healthflow
integrative health centre

Suite 117, 1330 15th Avenue SW
Calgary, Alberta
403.313.4354 ♦ info@healthflow.ca

Name: _____Date (mm/dd/yyyy):_____
Date of Birth (mm/dd/yyyy):_____Age:_____Gender: [ ]F [ ]M
Address:_____
City:_____Province:_____Postal Code:_____
Home phone:_____Cell phone:_____
E-mail:_____Occupation:_____
Employer:_____
Marital Status: [ ]M [ ]S [ ]D [ ]W
Family Doctor & Specialists:_____
_____
Emergency Contact/relation:_____
Phone:_____
How did you hear about us? [ ]Friend [ ]Relative [ ]Heath care referral [ ]Internet
Other:_____
If you chose friend or relative, whom can we thank?_____

What is your reason for this visit?

When did it begin?_____Is it getting worse? [ ]Yes [ ]No
What makes it better?_____
Describe what caused it:

What (if any) medical diagnosis have you received?

What (if any) treatments have/are you receiving for this and other conditions?

Please list all medications, herbs, and supplements you are taking and their dosage:

Are you allergic to any medicines or substances? If so, what?

Do you have a cardiac pacemaker? Yes No

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Hospitalizations: (list as best you can)

Type of illness/operation/procedure	Date	Hospital

FAMILY HISTORY

Is there any family disease tendency of which you are aware? If so, please list below:

LIFESTYLE & EMOTIONS

Is your living environment: [ ]Dry [ ]Damp (Eg. Basement suite)

Do you have a preference for the following flavors

[ ]Spicy [ ]Sour [ ]Sweet [ ]Salty [ ]Greasy

Are you frequently thirsty? [ ]Always [ ]Never [ ]Sometimes

Do you drink:

[ ]Coffee (____ cups/day) [ ]Cold drinks [ ]Warm drinks

Do you use:

[ ]Cigarettes (____ pkgs/day)[ ]Alcohol (_____ drinks/wk) [ ]Recreational drugs

Are you an ex-smoker? [ ]Yes [ ]No If yes, how long ago did you quit?

What do you do for exercise? (Please indicate type and frequency)

What are your major causes of stress? And how would you rate your stress level (please circle)?

Low 1 2 3 4 5 6 7 8 9 10 High

How do you relax?

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Please mark 'C' for those you are currently experiencing, and 'P' for those experienced in the past:

____ Anxiety ____ Depression ____ Confusion ____ Poor memory
____ Fearfulness ____ Frequent sighing ____ Panic attacks ____ Racing thoughts
____ Irritability/anger ____ Chest tightness ____ Worry ____ Difficulty concentrating

Are you in a relationship? [ ]Yes [ ]No
How do you feel about it?_____
How many hours of sleep do you get?_____
Do you feel refreshed? [ ]Yes [ ]No
Do you have difficulty with any of the following? (please check any that apply)
[ ]Falling asleep [ ]Staying asleep [ ]Dream disturbed sleep [ ]Recurrent dreams
[ ]Nightmares [ ]Waking to urinate_____# of times
[ ]Waking with trouble falling back asleep What time?_____

GASTROINTESTINAL

Please mark 'C' for those that you currently experience, and 'P' for those experienced in the past:

____Bitter taste ____Metallic taste ____Sticky taste ____Loss of appetite
____Gnawing hunger ____Belching ____Bloating ____Gas
____Nausea ____Heartburn ____Indigestion ____Acid reflux
____Ulcers ____Vomiting ____Vomiting of blood
____Food cravings, (please specify)_____
Frequency of bowel movements:_____ x's per day or week (please circle day or week)
____Constipation ____Diarrhea ____Irregular ____Cramping
____Loose stools ____Hard stools ____Burning sensation
____Painful to pass ____Undigested food ____Pellet-like stools ____Mucous in stools
____Blood in stools ____Stools with strong odor ____Hemorrhoids

FLUID METABOLISM

Please mark 'C' for those you are currently experiencing, and 'P' for those experienced in the past:

____Spontaneous sweating ____Night sweating ____Sweating palms
____Yellow sweating (can be noticed as stains armpits and neckline of clothing)
____Frequent urination ____Incontinence ____Burning urination
____Kidney stones ____Urinary tract infection ____Cloudy urination

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____Blood in urine ____Weak urine stream, or trouble starting

SKIN

Please mark 'C' for those you are currently experiencing, and 'P' for those experienced in the past:

____Skin rash ____Eczema/Dermatitis ____Dry skin ____Itchy skin
____Hives ____Oily skin ____Acne ____Boils or pustules
____Bruising easily ____Soft or brittle nails ____Nail infections

HEAD & NECK

Do you experience headaches (please check)? [ ]Yes [ ]No How often?_____
Rate severity: (least) 1 2 3 4 5 6 7 8 9 10 (most)
[ ]Unilateral [ ]Bilateral [ ]Temples [ ]Behind eye(s)
[ ]Occipital/neck [ ]Top of head [ ]Forehead [ ]Whole head
[ ]Sinuses [ ]Fixed spot [ ]Moving
What type of pain do they present with?
[ ]Boring/stabbing [ ]Dull/achy [ ]Throbbing [ ]Wrapped up feeling
[ ]Full [ ]Empty [ ]Stiffness/ pulling [ ]Bursting
Aggravating factors: _____
Alleviating factors: _____
How many times per year do you catch colds/flus?_____
What kind?(eg. Common cold, influenza, intestinal flu or other)_____
_____
Body temperature: [ ]Hot [ ]Cold [ ]Even [ ]Hot extremities
[ ]Cold extremities [ ]Hot upper body
[ ]Cold lower body
Do you feel these temperatures: [ ]All day [ ]AM [ ]PM [ ]Do not know

Please mark 'C' for those you are currently experiencing, and 'P' for those experienced in the past:

____Chills ____Fever ____Alternating chills & fever
____Chronic cough ____Nose bleeds ____Nasal congestion ____Bleeding gums
____Canker sores ____Cold sores ____Dry mouth ____Sore throat ____Dry throat ____Lump in throat ____Excessive mucous ____Bad breath ____Dry eyes ____Red/painful eyes ____See spots/floaters ____Ear pain
____Blurred vision ____Dizziness/vertigo

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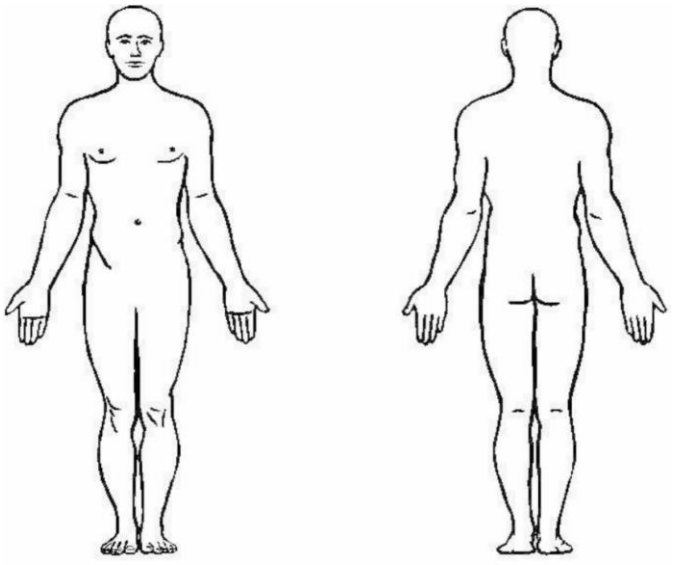
____Ear ringing/tinnitus If so, high pitch or low pitch?_____
____Cataracts ____Glaucoma ____Facial palsy/tic

PAIN

What type of pain do you experience? Please rate on a scale of 1-3 (mild to severe) on the illustration below



What is the cause? (if not listed yet)

What is the quality of pain? (please check)

[ ]Wandering pain [ ]Fixed pain [ ]Superficial pain [ ]Deep pain
[ ]Stabbing pain [ ]Pricking pain [ ]Burning pain [ ]Shooting pain
[ ]Sharp pain [ ]Dull pain [ ]Aching [ ]Gripping pain [ ]Numbness [ ]Tingling [ ]Pins and needles

Please mark 'W' for worse, or 'B' for better

____With cold ____With heat ____With pressure ____When resting
____When active ____When tired ____When under stress
____Upon awakening ____In the evening
____Other, please explain:

FEMALE REPRODUCTIVE

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____Breast lumps ____Nipple discharge ____Breast pain
____Pelvic pain ____Vaginal discharge ____Vaginal itching or burning
____Unpleasant odor ____Genital eruptions ____Painful sex
____Lack of sexual desire ____Excessive sexual desire ____Spotting between periods
____Menstruation absent ____Clotting in menstruation ____Irregular menstruation
Color of period: [ ]Normal [ ]Dark red/purple [ ]Bright red
[ ]Pale/pink [ ]Brown/dry
Would you say the flow is:
[ ]Light [ ]Normal [ ]Heavy [ ]Choppy
Are you sexually active? [ ]Yes [ ]No
Do you use birth control? [ ]Yes [ ]No
If yes, for how long?_____
Age of first menstruation:_____
Periods occur every_____days, and last for_____days
Date of last period:_____
Please indicate any of the following that you experience, and underline those that you have experienced in the past. Mark 'B' for before, 'D' for during, and 'A' for after your period.
____Mood changes ____Irritability ____Anxiety ____Insomnia
____Crying ____Forgetfulness ____Clumsiness ____Fatigue
____Dizziness/faint ____Bloating ____Cramping ____Increased appetite
____Sweet cravings ____Weight gain ____Breast tenderness____Back pain
____Change in bowel movements or stools (eg. loose, pellets, hard)
____Other (please specify)_____
Are you currently pregnant? [ ]Yes [ ]No
Any complications of pregnancy? [ ]Yes [ ]No
If yes, please explain:
____# of pregnancies ____# of births ____# of miscarriages
____# of abortions
Do you currently or have in the past experience(d) problems with fertility? [ ]Yes [ ]No
If yes, please explain:

MALE REPRODUCTIVE
Are you sexually active? [ ]Yes [ ]No
How would you describe your libido?_____

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Please mark ‘C’ for those you are currently experiencing, and ‘P’ for those experienced in the past:

____Vasectomy
____Prostate problems
____Male infertility
____Painful erection
____Difficult/premature ejaculation
____Erectile difficulty
____Penile discharge
____Swelling, lumps, pain in testes
____Other_____

Date of last prostate exam:_____