

***Fredericton Naturopathic Clinic***  
**Drs. Parissa and Judah Bunin, Naturopathic Doctors**  
150 Cliffe St-Unit 10, Fredericton, NB E3A 0A1  
Ph: 450-9440 Fax: 455-4417

Please complete this form and have it with you for your first visit. It will allow us to use our time together more effectively. All information that you disclose is *confidential and will not be released* without your permission.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Emergency Contact (Relationship): \_\_\_\_\_ Telephone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Religion: \_\_\_\_\_  
Name of family physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

List reason(s) for your visit in order of importance (include date of onset with each concern):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Are you currently receiving any treatment(s) for these concerns? Have they been effective?

\_\_\_\_\_  
\_\_\_\_\_

List any medications you are now taking or have taken in the past (include duration, dosage, and frequency): \_\_\_\_\_

\_\_\_\_\_

List any vitamin, mineral, or herbal supplements you are taking or have taken in the past (include duration, dosage, and frequency): \_\_\_\_\_

\_\_\_\_\_

List any screening tests done recently (bloodwork, x-rays, etc.; include year and results): \_\_\_\_\_

\_\_\_\_\_

List any surgeries that you have had: \_\_\_\_\_

\_\_\_\_\_

List any hospitalizations, accidents, or serious injuries: \_\_\_\_\_

\_\_\_\_\_

List any known allergies or intolerances: \_\_\_\_\_

Have you ever had any transfusions?     Yes     No

## IMMUNIZATIONS

- |   |                                    |
|---|------------------------------------|
| <input type="checkbox"/> Measles, mumps, rubella        | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Diphtheria, pertussis, tetanus | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Polio                          | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Other _____                    |                                    |

Have you had any adverse reactions to any immunizations? Explain: \_\_\_\_\_

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## PERSONAL HEALTH HISTORY

<i>General state of health:</i>	<b>Poor</b>	<b>Fair</b>	<b>Good</b>	<b>Excellent</b>
As adult:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As teenager:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As child:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Is there any condition (physical, mental, or emotional) from which you feel that you have not fully recovered? \_\_\_\_\_

## FAMILY HISTORY

Have any family members (including immediate family, grandparents, aunts and uncles) had any of the following conditions:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Arthritis     |
| <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Birth Defects |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Anemia        |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Allergies      | <input type="checkbox"/> Other? _____  |

## PAST MEDICAL HISTORY

Have you ever had any of the following?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abscesses      | <input type="checkbox"/> Gonorrhea               | <input type="checkbox"/> Parasites                   |
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Peritonitis                 |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Hayfever                | <input type="checkbox"/> Pneumonia                   |
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Pleurisy                    |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> HIV                     | <input type="checkbox"/> Prostatitis                 |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Influenza               | <input type="checkbox"/> Strep Throat                |
| <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Syphilis                    |
| <input type="checkbox"/> Cold Sores     | <input type="checkbox"/> Leukemia                | <input type="checkbox"/> Tonsillitis                 |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Low/High Blood Pressure | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Lyme Disease            | <input type="checkbox"/> Typhoid                     |
| <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Malaria                 | <input type="checkbox"/> Venereal Warts              |
| <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Measles                 | <input type="checkbox"/> Whooping Cough              |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Mononucleosis           | <input type="checkbox"/> Worms                       |
| <input type="checkbox"/> Gall Stones    | <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Yellow Fever                |
| <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Mumps                   | <input type="checkbox"/> Other? _____                |

**LIFESTYLE / ENVIRONMENTAL FACTORS**

*Do you consume any of the following **at least once a week**?*

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Antacids          | <input type="checkbox"/> Artificial Sweeteners | <input type="checkbox"/> Alcohol      |
| <input type="checkbox"/> Carbonated Drinks | <input type="checkbox"/> Distilled Water       | <input type="checkbox"/> Fried Foods  |
| <input type="checkbox"/> Laxatives         | <input type="checkbox"/> Luncheon Meat         | <input type="checkbox"/> Margarine    |
| <input type="checkbox"/> Salt (in excess)  | <input type="checkbox"/> Tea                   | <input type="checkbox"/> Tobacco      |
| <input type="checkbox"/> Coffee            | <input type="checkbox"/> Fast Foods            | <input type="checkbox"/> Sweets/Candy |

Do you have any dietary restrictions? Explain. \_\_\_\_\_

\_\_\_\_\_

Are you exposed to any chemicals at work or at home? Explain. \_\_\_\_\_

\_\_\_\_\_

Are you under excess stress? Explain. \_\_\_\_\_

\_\_\_\_\_

How do you relax (include hobbies and leisure activities)? \_\_\_\_\_

\_\_\_\_\_

How is your energy level? Rate on a scale of 1 to 10 (1=very low; 10=excellent). \_\_\_\_\_

\_\_\_\_\_

Do you exercise regularly (include frequency, duration, and type)? \_\_\_\_\_

\_\_\_\_\_

What is your current weight? \_\_\_\_\_ Maximum? \_\_\_\_\_ Ideal? \_\_\_\_\_

Have you ever been physically, sexually, and / or emotionally abused? Explain. \_\_\_\_\_

\_\_\_\_\_

Do you use any recreational drugs (include type and frequency)? \_\_\_\_\_

How old is your residence? \_\_\_\_\_ Type of heating: \_\_\_\_\_ Any pets? \_\_\_\_\_

Type of flooring (hardwood, linoleum, carpets, rugs, etc.): \_\_\_\_\_

Please use the space below to include any further information regarding your personal health history, family history, past medical history or lifestyle / environmental factors that may be of relevance to your service provider: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## REVIEW OF SYSTEMS

Please check off any conditions you currently have (indicate with ✓) or have had in the past (indicate with ✕):

### General:

- Poor appetite
- Intolerance to heat/cold
- Fatigue/weakness
- Sleep Difficulties
- Fever/Chills
- Significant Weight Change

### Skin:

- Rash / hives
- Lumps
- Nail Problems/changes
- Eczema
- Other? \_\_\_\_\_
- Easy Bruising
- Itching
- Hair problems / changes
- Jaundice

### Head:

- Headaches
- Eye Problems
- Ear Infections
- Earaches
- Nasal Congestion
- Other? \_\_\_\_\_
- Dizziness
- Hearing Problems
- Ringing/Buzzing in ear(s)
- Nosebleeds
- Frequent Nasal Discharge

### Mouth, throat & neck:

- Frequent sore throats
- Chronic bad breath
- Speech Difficulties
- Swollen Glands
- Sore tongue/mouth/gums
- Dental cavities
- Cold sores
- Other? \_\_\_\_\_

### Respiratory system:

- Chronic cough
- Breathing noises (e.g. wheezing)
- Coughing up blood
- Other? \_\_\_\_\_
- Sputum/phlegm
- Shortness of breath/difficulty breathing
- Chest pain

### Abdomen & gastrointestinal system:

- Change in appetite
- Nausea/vomiting
- Tarry black stool
- Heartburn
- Bloating
- Constipation
- Food Allergies/intolerances
- Hepatitis
- Change in stool colour
- Other? \_\_\_\_\_
- Change in thirst
- Blood in stool
- Belching/flatus
- Indigestion
- Diarrhea
- Hernias
- Abdominal pain
- Change in bowel habit
- Change in stool odor

**Heart & circulation:**

- Murmurs
- Varicose veins
- Swelling of ankles/feet
- Palpitations
- Calf Pain
- Other? \_\_\_\_\_

**Urinary system:**

- Urinary frequency
- Sense of urgency
- Dribbling
- Difficulty passing urine
- Frequent infections
- Cloudiness
- Other? \_\_\_\_\_
- Frequency at night
- Pain
- Hesitancy (difficulty starting)
- Blood in urine
- Change in color
- Retaining water

**Female:**

Date of first period? \_\_\_\_\_ Length of full cycle? \_\_\_\_\_ of bleeding? \_\_\_\_\_

- Premenstrual Symptoms
- Frequent vaginal infections
- Breast Lumps
- Pregnancies (if so, how many? \_\_\_\_\_)
- Abortions
- Sexually transmitted diseases
- Sexual difficulties/difficulties with libido
- Other gynecological concerns? \_\_\_\_\_
- Painful periods
- Discharge
- Infertility
- Miscarriages
- Abnormal Pap tests
- Birth Control (if so what type? \_\_\_\_\_)

**Male:**

- Infertility
- Sexually transmitted diseases
- Rashes
- Varicose veins in scrotum
- Sexual/ libido difficulties
- Discharge
- Pain in genitals
- Other? \_\_\_\_\_

**Musculoskeletal:**

- Broken bones
- Joint swelling/pain/stiffness
- Bone pain
- Osteoporosis
- Muscle cramps
- Weakness
- Back pain
- Other? \_\_\_\_\_

**Nervous system:**

- Fainting
- Numbness/tingling
- Paralysis
- Other? \_\_\_\_\_
- Seizures/convulsions
- Loss of balance
- tremors

Signed: \_\_\_\_\_

Date: \_\_\_\_\_