

Health Assessment Form

Please answer the following questions to the best of your knowledge. All of the information provided is confidential. Try to be as detailed as possible as it will help us to complete a thorough evaluation of your health. If you have any questions, please do not hesitate to ask. We are committed to your well-being and it is our pleasure to work with you to achieve your goals.

Date: _____

CONTACT INFORMATION

Name: _____

Preferred name you would like to be referred to as: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Phone#(H): _____ Phone#(W): _____ Phone#(M): _____

Email: _____ Date of Birth: _____ Age: _____

Occupation: _____

Emergency Contact: _____ Relation: _____ Phone#: _____

Family Physician: _____ Phone#: _____

Family Physician's Address: _____

Source of referral: _____

OHIP# : _____

HEALTH STATUS

Chief complaints or health concerns:

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

Are you currently on any medication? Please include over the counter drugs and antibiotics.

MEDICATION (include dose)	ILLNESS/REASON

Are you taking any supplements or remedies at the present time? (e.g.) homeopathics, vitamins, herbal medicines,

SUPPLEMENT (include brand)	ILLNESS/REASON	DOSAGE

Height: _____ Current Weight: _____

Health Assessment Form

Please check “√” if you are experiencing the following symptoms or write ‘P’ beside the box if you have experienced these symptoms in the past.

General

- Poor/Change in appetite
- Nervousness
- Weight gain
- Weight loss
- Cancer
- Diabetes
- Poor sleep
- Fatigue
- Allergies
- Chills and fevers
- Night sweats
- Sweat easily
- Cravings
- Strong thirst

Skin and Hair

- Rash
- Itching
- Eczema
- Acne
- Loss of hair
- Thinning hair
- Dandruff
- Recent moles
- Dryness
- Hives or allergy reaction
- Boils
- Other skin problem(s)

Eyes Ears Nose Throat

- Ear aches
- Ear infections
- Ringing in ears
- Sinus infections
- Enlarged glands
- Enlarged thyroid
- Recurrent sore throat
- Tonsillitis
- Nasal obstruction
- Post nasal drip
- Nosebleeds
- Headaches
- Loss of taste/smell
- Eye pain
- Eye strain

- Blurry vision
- Vertigo
- Impaired vision
- Cataracts
- Facial pain/tics
- Jaw pain or clicks
- Mercury fillings
- Sores in mouth

Cardiovascular

- High blood pressure
- Low blood pressure
- Congestive heart failure
- Heart attack
- Phlebitis
- Stroke/cardiovascular accident
- Pacemaker or similar device
- Artificial valve
- Irregular heartbeat
- Dizziness
- Fainting
- Chest pain
- Varicose veins
- Cold hands or feet
- Swelling of limbs

Respiratory

- Difficulty breathing
- Chronic cough
- Bronchitis
- Asthma
- Emphysema
- Shortness of breath
- Coughing blood
- Throat phlegm
- Wheezing

Muscle, Bone & Joints

- Neck pain
- Back pain
- Muscle pain
- Muscle weakness
- Arthritis
- Bursitis
- Other pain
- Artificial joint

Gastrointestinal

- Indigestion
- Gas or burping
- Bad breath
- Constipation
- Diarrhea
- Incomplete bowel movements
- Abdominal pain or cramps
- Nausea
- Vomiting
- Chronic laxative use
- Rectal pain
- Hemorrhoids
- Blood in stool
- Constant hunger
- Colon trouble
- Bloating
- Gall bladder trouble
- Intestinal worms
- Jaundice

Neurological

- Loss of balance
- Irritable
- Poor memory
- Anxiety
- Depression
- Dizziness
- Lack of coordination
- Seizures/Epilepsy
- Concussion
- Loss of sensation
- Emotional problems
- Other psychological problem

Infections

- Hepatitis
- Tuberculosis
- HIV/AIDS

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- Genito-Urinary**
- Frequent urination
 - Urgency to urinate
 - Pain on urination
 - Wake up at night to urinate
 - Incontinence
 - Kidney stones
 - Kidney infection
 - Blood in urine

- Male**
- Prostate problem
 - Impotence
 - Sores on genitals

- Pain
- Infertility/low sperm count
- STD
- Hernia

- Female**
- Irregular periods
 - Heavy
 - Light
 - Clots
 - Painful periods
 - Vaginal discharge
 - Pregnant
 - Infertility
 - Low Sex Drive
 - Vaginal sores

- Sore breasts
 - STD
- Date of last Pap _____
 Age of first menses ____
 Menopausal Y N
 Age of last menses ____
 Pregnant Y N
 Do you practice birth control?
 Y N Type _____
 Number of:
- pregnancies _____
 - abortions _____
 - miscarriages _____
 - births _____

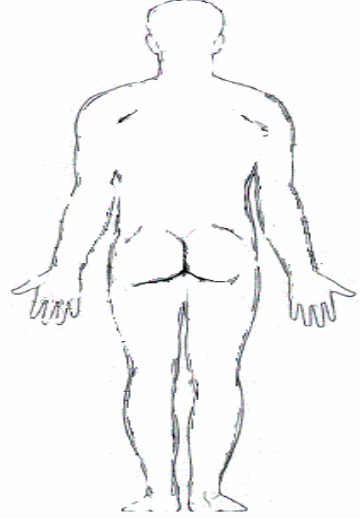
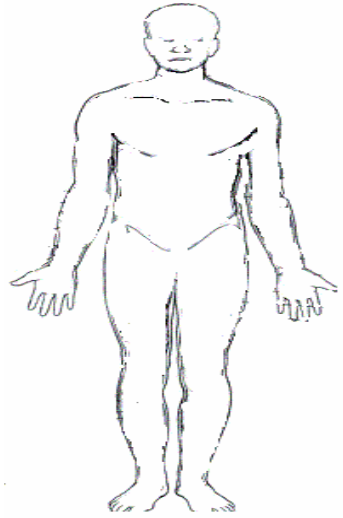
Visual Pain Rating Scale

Make a mark (/) along the line which you think represents your current level of pain

No pain at all _____

Pain Diagram

On the following diagrams, indicate all areas of:
 Pain – xxxx Stiffness - /// Numbness - 0000
 Other (Specify) Page 3



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*Please fill in the next sections only for the Wellness Programs, Naturopath and/or Nutrition counseling.

yes no Do you wish to lose weight?
 yes no Do you wish to gain weight?
 How long have you been trying? _____
 Do you have a goal weight? _____
 yes no Have you tried dieting in the past?
 If so, what programs, supplements, etc., have you tried?

 yes no Do you exercise?
 If so, what programs, supplements, etc., have you tried?

 How many hours do you sleep nightly? _____
 What time do you go to sleep? _____
 What time do you awaken? _____
 yes no Do you awaken feeling rested?
 What type of work do you do? _____
 yes no Do you enjoy your work?
 How many hours each day do you normally work? _____
 How many hours do you spend driving each day? _____

What level of stress do you feel you are experiencing at the moment?

Minimal Average Considerable Unbearable

What are the major causes or factors of your stress? (check all that apply)

Financial Career Personal
 Health Family Marriage
 Spiritual Unfulfilled Expectations Other

yes no Do you smoke?
 If so, how much? _____
 yes no If no, are you affected by household and/or workplace smokers?

Number of hours a day you:

_____ Watch television _____ Spend at the computer _____ Read

What are your interests or hobbies? _____

yes no Do you have any allergies?
 If so, please list: _____

Health Assessment Form

Have you ever been:

yes no Diagnosed with an illness?

Explain: _____

yes no Hospitalized?

For what reason: _____

How often do you have a bowel movement? _____

Do you strain to have a bowel movement? _____

DIETARY HABITS

How many times a day do you eat:

___ Main meals

___ Snacks

How often do you eat out per week? _____

Please describe (be specific-amounts, brands, etc.) what you would typically eat for:

Breakfast (Time:) _____

Lunch (Time:) _____

Dinner (Time:) _____

Snacks (Time:) _____

At what time do you have your last meal or snack of the day? _____

Check all that you eat or use:

- Aluminum pans
- Fried foods
- Microwave

- Candy
- Luncheon meats
- Nutra-Sweet/Aspartame

- Fast foods
- Margarine
- Refined foods

Health Assessment Form

Please indicate how many cups of the following you drink per day:

- | | | |
|--|---|--|
| <input type="checkbox"/> Beer | <input type="checkbox"/> Coffee | <input type="checkbox"/> Fresh fruit juices |
| <input type="checkbox"/> Fruit juices (prepared) | <input type="checkbox"/> Fresh vegetable juices | <input type="checkbox"/> Herbal tea |
| <input type="checkbox"/> Milk - circle type: homo,2%,1%,skim | <input type="checkbox"/> Soft drinks (diet) | <input type="checkbox"/> Soft drinks (regular) |
| <input type="checkbox"/> Soy milk | <input type="checkbox"/> Tea | <input type="checkbox"/> Water |
| <input type="checkbox"/> Wine, red | <input type="checkbox"/> Wine, white | <input type="checkbox"/> Other alcoholic beverages |
| <input type="checkbox"/> Other drinks _____ | | |

Are you:

- | | | |
|---------------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> A meat eater | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Vegan |
|---------------------------------------|-------------------------------------|--------------------------------|

How often do you eat meat?

- | | | |
|--------------------------------|---|--|
| <input type="checkbox"/> Daily | <input type="checkbox"/> 3-5 times/week | <input type="checkbox"/> Once/week or less |
|--------------------------------|---|--|

What are your favorite foods? _____

How often do you eat them? _____

yes no Do you experience any symptoms if meals are missed?
 Explain: _____

yes no Do you avoid certain foods?
 If yes, why? _____

yes no Do you experience any symptoms after meals?
 If yes, why? _____

MEDICAL HISTORY

Please indicate by checkmark which, if any, of the following conditions you may have experienced

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Abscesses | <input type="checkbox"/> Abortion |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chicken pox |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> HIV | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Kidney stones/disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Low/High blood pressure |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Malaria | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> MS | <input type="checkbox"/> Mumps | <input type="checkbox"/> Osteoporosis |

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- | | | |
|---|--|--|
| <input type="checkbox"/> Parasites | <input type="checkbox"/> Peritonitis | <input type="checkbox"/> Pelvic Inflammation Disease |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Venereal Warts |
| <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Worms | <input type="checkbox"/> Other |

Long term effects, if any, of a medical condition? _____

FAMILY MEDICAL HISTORY

Please check any conditions that have affected your parents, siblings, or grandparents. Please specify in comments section whom the condition affected.

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Alzheimers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis |

Comments/Other conditions: _____

HEALTH GOALS

Please identify your top three health goals in order of importance:

- | | | |
|--|---|--|
| <input type="checkbox"/> Abdominal fat | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Autoimmune disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anti-aging | <input type="checkbox"/> Detoxification |
| <input type="checkbox"/> Healthy blood sugar balance | <input type="checkbox"/> Endurance training | <input type="checkbox"/> Eye Health |
| <input type="checkbox"/> Increased Energy | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> General Support for: |
| <input type="checkbox"/> Healthy mind/memory | <input type="checkbox"/> Healthy prostate | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Healthy skin | <input type="checkbox"/> Heart health | <input type="checkbox"/> Healthy immunity |
| <input type="checkbox"/> Improve blood pressure | <input type="checkbox"/> Improve cholesterol | <input type="checkbox"/> Healthy joints |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Liver health | <input type="checkbox"/> Healthy libido |
| <input type="checkbox"/> Menopausal symptoms | <input type="checkbox"/> Men's health | <input type="checkbox"/> Healthy digestion |
| <input type="checkbox"/> Optimal Wellness | <input type="checkbox"/> Polycystic ovarian disease | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Health/mood | <input type="checkbox"/> Sleep improvement | <input type="checkbox"/> Smoking cessation |
| <input type="checkbox"/> Strength training | <input type="checkbox"/> Stress | <input type="checkbox"/> Surgery recover/support |

CLIENT CONSENT

I understand and acknowledge that the services hereby provided by The Truostar Health Practitioners are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Name (please print): _____

Signature: _____ Date: _____

Thank you for your cooperation!