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NAME _____ DATE _____
 AGE _____ BIRTH DATE ____/____/____ (D/M/Y) SEX: M / F
 ADDRESS _____ CITY _____ POSTAL CODE _____
 TELEPHONE: (Home) _____ (Work) _____
 E-MAIL _____
 CAN WE SEND CLINIC RELATED INFORMATION TO MAILING ADDRESS OR
 EMAIL ADDRESS? YES / NO Please Initial _____
 OCCUPATION _____ EMPLOYER _____
 EMERGENCY CONTACT _____ RELATION _____
 EMERGENCY PHONE NUMBER _____
 MARITAL STATUS (circle one) S M D W Sep NUMBER OF CHILDREN _____
 FOUND OUT ABOUT CLINIC BY _____

PLEASE LIST YOUR MAJOR COMPLAINTS IN ORDER OF IMPORTANCE

COMPLAINT	SINCE	POSSIBLE CAUSE(S)

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION	SINCE	ADVERSE EFFECTS

WHAT OTHER TREATMENTS ARE YOU CURRENTLY FOLLOWING? (IE. CHIROPRACTIC, PHYSIOTHERAPY, ETC.) _____

HAVE YOU EVER SEEN A NATUROPATHIC DOCTOR BEFORE? Y/N
 If yes, for what ailment(s)? _____
 PLEASE LIST ALL OF YOUR KNOWN ALLERGIES: (FOOD, ENVIRONMENTAL OR DRUG) _____

PLEASE LIST YOUR SUPPLEMENTS/VITAMINS WITH DOSAGES _____

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?

Abscesses	Depression	Heart Disease	Mononucleosis	Rubella	Tonsillitis
Alcoholism	Diabetes	Hepatitis	Mumps	Scarlet Fever	Tuberculosis
Allergies	Emphysema	Herpes Genitalia	Parasites	Sexual Abuse	Typhoid
Amnesia	Epilepsy	Influenza	Pelvic Inflammatory Disease	Skin Disease	Venereal Disease
Arthritis	Gall Stones	Kidney Disease	Peritonitis	Strep Throat	Warts
Asthma	Goiter	Leukemia	Pleurisy	Sinusitis	Whooping Cough
Cancer	Gonorrhea	Malaria	Pneumonia	Sunstroke	Worms
Chicken Pox	Gout	Measles	Prostatitis	Stroke	Yellow Fever
Cold Sores	Hay Fever	Miscarriage	Rheumatic Fever	Syphilis	

OTHER (Please List) _____

Are there any of the preceding conditions after which you have never been totally well again, or which have been severer than usual? Which ones? _____

DO YOU HAVE ANY OF THE FOLLOWING?

Amalgam (silver) fillings? Y/N If yes, how many _____
 Root Canal? Y/N If yes, how many _____
 Dental Implants? Y/N Orthodontics? Y/N Periodontal disease? Y/N

WHAT, IF ANY, OPERATIONS HAVE YOU HAD?

OPERATION	WHEN	COMPLICATIONS?

WHAT MAJOR INJURIES HAVE YOU HAD?

INJURY	WHEN	LONG TERM EFFECTS?

Family History

	Age if living	Age at Death	Cause of Death	Health Concerns
Mother				
Father				
Brother(s)				
Sister(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Any other blood relatives with notable health conditions (ie. Heart disease, cancer, etc.)				

Personal Habits/Lifestyle

Have you lost any weight lately? **Y/N** If yes, how many pounds? _____

HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING?

Tobacco: _____ Alcohol: _____ Coffee: _____ Soda Pop: _____
 Recreational Drugs: _____

HOW OFTEN DO YOU PARTICIPATE IN PHYSICAL ACTIVITIES/EXERCISES?

____ Daily ____ 2-3 times / week ____ once a week ____ less than once a week
 What type of activities? _____

On average, how many hours of sleep do you get per night? _____

Do you have interrupted sleep? **Y/N** Do you wake rested? **Y/N**

How many glasses of water per day? _____

What do you use for drinking water? Bottled ____ Filtered ____ Tap Water ____

What do you enjoy most in life? _____

What are your main interests or hobbies? _____

What do you worry about most? _____

How do you learn? **Read Listen(lectures) Television Stories Visual Hands On**

Typical Diet

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages _____
Any dietary restrictions? (Religious or otherwise) _____

Digestion (circle or fill in the answer)

Do you have any problems with gas, bloating or fullness after eating? **Y/N**
Any heartburn? **Y/N** How often? _____
How often do you have gas, fullness or bloating after eating? **Often / Sometimes / Never**
How severe is it? **Mild / Moderate / Severe**
Do you have gas in the upper or lower part of the abdomen or is it both areas? _____
How long have you had this problem? _____
How often do you have bowel movements? _____
Do you ever have any **blood, mucus, undigested food or black stools?**(circle)
Do you have rectal itching? **Y/N** Do your stools tend to be formed or loose? _____
How often do you have diarrhea? _____ Do you ever have alternating
constipation and diarrhea? **Y/N**
How often do you have thin, long and narrow stools? **Often / Sometimes / Never**
Do you ever have small and hard stools? **Often / Sometimes / Never**
Do your stools have a strong disagreeable odor? **Often / Sometimes / Never**
Have you traveled outside of Canada in the last 5 years? **Y/N**
Camping in the past 5 years? **Y/N**

Kidneys and Bladder:

Have you had recurrent bladder infections? **Y/N** How many in the last 3 years? _____
How were they treated? _____
Do you have any burning sensation during or after urination? **Y/N** Past ___ Present ___
Is your urine **dark yellow, bright yellow, cloudy, pale or clear?** Circle one.
Does your urine have a strong odor to it? **Y/N**
Do you have difficulty starting or stopping when urinating? **Y/N**
Do you have difficulty perspiring? **Y/N**
Do you perspire when you exercise? **Slightly Moderately Heavily**
Do you perspire at other times, other than when exercising? **Y/N**. If yes, when:

Does your perspiration have a strong smell? **Y/N**.
Does your temperature tend to run **low / high / average** compared to others?

Occupational/Household:

How long have you lived at your present address? _____
Where have you lived previously? _____
Please describe location, if old or new building, i.e., new construction, older construction, damp or moldy, etc. _____
Do you have specialized air filtration at home? Y/N Do you live in a city? Y/N
Do you work in an office building? Y/N Do the windows open? Y/N
Do you work in the presence of toxic fumes or chemicals? Y/N
Do any of your hobbies involve toxic materials? Y/N
Are you exposed to second hand smoke currently? Y/N

(Women only)

Female Reproductive System

Age of first menses _____ Have your periods stopped? Y/N At what age? _____
Are your cycles regular? Y/N Periods begin every _____ days, and last _____ days
Are your periods: **Heavy Medium Light**? Are there any clots? Y/N
Any cramps with your periods? Y/N Any spotting/bleeding between periods? Y/N
Do you have any premenstrual symptoms? (please circle) **Water retention Depression
Breast tenderness Headaches Mood swings Bloating Acne Cravings**

Number of pregnancies _____ Number of abortions _____ Number of miscarriages _____
Any problems getting pregnant? Y/N Last Menstrual Period _____
Last PAP (date) _____ Any abnormal PAP's? Y/N

Last Breast Exam (date) _____ Do you do monthly breast exams? Y/N
Are you currently sexually active? Y/N Do you use birth control? Y/N
What type of birth control? _____ Any problems with sex drive? Y/N

(Men only)

Male Reproductive System

How often do you get up in the night to urinate? _____
Do you have difficulty with maintaining or achieving an erection? Y/N
Last prostate exam _____ PSA (blood test done) Y/N
Are you currently sexually active? Y/N Do you use birth control? Y/N
What type of birth control? _____ Any problems with sex drive? Y/N

Do you have anything else you would like to comment on? _____

Context of Care Questionnaire

Why did you choose me as your Naturopathic Doctor?

What do you know about my approach?

What three expectations do you have from your first visit with me?

What long term expectations do you have from working with me?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? 1-10 (circle)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are destructive to your health? (please list)

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know with will sincerely support you consistently with the beneficial lifestyle changes you will be making?

***Thank you for taking the time to fill in this lengthy questionnaire.
It will be a valuable tool in assessing your health care needs.***

CANCELLATION POLICY

We will call to confirm 48-72 hours before your scheduled appointment. We require a return confirmation phone call. Appointments cancelled with less than 24 hours notice will be charged \$35.00. Appointments cancelled the same day or missed completely will be charged the full fee.

Signed _____ **Dated** _____