Kawartha Natural Health Clinic

Your Health Matters To Us!

Welcome To Our Office!

Date: _____

Mr. Mrs. Ms. Miss

Name: ☐☐ ☐ ☐ _____ _____

(Please Print) First Last

Address: _____ Postal Code: _____

Street

City: _____ Province: _____ Country: _____

Telephone: _____ _____ Email: _____

Home Business

Occupation: _____ Birth Date: _____

Referred by: _____

Name of Family Physician: _____

Are you currently seeing a Chiropractor? Yes or No Name: _____

Are you currently seeing a Naturopath? Yes or No Name: _____

Health Concerns

Primary Complaints:

1. _____

2. _____

3. _____

List Prescription Medication: _____

Would you like our office to provide a team member to present a health and wellness talk such as ergonomics, lifting, sleep troubles, stress busters, herbal solutions, detoxing or weight loss to your sports team/ workplace/community group?

Yes, I'm interested and would like more information_____

No thank you. _____

Patient Questionnaire

	Never	Rarely	Sometimes	Frequently	Daily
1) Do you experience recurrent infections, sinusitis, postnasal drip, or swollen lymph nodes, etc.?	☐	☐	☐	☐	☐
2) Do you experience bouts of diarrhea or constipation gas, bloating, etc.?	☐	☐	☐	☐	☐
3) Do you have cold fingers or toes, blood pressure problems, varicose veins, arteriosclerosis, etc.?	☐	☐	☐	☐	☐
4) Do you have slow metabolism, are you always hungry, have low energy at specific times of day?	☐	☐	☐	☐	☐
5) Do you experience palpitations, arrhythmia, impairments from prior infections, weak valves, etc.?	☐	☐	☐	☐	☐
6) Do you experience spinal stiffness or pain, headaches, mental confusion, depression, etc.?	☐	☐	☐	☐	☐
7) Do you experience chronic fatigue, recurring infections, lowered immune response, etc.?	☐	☐	☐	☐	☐
8) Do you experience recurrent respiratory infections, coughs, bronchitis, pneumonia, asthma, etc.?	☐	☐	☐	☐	☐
9) Do you experience irritability, nervousness, trembling, anxiety, or memory problems?	☐	☐	☐	☐	☐
10) Do you react to pollens, molds, foods, seasonal irritants, perfumes, animal dander, etc.?	☐	☐	☐	☐	☐
11) Do you have mood swings, problems sleeping, are you always cold, have chemical imbalances, etc.?	☐	☐	☐	☐	☐
12) Do you have recurrent yeast infections, frequent antibiotic use, poor diet, gas, bloating, etc.?	☐	☐	☐	☐	☐
13) Do you have diabetes, hypoglycemia, irritability, shaking if you skip a meal, etc.?	☐	☐	☐	☐	☐
14) Do you experience jaundice, high cholesterol, discomfort in the liver region, blood disorder, etc.?	☐	☐	☐	☐	☐
15) Do you have arthritis, back pain, discomfort when moving, weather triggered ailments, etc.?	☐	☐	☐	☐	☐
16) Do you have Fibromyalgia, rheumatism, carpal tunnel, slow recovery after exercise, etc.?	☐	☐	☐	☐	☐
17) Do you have lymphomas, degenerative liver disease, breast tumors, problems burning fat, etc.?	☐	☐	☐	☐	☐
18) Do you experience impotence, miscarriages, sterility, gynecologic or genital disorders, etc.?	☐	☐	☐	☐	☐
19) Do you have recurring infections, itching or yeast problems, painful urination, "leaking", etc.?	☐	☐	☐	☐	☐
20) Do you experience digestive disturbances, high acidity, bloating or gas after meals, etc.?	☐	☐	☐	☐	☐
21) Do you have rashes, dryness or cracking, scaly patches, eczema, acne psoriasis, etc.?	☐	☐	☐	☐	☐
22) Do you have a history of gallstones, discomfort after eating rich foods, low fat metabolism, etc.?	☐	☐	☐	☐	☐
23) Do you experience edema, gout, pain in the lower back, burning urination, kidney stones, etc.?	☐	☐	☐	☐	☐
Ovary & Uterus: Do you have PMS, menstrual pains or discomfort, irregular periods, mood swings, etc.?	☐	☐	☐	☐	☐
Prostate: Do you experience urinary discomfort, frequency of urination, etc.?	☐	☐	☐	☐	☐
Teeth: Do you have sensitive teeth or experience pain or discomfort in the teeth, gums or jaw region?	☐	☐	☐	☐	☐
Stress: Do you experience stress from work, finances, society, or relationships that you feel cause physical ailments?	☐	☐	☐	☐	☐
Energy: Do you lack motivation, drive, perseverance, stamina, or endurance?	☐	☐	☐	☐	☐
Feelings of Well-being: Do you lack a sense of happiness, joy, feelings of fulfillment, a positive outlook on life?	☐	☐	☐	☐	☐
Immune System: Are you susceptible to infections, allergies, or sensitive to pollution, or work environment?	☐	☐	☐	☐	☐
State of Health: Do you experience symptoms affecting your emotions, mental focus?	☐	☐	☐	☐	☐