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Health Services

2 College St. suite 105
Toronto, ON M5G 1K3
info@mahayahealth.com
www.mahayahealth.com
T: 647.435.0152 F: 647.435.0163

# NATUROPATHIC PATIENT INFORMATION FORM

| Date of initial visit: | Practitioner's name: |
|---|---|

## PATIENT INFORMATION

| Last Name: | First Name: | Middle Initial: |
|---|---|---|
| Street Address: | | City: |
| Postal Code: | Cell phone number: | Work or Home phone number: |
| May we leave messages relating to your visit? ☐ Yes ☐ No | Email: Would you like to receive our newsletter? ☐ Yes ☐ No | |
| Date of Birth: (MM/DD/YYYY) | Sex: | |

## EMERGENCY CONTACT INFORMATION

| 1. Full Name: Relationship: Daytime phone number: Evening phone number: | 2. Full Name: Relationship: Daytime phone number: Evening phone number: |
|---|---|

## OTHER HEALTH CARE PROVIDERS

| Name: Phone number: Specialty/focus: | Name: Phone number: Specialty/focus: | Name: Phone number: Specialty/focus: |
|---|---|---|
| Date of last visit to medical doctor: Are you currently under his/her care? ☐ Yes ☐ No | Please list regular screening tests done by other physicians (blood tests, physical screening tests): | |

Are you interested in information about one of our other holistic health practitioners? If so, which ones?

☐ Osteopathic Practitioner ☐ RMT ☐ Holistic Nutritionist ☐ YOGA

How did you learn about Mahaya? ☐ Mahaya Website Booking

☐ Google ☐ Facebook ☐ Yelp ☐ Friend ☐ Other _____

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| MAIN HEALTH CONCERNS | Health concerns in order of importance to you: |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your

| Date of last physical exam: | Have you been to a Naturopathic Doctor before? ☐ Yes |
|---|---|

Immunizations:

| | | |
|---|---|---|
| ☐ Tetanus | ☐ Smallpox | ☐ DPT (diphtheria, polio, tetanus) |
| ☐ Hepatitis A | ☐ Tuberculosis | ☐ Chickenpox |
| ☐ Hepatitis B | ☐ Influenza (flu shot) | ☐ MMR (measles, mumps, rubella) |

List if any of these caused adverse reactions:

Childhood illnesses: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐

List any other medical conditions that other doctors have diagnosed:

1.

2.

3.

4.

Surgeries:

| Year | Type of Surgery | Reason |
|---|---|---|
| | | |

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| | | |
|---|---|---|
| | | |
| | | |

Other Hospitalizations:

| Year | Reason |
|---|---|
| | |
| | |

List your prescribed drugs, over-the-counter medications, supplements (pain killers, vitamins, herbs,

| Medication | Dosage/day | Date started |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever had a blood transfusion? ☐ Yes ☐ No

Please list all allergies (medications, foods, supplements, environmental, etc…)

| Name of allergen: | Reaction you had: |
|---|---|
| | |
| | |
| | |
| | |
| | |

## LIFESTYLE CHOICES

| | | | |
|---|---|---|---|
| **Exercise** | ☐ Sedentary (No exercise) | | |
| | ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | |
| | ☐ Regular vigorous exercise (i.e., work or recreation at least 3x/week for 30 minutes) | | |
| **Diet** | Are you dieting? | | ☐ Yes ☐ No |
| | If yes, are you on a physician prescribed medical diet? | | ☐ Yes ☐ No |
| | # of meals you eat in an average day? | | |
| | Dietary restrictions / preferences? (Religious, vegetarian, vegan?) | | |
| | Rank salt intake | ☐ High ☐ Medium ☐ Low | |
| | Rank fat intake | ☐ High ☐ Medium ☐ Low | |
| | Rank carbohydrate | ☐ High ☐ Medium ☐ Low | |
| **Caffeine** | Intake ☐ None ☐ Coffee ☐ Tea ☐ Cola | | |
| | # of cups/cans per day? | | |
| **Sex** | Are you currently sexually active? | | ☐ Yes ☐ No |
| | Your current sexual partner(s) are: ☐ Male ■ Female ☐ Transgendered | | |
| | Are you currently using any form of contraceptive? | | ☐ Yes ☐ No |
| | If yes, please name the contraceptive(s) you are using: | | |
| **Alcohol** | Do you drink alcohol? | | ☐ Yes ☐ No |

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| | | |
|---|---|---|
| | How many drinks per week? | |
| **Tobacco** | Are you exposed to second hand smoke? | ☐ Yes ☐ No |
| | Do you use tobacco? | ☐ Yes ☒ No |
| | ☐ Cigarettes – pks./day | ☐ Other (add amount) |
| | ☐ # of years | ☐ Or year quit |
| **Drugs** | Do you currently use recreational drugs? | ☐ Yes ☐ No |

## FAMILY HEALTH HISTORY

INCLUDING: ALLERGIES, ASTHMA, HEART DISEASE, HIGH BLOOD PRESSURE, CANCER, DIABETES, DEPRESSION, OTHER MENTAL ILLNESS, DRUG ABUSE, ALCOHOLISM, KIDNEY DISEASE AND ANY OTHER

| | AGE | SIGNIFICANT HEALTH | | | AGE | SIGNIFICANT HEALTH PROBLEMS | |
|---|---|---|---|---|---|---|---|
| FATHER | | | | | | Sex: | |
| MOTHER | | | | | | Sex: | |
| SIBLINGS | | Sex: | | CHILDREN | | Sex: | |
| | | Sex: | | | | Sex: | |
| | | Sex: | | | | Sex: | |
| GRANDMOTHER | | | | GRANDMOTHER | | | |
| GRANDFATHER (maternal) | | | | GRANDFATHER(paternal) | | | |

☐ I don't know my family history

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| SYSTEMS REVIEW | |
|---|---|
| Beside each item please indicate Y (Yes), N (No), or P (Past). Please write any additional information required in the space provided. | |
| **SKIN** | |
| Rashes | |
| Eczema | |
| Hives | |
| Acne or boils | |
| Itching | |
| Colour change | |
| Lumps | |
| Dryness | |
| Moistness | |
| Nail changes | |
| Changes in mole(s) | |
| Skin cancer | |
| Night sweats | |
| Other | |
| **HEAD** | |
| Headache | |
| Head injury | |
| Other | |
| **EYES** | |
| Impaired vision | |

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| | |
|---|---|
| Eye pain | |
| Tearing | |
| Dryness | |
| Double vision | |
| Glaucoma | |
| Cataracts | |
| Blurring | |
| Bothered by sun | |
| Itching | |
| Redness | |
| Discharge | |
| Blind spot | |
| Other | |

| **EARS** | |
|---|---|
| Impaired hearing | |
| Earache | |
| Dizziness | |
| Discharge | |
| Infections | |
| Other | |

| **NOSE AND SINUSES** | |
|---|---|
| Frequent colds | |
| Nose bleeds | |
| Stuffiness | |
| Hayfever | |
| Sinus problems | |

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| | |
|---|---|
| Other | |
| **MOUTH AND THROAT** | |
| Frequent sore throat | |
| Sore tongue or mouth | |
| Gum problems | |
| Hoarseness | |
| Dental cavities | |
| Loss of taste | |
| Sores in and around the mouth | |
| Other | |
| **NECK** | |
| Lumps | |
| Swollen glands | |
| Goiter | |
| Pain or stiffness | |
| Other | |
| **RESPIRATORY** | |
| Cough | |
| Sputum/phlegm | |
| Wheezing | |
| Asthma | |
| Bronchitis | |
| Pneumonia | |
| Emphysema | |

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| | |
|---|---|
| Difficulty breathing | |
| Pain on breathing | |
| Shortness of breath | |
| Tuberculosis | |
| Last tuberculin test | |
| Last chest xray | |
| Other | |
| **CARDIOVASCULAR** | |
| Heart disease | |
| Angina | |
| High blood pressure | |
| Murmurs | |
| Rheumatic fever | |
| Chest pain | |
| Swelling in ankles | |
| Palpitations/fluttering | |
| Cyanosis | |
| Other | |
| Past ECG | |
| Other heart tests | |
| **BREAST** | |
| Do you do self-breast exams? | |
| Lumps | |

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| | |
|---|---|
| Pain or tenderness | |
| Nipple discharge | |
| **GASTRONINTESTINAL** | |
| Trouble swallowing | |
| Heartburn | |
| Change in thirst | |
| Change in appetite | |
| Nausea | |
| Vomiting | |
| Vomiting blood | |
| Blood in stool | |
| Belching or passing gas | |
| Liver disease | |
| Gallbladder disease | |
| Jaundice (yellow skin) | |
| Ulcer | |
| Indigestion | |
| Diarrhea | |
| Rectal bleeding | |
| Hemorrhoids | |
| Black tarry stool | |
| Light grey stool | |
| Hernias | |
| Bowel movements (how often?) | |
| Is this a change? | |

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|---|---|
| | |
| **URINARY** | |
| Pain on urination | |
| Increased frequency | |
| Frequency at night | |
| Inability to hold urine | |
| Frequent urinary infections | |
| Kidney stones | |
| Blood in urine | |
| Urgency | |
| Hesistancy | |
| Other | |
| **MUSCULOSKELETAL** | |
| Joint pain or stiffness | |
| Arthritis | |
| Broken bones | |
| Muscle spasms or cramps | |
| Weakness | |
| Joint swelling | |
| Backache | |
| Other | |
| **PERIPHERAL VASCULAR** | |
| Deep leg pain | |
| Cold hands and feet | |
| Varicose veins | |

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| | |
|---|---|
| Thrombophlebitis | |
| Leg cramps | |
| Extremity numbness | |
| Extremity swelling | |
| Extremity ulcers | |
| Other | |
| **NEUROLOGICAL** | |
| Dizziness | |
| Fainting | |
| Seizures/convulsions | |
| Paralysis | |
| Muscle weakness | |
| Numbness or tingling | |
| Loss of memory | |
| Involuntary movement | |
| Loss of balance | |
| Speech problems | |
| Other | |
| **ENDOCRINE** | |
| Excessive thirst | |
| Excessive urination | |
| Excessive sweating | |
| Excessive hair growth | |
| Other | |
| | |
| Anemia | |

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| | |
|---|---|
| Easy bleeding or bruising | |
| Lymph node swelling | |
| Other | |
| **EMOTIONAL** | |
| Depression | |
| Mania | |
| Mood swings | |
| Anxiety and nervousness | |
| Phobias | |
| Insomnia | |
| Other | |
| **HOBBIES AND HABITS** | |
| Do you eat three meals a day? | |
| Do you sleep well? | |
| Do you average 8 hours sleep a night? | |
| Do you enjoy your work? | |
| Do you watch television? | If yes, how many hours? |
| Do you take vacations? | |
| What are your hobbies? | |

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| | |
|---|---|
| We recognize that not all bodies fit neatly into the male and female categories, please fill in the section(s) below which will best represent your body's medical history. | |
| **FEMALE Specific Questions** | |
| Please describe your sexual orientation: ☐ heterosexual ☐ bisexual ☐ gay ☐ lesbian ☐ queer ☐ questioning / unsure | |
| Date of last pap: | |
| Age at onset of menstruation: | |
| Date of last menstruation: | |
| Period every _____ days | |
| Heavy periods, irregularity, spotting, pain, or discharge? | |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | |
| Any recent breast tenderness, lumps, or nipple discharge? | |
| Any urinary tract, bladder, or kidney infections within the last year? | |
| Any blood in your urine? | |
| Any problems with control of urination? | |
| Any hot flashes or sweating at night? | |
| Are you pregnant or breastfeeding? | |
| Are you and your partner currently trying to get pregnant? | |
| Have you had a D&C, hysterectomy, or Cesarean? | |
| Number of pregnancies _____ Number of live births _____ | |
| Do you experience any discomfort during intercourse? | |
| **MALE Specific Questions** | |
| Please describe your sexual orientation: ☐ heterosexual ☐ bisexual ☐ gay ☐ lesbian ☐ queer ☐ questioning / unsure | |
| Date of last prostate and rectal exam? | |
| Do you usually get up to urinate during the night? | |
| If yes, # of times _____ | |
| Do you feel pain or burning with urination? | |
| Any blood in your urine? | |

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| | |
|---|---|
| Do you feel burning discharge from penis? | |
| Has the force of your urination decreased? | |
| Any kidney, bladder, or prostate infections in the last 12 months? | |
| Do you have any problems emptying your bladder completely? | |
| Any difficulty with erection or ejaculation? | |
| Any testicle pain or swelling? | |
| Are you and your partner currently trying to get pregnant? | |
| Do you experience any pain with intercourse | |

THANK YOU FOR COMPLETING THIS FORM

IT WILL HELP YOUR DOCTOR GAIN MORE INSIGHT ON YOUR ENTIRE CASE