _____

Kidney or Liver Disease: _____

Mental Illness: _____

Cancer (type?): _____

_____

Other Conditions: _____

***Thank you for taking the time to fill in this form.***

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**Healthcare Team CONSENT**

We like to stay in touch with your healthcare team. Please list your healthcare providers below, let us know who (if anyone) we may speak with.

| Profession / Speciality | Name | Phone / Email | Address |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

1) If we are contacted by a member of your healthcare team, who may we speak with:
O No-one without checking with me first
O Medical doctor and medical specialists only
O Only those listed here: _____
_____

2) May we send an introductory letter to your family doctor and/or specialist explaining our assessment and treatments? O Yes O No O I wish to disuss this further
If yes, please specify who we should contact: _____
_____

3) If we are contacted by a friend or family member, who may we speak with:
O No-one without checking with me first
O Only those listed below (for your protection, please cross out any box you don't need):

| Name | Relationship | Name | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Patient Name (please print): _____ Date: _____

Signature of Patient or Guardian: _____

***You are free to change any of these permissions at any time.***