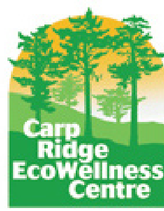
Carp Ridge EcoWellness Centre
4596 Carp Road, Carp ON. K0A1L0

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______________________________________________________________________________

**Adult Patient Health History**

Date:_________________________________

First Name: ___________________________________ Last Name: ______________________________________

Address: ________________________________________________________________________________________

Phone # :_________________ Email Address:________________________________________________________

Age: ________ Birthdate: mm/dd/yy_____/_____/______
Marital Status: □ single □ married □ separated □divorced
Number of Children & Ages: ______________________________________________________________________
Pets in the house? □yes □ no Type?________________________________________________________________

Occupation(s): _____________________________ Religion/Spiritual Path:_________________________________

Other Healthcare providers you are seeing:
1. ________________________ 2. _________________________ 3.______________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
(_______)__________________ (_______)__________________ (_______)__________________

Please fill in the following pages as best you can. Put an 'x' beside the areas you wish to discuss.

Primary Problem: ________________________________________________________________________________
(this will be discussed in detail in your first visit)

Other health concerns, in order of importance to you:
1. _____________________________________________________________________________________________
2. _____________________________________________________________________________________________
3. _____________________________________________________________________________________________
4. _____________________________________________________________________________________________

**A. MEDICAL HISTORY:**

Prenatal Influences: □ Alcohol □ coffee □ cigarettes □ drugs □ stress □other____________________________
Nature of birth (if known): □ trauma □ forceps □ drugs □ natural □ other ______________________________
Were you breast fed?: □yes □no □not known / For how many months? __________________________________

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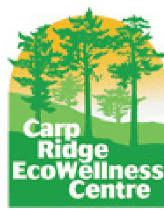


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Vaccinations : □ all scheduled □DTap □MMR □ Hep B □ Men C □ Varicella □ Hib □ HPV □ Pneu

Any Complications? ___

Normal Childhood Diseases: □ chicken pox □ mumps □ measles □ other ___

Any Complications? ___

Any chronic problems as a child? (lungs, stomach, throat etc..) ___

___

Tonsils out? □ Yes □ No Age? ___ Complications? ___

Specific teenage problems? (acne, weight, development, mono, etc…)___

___

| Adult Illnesses: | Age | How Severe (hospitalized?) |
|---|---|---|
| ___ | ___ | ___ |
| ___ | ___ | ___ |
| ___ | ___ | ___ |
| ___ | ___ | ___ |
| ___ | ___ | ___ |

When did you notice changes to your health? ___

___

___

Do you smoke? □ yes □ no How many cigarettes per day? ___

Does anyone in your household smoke? □ yes □ no

**B. FAMILY HISTORY**:

Appearance of parents (build, colouring, hair texture, glasses, eye colour)

Mother: ___

Father: ___

Which side of the family do you take after in physical appearance? □ mother □ father □not known

Health problems of mother: ___

father: ___

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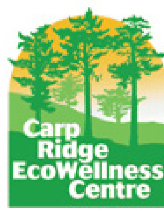


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Please check any diseases which have occurred in your family, who had them and at what age. Specify if on maternal or paternal side.

| M / P | Who / Age | M/P | Who / Age |
|---|---|---|---|
| □/□ cancer (type) | ____________________ | □/□ Kidney Disease | ___________________ |
| □/□ diabetes | ____________________ | □/□ Arthritis | ___________________ |
| □/□ heart disease | ____________________ | □/□ Anemia | ___________________ |
| □/□ Mental illness | ____________________ | □/□ Headaches | ___________________ |
| □/□ Tuberculosis | ____________________ | □/□ Alcoholism | ___________________ |
| □/□ High Blood pressure | __________________ | □/□ Osteoporosis | ___________________ |
| □/□ Obesity | ____________________ | □/□ Intestinal Disease | ___________________ |
| □/□ Stroke | ____________________ | □/□ Ulcers | ___________________ |

## C. ENVIRONMENT:

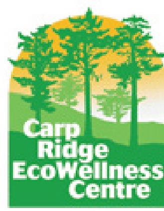
Where do you live? □ country □ suburbs □ city □ farm
Type of home? □ condo/apt □ townhouse □ detached house
Do you live near hydro towers? □ yes □ no
Type of heat? □ oil □gas □electric □ wood □other
Any hobbies using chemicals? ______________________________________________________________
Have you done any travelling recently? □yes □no Where?____________________________________________
Describe workplace: □ windows open □chemicals present □ climate controlled
If you garden, do you use: □ pesticides □ herbicides
Please list any checmicals, toxins, or other factors in your environment that might be affecting your health?

_____________________________________________________________________________________

## D. DAILY ACTIVITIES:

List the number of hours you spend each day for the following activities. This will likely add up to more than 24 hours.

| Hours | Activity | Hours | Activity |
|---|---|---|---|
| _______ | Sleeping | _______ | Commuting/Driving |
| _______ | Working | _______ | Watching television |
| _______ | On the computer | _______ | House or yard work |
| _______ | Listening to music | _______ | Reading |






________ Being Outside ________ Relaxing or meditating

________ Interacting with family ________ Time Alone

Please circle your level of satisfaction of the following aspects of your life:

1 – not satisfied or comfortable at all with my current situation
2 – low level of satisfaction or comfort with my current situation
3 – okay some of the time with my current situation
4 – quite satisfied or comfortable with my current situation
5 – high level of satisfaction or comfort with my current situation

| | | | | | | Changed In the Past Year | |
|---|---|---|---|---|---|---|---|
| DIET | 1 | 2 | 3 | 4 | 5 | YES | NO |
| EXERCISE | 1 | 2 | 3 | 4 | 5 | YES | NO |
| WELLNESS | 1 | 2 | 3 | 4 | 5 | YES | NO |
| LIFESTYLE | 1 | 2 | 3 | 4 | 5 | YES | NO |
| HOUSE /LIVING | 1 | 2 | 3 | 4 | 5 | YES | NO |
| WORK | 1 | 2 | 3 | 4 | 5 | YES | NO |
| FAMILY | 1 | 2 | 3 | 4 | 5 | YES | NO |
| RELATIONSHIPS | 1 | 2 | 3 | 4 | 5 | YES | NO |

## E. HABITS:

**Diet:** □ normal □ junk food □ vegetarian □other: ____________________________________________

What is an average day's food intake? Please include beverages.
Breakfast: ____________________________________________
Lunch: ____________________________________________
Dinner: ____________________________________________
Snacks: ____________________________________________
Do you eat quickly? ___ Standing up? ___ On the run? ___
at restaurants often? ___, and if so, what type of restaurants? ______________________________

Do you monitor your intake of : □ fat? □ calories? □ salt? □ fiber?□ sugar?
Do you enjoy preparing food? □yes □ no
Do you enjoy eating? □ yes □ no

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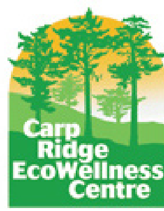


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Are you aware of any differences in how you feel with different foods? □ yes □ no
Do you pay attention to the quality of food you eat? □ yes □ no
Do you prepared or take-out meals often? □ yes □no

**Supplements:**

| (vitamins, minerals, herbs, etc.) | Reason For Taking |
|---|---|
| ______________________________ | __________________________________________________________ |
| ______________________________ | __________________________________________________________ |
| ______________________________ | __________________________________________________________ |
| ______________________________ | __________________________________________________________ |
| ______________________________ | __________________________________________________________ |
| ______________________________ | __________________________________________________________ |

**Exercise:**

Type: ___________________________________________ Amount per week: ___________________________

**F. PSYCHOSOCIAL HISTORY:**

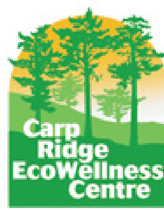
List any important life experiences in chronological order, especially traumatic events:

| Age | Event | Comment |
|---|---|---|
| _____ | ____________________________ | ________________________________________________________ |
| _____ | ____________________________ | ________________________________________________________ |
| _____ | ____________________________ | ________________________________________________________ |
| _____ | ____________________________ | ________________________________________________________ |
| _____ | ____________________________ | ________________________________________________________ |

Have you ever had a nervous breakdown? □ yes □ no
If yes, please describe the circumstance ____________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Who are the most significant others in your life and what are the challenges in each relationship:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Religious or spiritual beliefs ______________________________________________________________________






What is your view of the present and your outlook for the future? ____________________

How do you feel about yourself? ____________________

## G. SUMMARY

Do you have a preference for the type of naturopathic treatments used?
____________________

Are there any treatments you are presently aware of which you would rather not have?
____________________

Do you have a supportive environment (home / work) for making lifestyle changes?____________________

What are your short-term health goals?____________________

What are your long-term health goals? ____________________

Is there any information that you would like to add? ____________________

Thank you for taking the time to fill out this health history.