

Dr. Penny Seth-Smith N.D.
Naturopathic Family Physician
Board Certified in Acupuncture

Patient Information

Name _____ Age _____ M F Date _____

Street Address _____ Birthdate _____

City _____ Province _____ Postal Code _____ Home Phone _____

Occupation _____ E-mail (optional) _____

Work Phone _____ Fax _____

Marital status: Single Married Separated Divorced Widowed Other _____

Name of Spouse / Partner _____ Types of pets _____

Children (Names / Ages) _____

If patient is a child: Mother's name _____

Father's name _____

How did you learn about this clinic? Friend Relative Professional Other

If other, please describe _____ If referred, by whom? _____

Are you familiar with the services offered by Naturopathic Doctors? Yes No

Have you had previous naturopathic care? Yes No If yes, when? _____

With whom? _____ For what ailments? _____

Other Health Care Providers: Medical Doctor(s) _____

Chiropractor _____ Others _____

2518 Blackwood St., Victoria, B.C., V8T 3W1
Tel: (250) 361-9888

HEALTH QUESTIONNAIRE

Please answer all questions carefully. This information is necessary for Dr. Penny Seth-Smith to assess your total health picture as it relates to your current problem. It is a confidential record of your medical history and will not be released to any other person without your authorization.

Your Main Health Concerns

Please describe your major complaint(s):

- 1. _____
- 2. _____
- 3. _____

When did the condition(s) begin? _____

Describe the pain or discomfort _____

What movements or circumstances aggravate the conditions (e.g. bending, damp, anger) _____

Have you had the condition(s) before? No____ If yes, when? _____

Please list doctors seen, treatments used and results achieved for the above conditions

What other measures have you tried, with what results?

Is your health currently getting better, worse, or staying the same? How do you know?

What do you feel is your weakest organ system, and why?

How frequently do you have a full and complete bowel movement?

Have you taken antibiotics? If yes, most recent date:

How frequently do you have a cold, sinusitis, flu, sore throat, or bronchitis?

How long do they usually last and are they severe?

Have you ever fainted, blacked out or had a convulsion?

Do you wear a medicalert bracelet or tag? If so, why?

Any severe allergies? If so, to what?

Please list the five most significant, stressful events in your life, and whether they continue to impact your life:

Your past medical history	Please tick
---------------------------	-------------

- | | | |
|--|---|---|
| <input type="checkbox"/> Abscesses
<input type="checkbox"/> alcoholism
<input type="checkbox"/> allergies
<input type="checkbox"/> amnesia
<input type="checkbox"/> ankylosing
spondylitis
<input type="checkbox"/> arthritis:
osteo/rheumatoid
<input type="checkbox"/> asthma
<input type="checkbox"/> auto-immune
disease
<input type="checkbox"/> cancer
<input type="checkbox"/> candida
<input type="checkbox"/> chicken pox
<input type="checkbox"/> chlamydia
<input type="checkbox"/> cold sores
<input type="checkbox"/> cystitis
<input type="checkbox"/> depression
<input type="checkbox"/> diabetes
<input type="checkbox"/> diphtheria
<input type="checkbox"/> ear infections
<input type="checkbox"/> emphysema
<input type="checkbox"/> epilepsy
<input type="checkbox"/> fibroids or cysts
<input type="checkbox"/> gallstones
<input type="checkbox"/> goitre | <input type="checkbox"/> gonorrhoea
<input type="checkbox"/> gout
<input type="checkbox"/> hayfever
<input type="checkbox"/> heart disease
<input type="checkbox"/> hepatitis
<input type="checkbox"/> herpes genitalia
<input type="checkbox"/> high blood pressure
<input type="checkbox"/> hiv/aids
<input type="checkbox"/> hives
<input type="checkbox"/> hypoglycemia
<input type="checkbox"/> influenza
<input type="checkbox"/> kidney disease
<input type="checkbox"/> kidney stones
<input type="checkbox"/> leukemia
<input type="checkbox"/> malaria
<input type="checkbox"/> measles: German
<input type="checkbox"/> measles red
<input type="checkbox"/> mercury (silver)
fillings
<input type="checkbox"/> miscarriage
<input type="checkbox"/> mononucleosis
(Epstein Barr virus)
<input type="checkbox"/> mumps
<input type="checkbox"/> osteopenia
<input type="checkbox"/> osteoporosis | <input type="checkbox"/> parasites / worms
<input type="checkbox"/> pelvic inflammatory
disease
<input type="checkbox"/> pleurisy
<input type="checkbox"/> pneumonia
<input type="checkbox"/> prostatitis
<input type="checkbox"/> rheumatic fever
<input type="checkbox"/> rheumatism
<input type="checkbox"/> scarlet fever
<input type="checkbox"/> sexual abuse
<input type="checkbox"/> seizures
<input type="checkbox"/> shigella
<input type="checkbox"/> sinusitis
<input type="checkbox"/> skin disease
<input type="checkbox"/> strep throat
<input type="checkbox"/> sunstroke
<input type="checkbox"/> stroke
<input type="checkbox"/> syphilis
<input type="checkbox"/> thyroid disease
<input type="checkbox"/> tonsillitis
<input type="checkbox"/> tuberculosis
<input type="checkbox"/> typhoid fever
<input type="checkbox"/> venereal warts
<input type="checkbox"/> warts elsewhere
<input type="checkbox"/> whooping cough |
|--|---|---|

Any other major condition or hospitalisation? _____

Significant traumas (auto accidents, falls etc.) _____

Surgeries (please list and date) _____

Please indicate if you have never been totally well after any of the preceding conditions, or if they were more severe than usual.

Family History: please indicate family member, and F if father's side, M if mother's side.
--

- | | |
|--|--|
| <input type="checkbox"/> Allergies
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Digestive disorders (chronic)
<input type="checkbox"/> Gonorrhoea
<input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure
<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Seizures
<input type="checkbox"/> Syphilis
<input type="checkbox"/> Thyroid disease/goitre
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Other major illness |
|--|--|

Occupational Stress (chemical, physical, psychological)

Weekly Exercise

Medications: Please include prescription drugs, over the counter drugs, vitamins, minerals, herbs and any non-medical drugs you presently use, and any you have taken in the past for more than 3 months. Use a separate sheet if necessary.

What vaccinations have you had?
Did you suffer any adverse effects from them?

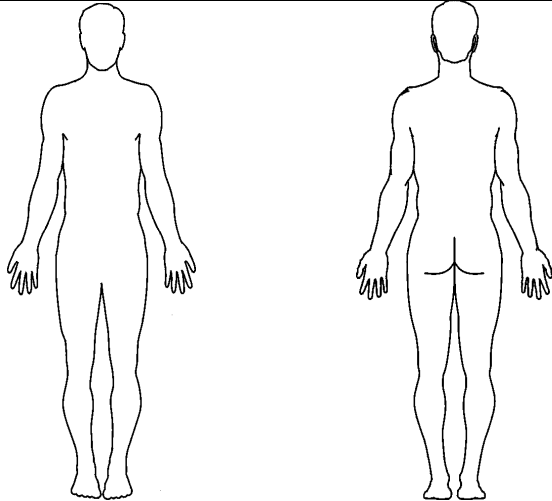
Diet

Are you or have you ever been on a restricted or specialised diet?
If so, what kind?

How many cups of tea ___ coffee ___ pop ___ alcohol ___ do you drink per week?

Do you smoke? No If yes : How many per day: Cigarettes _____ Cigars _____
Pipe _____ Other _____

Please Indicate Painful or Distressed Areas on the Diagram Below



Please indicate whether the following symptoms are current (please tick) or Past (P)

General

- | | | |
|---|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Weight gain (how much?) |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Cravings | <input type="checkbox"/> Strong thirst |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Fevers | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Other | | - if regular, at what time? |

Skin and Hair

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples | <input type="checkbox"/> Loss of hair |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Recent moles | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Other rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Change in hair or skin texture | | <input type="checkbox"/> Other skin or hair problems |

Head, Eyes, Ears, Nose and Throat

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches (when & where?) | <input type="checkbox"/> Colour blindness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Head or neck problems | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Jaw clicks |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Recurrent sore throats | <input type="checkbox"/> Glasses | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Other |

Cardiovascular

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Other |

Respiratory

- | | | |
|---|---|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain with a deep breath | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Production of phlegm (colour?) | <input type="checkbox"/> Other |

Gastrointestinal

- | | | |
|---|---|---|
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Nausea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Regular laxative use | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Known or suspected parasites | | <input type="checkbox"/> Other digestive symptoms |

Genito-Urinary

- | | | |
|--|--|--|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Any particular colour | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Do you wake to urinate? | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Other problems |

Gynecology and Pregnancy

- | | | |
|--|--------------------------------|--|
| ____ Age of first period | Unusual menses: | <input type="checkbox"/> Irregular periods |
| ____ Duration of flow | <input type="checkbox"/> Heavy | <input type="checkbox"/> Painful periods |
| ____ Days between periods (start to start) | <input type="checkbox"/> Light | <input type="checkbox"/> Vaginal discharge |
| ____ Date of last period | <input type="checkbox"/> Clots | <input type="checkbox"/> Vaginal sores |
| ____ Date of last PAP exam | <input type="checkbox"/> Other | <input type="checkbox"/> Yeast infections |
| ____ Date of last mammogram | | <input type="checkbox"/> Breast tenderness |
| <input type="checkbox"/> Changes in body or emotions before period | | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Do you practice birth control? | | |

What type _____ for how long? _____

Number of pregnancies ____ Number of births ____ Miscarriages ____ Abortions ____

Musculoskeletal

- | | | |
|--|---|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Other muscle problems |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Other joint or bone problems | |

Neuropsychological

- | | | |
|---|--|--|
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Depression | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Quick temper/irritable | <input type="checkbox"/> Susceptible to stress | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Lack of co-ordination | |

Travel History

To what countries have you travelled?

Were you ill there or shortly after your return?

Mental / Emotional History

Have you ever been treated for emotional problems?

If so, what kind of treatment? _____

Have you ever considered suicide or attempted it ?

Any other neurological problems? _____

Any other psychological problems? _____

Anything else?

Please describe any other problems or situations you would like to discuss.

PLEASE NOTE

Please bring this completed form with you to your first visit.

Copies of any recent test results from other health care professionals may be helpful. Please bring these with you if possible.

Missed visits and cancellations less than 24 hours before the appointment time will be charged at half of the visit fee, as this time has been set aside for you. If you need to cancel or reschedule, please give as much notice as possible.

I accept payments by cash, cheques, VISA, MasterCard and Interac direct debit. Payment is due at the end of the visit.

My office is "fragrance free", as some patients are sensitive to perfumes and colognes. If you like to wear scents, please refrain from using them until after your appointments.

THANK YOU