SAGE HOMEOPATHY

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www.sagehomeopathy.ca

(Please be certain that all in take forms are completed and returned on time)

Personal Health History

NAME: _____ DATE:_____

OHIP # _____ D.O.B : _____ AGE: _____

PHONE: _____ MAY WE LEAVE A MESSAGE AT THIS NUMBER? YES NO

Primary Care Provider (if not joining our Primary Care Practice)? _____

Please list all physicians that you see. (Please include Mental Health Professionals)

Name	Address	Specialty, or condition being treated

Please List any complementary and/or alternative practitioners you see or have seen in the past (i.e. chiropractor, acupuncturist, naturopath, massage therapist, spiritual healer, etc.)

Approximate Dates of Treatment	Name of Therapist or Treatment Facility	Type of Treatment	Reason For Treatment	Beneficial Experience?

What Health Issues Do You Want To Focus On During This Visit?

Current Medical Problems (e.g. diabetes, heart disease, hypertension, etc.)

1.	4.	7.
2.	5.	8.
3.	6.	9.

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Past Medical History: List any major past illnesses, hospitalizations (include year and date if known).

	Date		Date

Past Surgical History: List any past surgeries (date /year)

	Date		Date

Past Gyn/Obstetrical History: List any past pregnancies.

Vaginal Births		Miscarriage/ Still Birth	
Caesarian Section		Pregnancy Terminations	
Abnormal PAP tests		Other GN Procedures	

Family History: Have your close relatives (parent, brother or sister, child, grandparent) had the following?

	Yes	No	If yes, which relative	Age at Diagnose
Heart Attack, Angina				
Stroke				
High Blood Pressure				
High Cholesterol				
Diabetes				
Thyroid Disease				
Breast Cancer				
Other Cancer- What type?				
Kidney Disease				
Osteoporosis				
Rheumatoid Arthritis				
Asthma				
Mental Health Disorder				
Substance Abuse				

Pharmaceuticals and Supplements:
Do you have Medication Allergies? YES NO if Yes, Please list:

Medication	Reaction	Medication	Reaction

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Please List All Prescribed And Over-The-Counter Medications You Take Regularly. ***Please Include All Supplements, Vitamins Or Herbal Products***

Medicine/ Supplement including Dose	Frequency	Medicine/ Supplement including Dose	Frequency
1.		8.	
2		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Please Outline Your Use Of The Following, Past Or Present:

Product	Current Use? Yes No	Quantity Per Day	Quantity Per Week	Past Use? Yes No	Do You Have Concern About Your Usage?

Do You Routinely Wear a Seat Belt? Yes No

Preventive Health: Please Provide the Dates and Documentation When Possible.

	Date		Date
Pap/ Pelvic exam (Females)		Tetanus Vaccine (Specify Td or Tdap)	
Mammogram (Females)		Flu Vaccine	
Colonoscopy		Pneumonia Vaccine	
Test of Stool For Blood (Stool Guaiac)		Zoster (shingles) Vaccine	
Rectal Prostrate Exam (Males)		Hepatitis A	
Prostate Specific Antigen (Males)		Hepatitis B	
Bone Density (Dexa)		MMR	
Eye Exam		Gardasil (HPV Vaccine	
Cardiovascular Stress Test		Other	

Trauma History: Have you ever been the victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and /or being a victim of an accident, violent crime, or a natural disaster)?
Yes No
If YES, is this an active issue in your life that you would like to address while you are here? Yes No

_____

_____

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Review of Symptoms: Please check no or yes for the following **current** symptoms (within past 3 months)

GENERAL	YES	NO	GASTROINTESTINAL	YES	NO
Fever			Diarrhea/ Constipation		
Sweats at Night			Indigestion/ heartburn		
Hot flashes			Nausea		
Temperature Intolerance			Blood in stool		
Excessive Thirst			**GENITOURINARY**		
Fatigue			Pain or burning on urination		
Sleep Difficulties			Frequent urination		
Daytime sleepiness			Waking to urinate more than once		
Unplanned weight change			Excessive urination		
SKIN			Difficulty emptying bladder		
Rash			Urinary incontinence		
New or changing moles			Decreased sexual desire		
EYES			Pain with intercourse		
Pain			Sexually transmitted disease		
Redness			Fertility issues		
Vision change			**MEN**		
EAR, NOSE, THROAT			Erectile dysfunction		
Hearing loss			**WOMEN**		
Ringing in ears			Heavy vaginal discharge		
Dizziness or vertigo			Heavy menstrual bleeding		
Bleeding gums			Painful menstrual periods		
Nosebleeds			Irregular menstrual bleeding		
BREAST			**MUSCULOSKELETAL**		
Breast pain			Generalized or all-over pain		
Masses and lumps			Joint pain		
Nipple discharge			Stiffness		
Skin changes			Joint swelling		
CARDIOVASCULAR			Joint redness		
Chest			Back or neck pain		
Heart murmur			**NEUROLOGICAL**		
Irregular heart beat (palpitations)			Abnormal gait (Trouble walking)		
Leg swelling or edema			Falling		
PULMONARY			Headaches severe/ or frequent		
Wheezing or shortness of breath			Seizures		
Chronic cough			Muscle weakness, TIA or stroke		
HEMATOPOIETIC			Fainting or loss of consciousness		
Swollen lymph glands			Localized numbness, tingling, neuropathy		
Blood clots			**PSYCHOLOGICAL**		
Excessive bleeding			Anxiety		
Anemia			Depression		
			Memory loss		
			Mood swings		

Movement, Exercise and Rest:

What forms of exercise do you enjoy? _____

Please describe your usual physical activity

Activity	How Often	How Long Each Time

How many hours of sleep do you usually get each night? _____

Describe any issues you have with sleep? _____

_____

Nutrition: please list any food allergies or sensitivities:

Foods	Reaction	Foods	Reaction

Please list everything you ate in the last 24 hours.

Morning:
Afternoon:
Evening:
Snacks:

Do you currently or have you ever had a problem with weight or eating? Yes No if YES please describe: _____

Are you comfortable with your relationship with food? Yes No

Do you feel knowledgeable about your nutritional needs? Yes No

Who prepares your meals? _____

Personal and Professional Development: are you currently EMPLOYED / RETIRED / UNEMPLOYED WORKING AT HOME / CARE-TAKING / DISABLED indicate your occupation if applicable:

_____

Are you happy with your occupation? Yes No

Why? _____

_____

Do you anticipate any work changes in the near future? Retirement, etc. _____

_____

Do you have a Racial / Cultural heritage that important to you? _____

_____

Relationship:

Relationship status: _____ If married or partnered, what is your relationship length? _____

What are your living arrangements?_____ Number of children and ages: _____

Are you sexually active? Yes No Are you happy with your sexual life? _____
Which relationship(s) fulfill and /or empower you? _____
Who or what drains your energy? _____

Physical Environment:

Do you have specific health concerns about your current home or environment (quality of air, water, etc.)? _____
Have you had hazardous environmental or occupational exposures? If yes, please describe.
_____

Spirituality:

What things or activities bring you your greatest joy and meaning? What inspires you? _____
_____
_____
What things create the greatest challenge you? _____
_____
What makes you feel connected to the larger world? Describe your spiritual or religious practices if any (i.e. meditation, prayer, time in nature, worship attendance, etc.) _____
_____
If time and money were not an issue, describe the things you long to do in your life. _____
_____
_____

Mind Body Connection:

Rate the amount of stress in your life: None / A Little Bit / Moderate / Quite a Lot / Extreme
How well do you manage stress? Not at All / A Little Bit / Moderate / Quite Well / Excellent
What are your main sources of stress in life? (Personal, professional, financial etc.) _____
_____
_____

What Are Your Health Goals? What are your overall goals for improving your health and your life?
_____
_____
_____
_____
Is there anything else that would be helpful for us to know about you? _____
_____
_____
_____