Holistic Clinic

*Sports and Occupational Injury Management*

# Confidential Patient Health Record: Nutritional

## Patient Information

Date (dd/mm/y) ____/____/____

Name: _____

Date of birth (dd/mm/y): _____/_____/_____ Age: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone #: (Cell) (____)_____ Work: (____) _____

(Home) (____)_____Email:_____

Employer: _____ Occupation: _____

Address: _____

How did you hear about this clinic? Doctor ☐ Internet ☐ Friend ☐ Other: _____

Name of emergency contact: _____

Telephone number: (____) _____

Relationship: _____

Name of Medical Doctor: _____

Address: _____

May we contact your medical doctor? Yes ☐ No ☐

Date of last physical or visit to MD (dd/mm/yy): ____/____/____

Date of last dental exam: (dd/mm/yy): ____/____/___

## Current health condition

Purpose of this appointment:

_____

_____

Give a brief detailed description of the problem you are currently experiencing:

_____

_____

_____

_____

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Patient Name: _____ Date: _____

How long have you had this condition? Is it getting better/worse?

_____

_____

When does it bother you? Work? Sleep? All the time? Other?

_____

_____

What seemed to be the initial cause?

_____

_____

**Past Health history**

Medical problems / hospitalizations / treatment:

_____

_____

_____

Previous surgeries: _____

_____

_____

Current medications / vitamins: _____

_____

_____

_____

Allergies to drugs / medications: _____

_____

Falls and accidents: _____

_____

Ever unconscious? _____

For how long? _____

Any previous fractures? _____

Surgeries recommended but not performed: _____

_____

Have you ever been treated for depression? Yes ☐ No ☐

When? _____

**Health and wellness screening questionnaire**

Do you have any skin problems? Describe. _____

_____

Do you have any nerve/psychiatric/psychological problems? Describe.

_____

Do you have any problems with your eyes/ears/nose/throat? Describe.

_____

Do you have any respiratory problems (asthma, bronchitis)? Describe.

_____

**Doctors only**

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Patient Name: _____ Date: _____

Do you have any digestive problems (ulcer, irritable bowel, IBD, SIBO, indigestion, constipation, hiatus hernia)? _____

_____

Do you have any urinary system problems (recurrent infection, prostate, kidney problems)? Describe _____

_____

Do you suffer from frequent or intense headaches? Yes ☐ No ☐

_____

**Cardiovascular system**

Do you have a history of (please circle)

| | | |
|---|---|---|
| High cholesterol | High blood pressure | Heart attack |
| Angina | Heart surgery | Diabetes |

Has your mother, father, a brother, or sister developed heart problems before the age of 60? Yes ☐ No ☐

**Doctors only**

☐

**Arthritis**

Have you ever been diagnosed with arthritis? Yes ☐ No ☐

Do you frequently suffer from joint pain, inflammation, or joint stiffness? Yes ☐ No ☐

**Questions for women only**

☐

Has your doctor ever indicated that you have osteoporosis?

Does osteoporosis run in your family?

Have you had a bone density test in the past two years? Are you pregnant or planning pregnancy? Yes ☐ No ☐

Do you have any problems with your breasts, menstrual cycle, Menopause?

Yes (Please describe) _____ No ☐

**Init:** _____

_____

_____

**Lifestyle Habits**

Do you smoke? Yes ☐ No ☐ How many packs per day? _____ Number of years _____

Do you consume alcohol? Yes ☐ No ☐ How many drinks per week? _____

Do you drink coffee? Yes ☐ No ☐ How many cups per day? _____

Rate your diet: Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent ☐

Rate your appetite: Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent ☐

How many glasses of water do you drink per day? _____

How many meals do you eat per day? _____

Do you have a history of repeated weight loss followed by weight gain? Yes ☐ No ☐

**Sleep**

How many hours per night do you usually sleep? _____ Do you wake rested? _____

Do you wake in the middle of the night? Yes ☐ No ☐ At what time? _____

How do you sleep? On your: Side ☐ Front ☐ Back ☐

Do you clench or grind your teeth at night? Yes ☐ No ☐

Do you have sleep apnea? Yes ☐ No ☐

How old is your mattress? _____

Patient Name: _____ Date: _____

**Activities**

How many days a week do you exercise? _____ Inside _____Outside

What type of activities do you do? Weights ☐ Aerobics ☐ Other _____

_____

How often do you stretch? _____

**Goals**

What are your key wellness goals?

_____

_____

_____

What are you prepared to do to achieve these goals?

_____

_____

_____

Is there anything else that your healthcare provider should know?

_____

_____

_____

Signature: _____ Date: (dd/mm/yy) ____/____/____

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# METABOLIC SCREENING QUESTIONNAIRE

**NAME :** _____ DATE : _____

Rate each of the following symptoms based upon your health profile for the past 30 days.

POINT SCALE

0 = Never or Almost Never have the symptom
1 = Occasionally have it, effect is *not* severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is *not* severe
4 = Frequently have it, effect is severe

| | | |
|---|---|---|
| DIGESTIVE TRACT | | Total |
| | _____ Nausea or Vomiting | |
| | _____ Diarrhea | |
| | _____ Constipation | |
| | _____ Bloated Feeling | |
| | _____ Belching or Passing Gas | |
| | _____ Heartburn | _____ |
| EARS | | Total |
| | _____ Itchy Ears | |
| | _____ Earaches, Ear Infections | |
| | _____ Draining from ears | |
| | _____ Ringing in ears, Hearing Loss | _____ |
| EMOTIONS | | Total |
| | _____ Mood Swings | |
| | _____ Anxiety, Fear or Nervousness | |
| | _____ Anger, Irritability or Aggressiveness | |
| | _____ Depression | _____ |
| ENERGY / ACTIVITY | | Total |
| | _____ Fatigue, Sluggishness | |
| | _____ Apathy, Lethargy | |
| | _____ Hyperactivity | |
| | _____ Restlessness | _____ |
| EYES | | Total |
| | _____ Watery or Itchy Eyes | |
| | _____ Swollen, Reddened or Sticky Eyelids | |
| | _____ Bags or Dark Circles under eyes | |
| | _____ Blurred or Tunnel Vision (does not include near-or-far sightedness) | _____ |
| HEAD | | Total |
| | _____ Headaches | |
| | _____ Faintness | |
| | _____ Dizziness | |
| | _____ Insomnia | _____ |
| HEART | | Total |
| | _____ Irregular or Skipped heartbeat | |
| | _____ Rapid or Pounding heartbeat | |
| | _____ Chest pain | _____ |

| | | |
|---|---|---|
| JOINTS / MUSCLES | | Total |
| | _____ Pain or Aches in joints | |
| | _____ Arthritis | |
| | _____ Stiffness or Limitation of movement | |
| | _____ Pain or Aches in muscles | |
| | _____ Feeling of weakness or tiredness | _____ |
| LUNGS | | Total |
| | _____ Chest Congestion | |
| | _____ Asthma, Bronchitis | |
| | _____ Shortness of Breath | |
| | _____ Difficulty Breathing | _____ |
| MIND | | Total |
| | _____ Poor Memory | |
| | _____ Confusion, poor comprehension | |
| | _____ Poor Concentration | |
| | _____ Poor physical coordination | |
| | _____ Difficulty in making decisions | |
| | _____ Stuttering or Stammering | |
| | _____ Slurred Speech | |
| | _____ Learning disabilities | _____ |
| MOUTH / THROAT | | Total |
| | _____ Chronic coughing | |
| | _____ Gagging, frequent need to clear throat | |
| | _____ Sore throat, Hoarseness, Loss of voice | |
| | _____ Swollen or Discolored tongue, Gums, Lips | |
| | _____ Canker sores | _____ |
| NOSE | | Total |
| | _____ Stuffy nose | |
| | _____ Sinus problems | |
| | _____ Hay Fever | |
| | _____ Sneezing attacks | |
| | _____ Excessive mucus formation | _____ |
| SKIN | | Total |
| | _____ Acne | |
| | _____ Hives, Rashes, or Dry skin | |
| | _____ Hair loss | |
| | _____ Flushing or Hot flashes | |
| | _____ Excessive sweating | _____ |
| WEIGHT | | Total |
| | _____ Binge eating/drinking | |
| | _____ Craving certain foods | |
| | _____ Excessive weight | |
| | _____ Compulsive eating | |
| | _____ Water retention | |
| | _____ Underweight | _____ |
| OTHER | | Total |
| | _____ Frequent Illness | |
| | _____ Frequent or Urgent urination | |
| | _____ Genital itch or discharge | _____ |
| **COMMENT :** | | **GRAND TOTAL** |
| | | _____ |

# HEALTH HABITS CHECKLIST

**Name:** _____
**Date:** _____

From the key provided, please choose the letter which best reflects your current integration of each of the actions below, and write it in the parentheses provided.

| A | B | C | D | E |
|---|---|---|---|---|
| Daily | Most days | Sporadically | Not at all, but I will. | I will not do this. |

( ) I get enough quality sleep to feel refreshed and revitalized upon arising and throughout the day. I.e. I do not require: an alarm to wake me, nor any caffeine through my day and do not feel sleepy until the evening.

( ) I get at least 15 minutes of natural light, twice daily. The first being early in day and the second later, without it being filtered through eye glasses, contact lenses, sunglasses or glass of any kind (windows, windshield, etc.).

( ) I get a minimum of 20-30 minutes of vigorous and enlivening exercise twice daily

( ) I get at least 6-8 large glasses of pure clean water

( ) I eat a substantial wholesome breakfast (conscientiously including quality proteins, fats and unprocessed carbs)

( ) I consume regular meals (at least 3 daily) on a consistent time-table.

( ) I get at least 50% of my daily caloric intake by mid-afternoon.

( ) I feel predominantly joy, gratitude, ease and appreciation throughout my day.

( ) I eat when I am hungry and trust my body's guidance, choosing my foods, beverages and the amount I consume intuitively and without negative feelings or regret afterwards.

( ) I make time to reflect positively on my health and wellness goals.

( ) I engage a specific activity to enhance and rejuvenate my mental and emotional state at least once daily (Deep Paced Breathing, HeartMath Freeze-Framer, Yoga, Tai Chi, Meditation, Relaxation Exercises, Prayers of Gratitude, etc.).

( ) I spend the quality time I want to with the people I love.

( ) I take each of the supplements and medicines which you have prescribed, and in the dosages you indicated. Please list the supplements and medications that you are taking daily:

_____
_____
_____

I have the following questions, concerns, comments to discuss with you today:

_____
_____
_____
_____
_____
_____