ZIEGLER
INTEGRATIVE HEALTH
Care for the whole person

CONFIDENTIAL HEALTH HISTORY FORM

Name: _____ Date: _____

Male: _____ Female: _____ Age: _____ Date Of Birth: _____

Home Address: _____
Number & Street

_____
City Prov Postal Code

Home Phone: (___)_____Work Phone: (___) _____

Email: _____

Emergency Contact: _____ Relationship: _____

Home Phone: (___)_____Work Phone: (___) _____

Referred By: _____

Source (Yellow pages, Natural Health Directory, etc.): _____
Would you like to receive our quarterly newsletter? Yes No

Have you received naturopathic care previously?
No _____ If yes, when? _____ Name of N.D. _____

Are you currently under the care of a medical doctor or other health care practitioner?
No _____ If yes, please name the practitioner(s) and reasons:

_____
_____
_____

In your opinion, what are your most important health concerns?

1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____

List any **Medications**, Herbs, Vitamins, etc. you are taking and dose: _____

_____
_____

2146 Robinson Street
Regina, SK S4T 2P7

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www.zieglerhealth.com
allison@zieglerhealth.com

Your Medical History: Place an " **X** " by any problems you **now** have. Place a "**P**" for any medical problems you may have had in the **past**.

General-Infectious **Immunizations**: Up to Date? Y N ?

__Measles	__Mumps	__Chicken Pox	__DPT	__MMR
__Scarlet Fever	__Tuberculosis	__Malaria	__Polio	__Hepatitis B
__Whooping Cough	__Typhoid Fever	__Rheumatic Fever	__Tetanus	

Allergies **Skin**

__Hay Fever	__Open Sore/Ulcer	__Eczema	__Itching	__Rashes
__Skin	__Nail Problem	__Acne	__Warts	__Hives
__Food	__Bruise Easy	__Psoriasis	__Corns	

__Medications: List any medication allergies:_____

_____

Eyes, Ears, Nose & Throat

Last Eye Exam _____

Last Dental Exam_____

__Eye Infections

__Dental Problems/Dentures

__Vision Problems

__Ringing in Ears

__Ear Wax Problems/Ear Aches

__Sore Throat/Tonsillitis

__Oral Herpes

__Nose or Sinus Problems

__Nose Bleeds

__Nasal Congestion

__Hearing Loss

Nervous System

__Paralysis

__Fainting

__Convulsions

__Loss Of Sleep

__Depression

__Alcoholism

__Drug Addiction

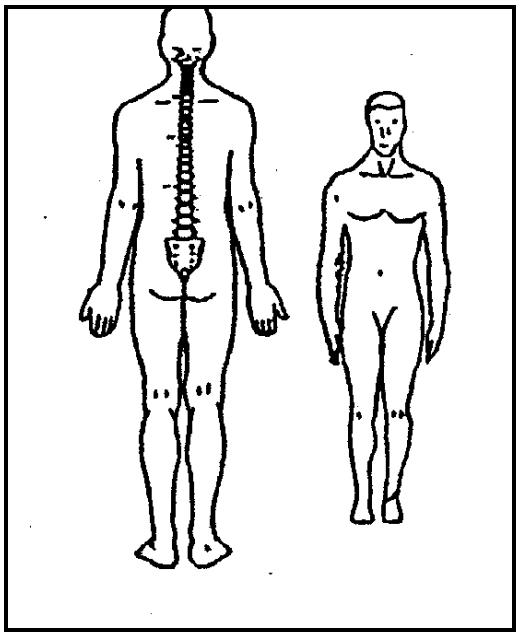
__Numbness in Thumbs

__Numbness in Fingers

__Burning Sensations

__Forgetfulness

__Hyperactivity



Please indicate on the drawings the location and type of symptoms that you are currently experiencing.

Aching	XXXX
Burning	*****
Stabbing	//////
Pins/needles	00000
Numbness	------
Spasm/Tight	SSSSS
Other	#####

Musculo-Skeletal

__Neck Pain/stiffness/pressure

__Upper Back Pain

__Pain Between Shoulders

__Shoulder Pain

__Lower Back Pain/stiffness/pressure

__Arthritis

__Gout

__Joint Pain, Stiffness, Bursitis

__Walking Problems

__Tail Bone Pain

__Hip Pain

__Clicking Jaw

__Leg/Knee Pain or Swelling

__Difficulty Chewing

__Pain, Tingling, Weakness or Numbness in Arms/Hands

__Pain, Tingling, Weakness or Numbness in Legs/Feet

__Chronic Sprains

__Spinal Curvature

__ Gout

__ Poor posture

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Gastrointestinal

How many Bowel movements per day? _____

__Poor or Excessive Appetite
__Excessive Thirst
__Gas/Bloating After Meals
__Fatigue after Eating
__Colon Trouble/Colitis
__Hiatal Hernia
__Laxative use
__Liver Trouble
__Gall Bladder Trouble
__Vomiting
__Heartburn
__Stomach Cramps
__Hemorrhoids
__Jaundice/Hepatitis
__Frequent Nausea
__Diarrhea
__Constipation
__Weight Trouble
__Ulcers

Cardiovascular/Respiratory

__Hardening of Arteries
__Chronic Cough
__Spitting up Blood
__Chest Pain/Angina
__Short of Breath
__Difficulty Breathing
__Irregular Heartbeat
__Poor Circulation
__Pleurisy
__Emphysema
__Cold Hands/Feet
__Heart Problems
__Varicose Veins
__Ankle Swelling
__Asthma
__Pneumonia

Genitourinary

__Bed Wetting
__Genital Herpes
__Venereal Disease
__Bladder Infections
__Kidney Infections
__Excessive Urination
__Frequent Urination
__Discolored Urine
__Discharges
__Kidney Stones
__Burning on/after Urination
__Wake up to Urinate

Endocrine/Hematology

__Diabetes Adult/Childhood
__Anemia
__Hypoglycemia/low blood sugar
__Thyroid Gland Trouble
__Pituitary Gland Trouble

Female Only

Date Last PAP_____
Date Last Mammogram _____
Date Last Period Began_____
Age 1st Period_____
Period Length_____
Cycle Length_____
Menstrual Cycles Regular? Y N
Number of Pregnancies_____
Number of Births_____
__Unable To Get Pregnant
Are You Pregnant? Y N
__Premenstrual Tension
__Menstrual Cramps/Backache
__Excessive Flow
__Vaginal Discharge,
__Menopause Age___
__Hysterectomy __Total __Partial
Do you do monthly Breast Self Exams? Y N
Birth Control pills y/n _____

Male Only

__Prostate Problems
__Dribbling of Urine
__Urgency to Urinate
__Retention of Urine
__Sexual Dysfunction

Breasts (Male & Female)

__Breast Pain
__Breast Lumps
__Discharge/Swelling

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Environmental Exposure
__Air Filters in Home Type: _____
__Air Filters at Work
__Work with Toxic Fumes or Chemicals List kind and Duration of Exposure:
_____
__Live in a City
__Exposed to Second Hand Smoke Duration: _____
__Pets Type: _____

Sleep
On average, what time do you go to bed_____ get up_____ number of hours slept_____

Do you feel refreshed upon waking in the morning? Yes _____ No _____

Do you nap during the day? No _____ Yes _____ If yes, for how long? _____

Is your sleep disturbed by waking each night? No _____ Yes _____ If yes, is there a regular time when you awaken and what is that time? _____

Do you have trouble getting to sleep? No _____ Yes _____ If yes, do you do or use anything to sleep? _____

List <u>All Surgeries</u> & Hospitalizations (and age at time):

_____
_____
_____
_____

<u>Broken Bones</u> (and age at time):

_____
_____
_____
_____

Was your mother's health normal during her pregnancy with you? Yes ____ No ____ If no, please explain the complications _____
_____

Was your birth process natural, without medical intervention such as forceps, C-section, epidural, anesthesia etc.? Yes ____ No ____ If no, please explain _____

Were you separated from your mother for any medical or other reason for the first six months after your birth? No ____ Yes ____ If yes, for approximately how long and why?
_____

Were you breastfed within the first 10 hours after birth? No ____ Yes ____

Were you breastfed at all? No ____ Yes ____ If yes, for how long? _____

Did you require medical attention, hospitalization or medication before the age of 10 years old? No ____ Yes ____ If yes, please explain in detail _____

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Family History: If any blood relatives have had any of the following please circle. Diabetes, hypoglycemia, heart disease, kidney disease, cancer, TB, allergies, bleeding disorders, glaucoma, seizures, mental illness, sickle cell anemia. Approximate age is O.K.

Grandparents: L=Living D=Deceased

Fathers Side	**Mothers Side**
Grandmother: L/D Age: _____	**Grandmother:** L/D Age: _____
_____	_____
_____	_____
_____	_____
Grandfather: L/D Age: _____	**Grandfather:** L/D Age: _____
_____	_____
_____	_____
_____	_____

Parents: L=Living D=Deceased

Father: L/D Age: _____	**Mother:** L/D Age: _____
_____	_____
_____	_____
_____	_____

List Brothers/Sisters and ages: Medical Problems: L=Living D=Deceased

B/S L/D Age: ____	B/S L/D Age: ____	B/S L/D Age: ____	B/S L/D Age: ____	B/S L/D Age: ____	B/S L/D Age: ____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Your Children and ages: Medical Problems: M=Son F=Daughter L=Living D=Deceased

M/F L/D Age: ____	M/F L/D Age: ____	M/F L/D Age: ____	M/F L/D Age: ____	M/F L/D Age: ____	M/F L/D Age: ____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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Social History: The following is important and will help the doctor determine how your lifestyle affects your health: **On an average day how much?**

Coffee Cups per day____
Tea Cups per day____
Milk Cups per day____
Juice Cups per day____
Soda Cups per day____
Water Cups per day____

Alcohol per day/week (oz) _____
Do you smoke? Y N # per day_____
Do you use other tobacco products? Y N
Do you use recreational drugs? Y N
Did you previously use recreational drugs? Y N
If YES, which ones:
Hours of sleep per night: _____

What do you typically eat for

Breakfast?	Lunch?	Dinner?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What do you snack on? _____
_____
Do you have an exercise program? ___ Yes ___No _____

Marital Status:(Circle one):

Married Widowed Divorced Single Living With Significant Other

_____

Employment:

Who is your employer?_____

What activities do you do at work? _____

Do you handle chemicals: _____

_____
Do you like your Job? Yes No Don't Know How long at this job? _____

_____ _____
Patient's Signature **Date**

_____
Name, Please Print

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