Centre intégratif de santé
Integrative Health Centre
Kadeja Lefebvre, BSc, ND.
63 Westminster Avenue N.
Mtl-West, QC H4X 1Y8
Tel: 514-485-6789
Fax: 514-485-1769

Patient History Form

Present Date: _____

Name: _____ Date of Birth: _____

Address: _____

Phone #: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Age: _____ Sex: M / F Height: _____ Weight: _____ Blood type: _____

Marital status: _____ No. of children: _____

Referred by: _____

General Practitioner: _____

Other Health Care providers: _____

What is the date of your last physical exam? _____

Do you have any mercury fillings? _____

Chief Health Concerns (in order of importance):

Describe carefully any factors that you suspect may have played a role in their onset and perpetuation:

_____

How stressful is your work or other aspects of your life? Rate it presently on a scale of 1-10:

_____

List the three most significant, stressful experiences in your life from the most recent to the most distant:

_____

Centre intégratif de santé
Integrative Health Centre
Kadeja Lefebvre, BSc, ND.
63 Westminster Avenue N.
Mtl-West, QC H4X 1Y8
Tel: 514-485-6789
Fax: 514-485-1769

What long-term goals and expectations do you have for working with me?

Men only:

Date of last prostate exam:

Do you have a history of (***Please circle/highlight if applicable***):

Hernia/Testicular Mass	Sexual Difficulty	Enlarged Prostate
Penile Discharge	Genital sores	Urinary Difficulties

Women only:

Age of first menstrual period: Date of last menstrual period:

Length of cycle: Days you menstruate:

Bleeding between periods? **Y / N** Is the cycle regular? **Y / N**

Do you have a history of (***Please circle/highlight if applicable***):

Cramps,	Abnormal vaginal discharge,
Excessive flow,	Pain during sexual activity

Are you currently pregnant? **Y / N** Number of pregnancies:

Number of miscarriages/abortions Date of last PAP smear:

Do you perform regular self breast exams? **Y / N**

Please circle/highlight if applicable: Lumps Tenderness Discharge

Have you ever used birth control pill? **Y / N** For how long? Any side effect?

Current Medications and supplements (prescription, over-the-counter, vitamins, herbs, homeopathic, etc.) _____

Centre intégratif de santé
Integrative Health Centre
Kadeja Lefebvre, BSc, ND.
63 Westminster Avenue N.
Mtl-West, QC H4X 1Y8
Tel: 514-485-6789
Fax: 514-485-1769

List past prescription medications: _____

How many times have you taken antibiotics in your life time? _____and last 2 years _____?

Do you frequently use the following? **(circle/highlight)**

Aspirin Laxatives Antacids Diet pills Birth control- pills/implants/injections

Alcohol--- how much /day or week_____
Tobacco--- form and amount / day _____
Caffeine--- form and amount / day _____
Recreational drugs--- what and how often_____ _____

Medical History:

Please indicate any serious conditions, illnesses or injuries, surgeries, and hospitalizations; along with approximate dates.

Condition	Date	Condition	Date
Cancer/Leukemia		Depression/Anxiety	
High blood pressure		Mental/Mood Disorder	
Childhood Illnesses (MMR, chicken pox, whooping cough)		Stroke	
Lung Disease (emphysema, Bronchitis, Pneumonia, Asthma)		Kidney problems (Stones, UTI)	
Chemical dependence (Drugs, alcohol)		Anemia	
Thyroid problems		Epilepsy	
Diabetes (Type 1, Type 2, Hypoglycemia)		STI, HIV (Gonorrhea, Herpes, HPV, Warts, Syphilis)	
Multiple sclerosis		Osteoporosis	
Digestive Disorders (IBS, Crohn's)		Skin problems (Eczema, psoriasis)	

Centre intégratif de santé
Integrative Health Centre
Kadeja Lefebvre, BSc, ND.
63 Westminster Avenue N.
Mtl-West, QC H4X 1Y8
Tel: 514-485-6789
Fax: 514-485-1769

Heart Disease		Allergies	
Strep Throat		Hepatitis	
Parasites		PMS	
Pelvic Inflammatory Disease		Prostatitis	
Arthritis (Rheumatoid, Gout)		Osteoarthritis	
Injuries:			
Surgeries:			

Other: _____

Diet:

Do you have any food allergies or intolerances?

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

What foods do you crave? Do you have any reactions to these foods?

Family History:

Indicate if a close relative (parent, grandparent, sibling) has had any of the following

Condition	**Who?**	**Condition**	**Who?**
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug/alcohol abuse	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes		Other	

Environment:

Centre intégratif de santé
Integrative Health Centre
Kadeja Lefebvre, BSc, ND.
63 Westminster Avenue N.
Mtl-West, QC H4X 1Y8
Tel: 514-485-6789
Fax: 514-485-1769

Occupation: _____

Hobbies: _____

Do you exercise regularly? **Y / N** What do you do and how often? _____

Are you exposed to significant tobacco smoke (work, home, etc)? **Y / N**

Are you frequently exposed to animals (work, pets, etc.)? **Y / N**

Diet Journal – (see attached next page!)

You may print up this page, fill it in by hand, and bring it with you to your first appointment.

The purpose of this daily record is to help you keep close watch over what you are eating, and help you discover which, if any, foods or beverages may be causing or contributing to your symptoms. Use this as a tool for yourself to become more in tune with your dietary habits. It is very important that the information your record in this diary be as accurate and as correct as possible. The more honest you are the more you will learn about yourself and the easier it will be to identify problem foods.

1. The following is to be done for 5 days in a row.
2. Write down everything that enters your mouth, including water, snacks, alcoholic beverages, soft drinks, coffee, and so on.
3. List the contents found inside mixed dishes and foods. It is not enough to write down "a ham sandwich". You should also write down the kind of bread, spread, and dressing (i.e.: ham sandwich – whole wheat bread, butter, mustard).

Centre intégratif de santé
Integrative Health Centre
Kadeja Lefebvre, BSc, ND.
63 Westminster Avenue N.
Mtl-West, QC H4X 1Y8
Tel: 514-485-6789
Fax: 514-485-1769

4. Whenever you make an entry in your diary, ask yourself, "Have I given myself and my Naturopathic Doctor enough information about what is in this food?"

DATE	***BREAKFAST***	***LUNCH***	***DINNER***	***SNACK/ BEVERAGES***	***Digestive, urinary, skin complaints***	***Overall Energy Mood***
DAY 1						
DAY 2						
DAY 3						
DAY 4						
DAY 5						