NEW PATIENT REGISTRATION-ADULT

Sean Ceaser, ND ______
Naturopathic Physician

Date:___________________________

Name:____

Mailing Address: _____________________________________ Apt. #: _________
City:___________________________Province:___________ Postal code:__________

Telephone #: Home:_________________________ Work:____________________
Cell:______________________ email:_________________________________
Age:____________ Sex: M / F Date of Birth:________________

Single/ Married/ Divorced/Common Law Spouse's name:___________________________

Your medical doctor:___________________________________

Phone # __________________________

Other health practitioners involved in care:

_______________________________ Phone #___________________________

_______________________________ Phone #___________________________

Emergency phone contact:
_______________________________ Phone #___________________________

Patient's occupation:_________________________ Place of work:________________
# of years at current occupation:_______________

Do you have private insurance that covers Naturopathic Medicine? Yes No
Does insurance cover Naturopathic Labs? Yes No
Insurance provider _________________________. Limit of coverage $_____________
Are you insured through a work plan? Yes No PHIN # _________________________

How did you hear about the clinic?____

MEDICAL HISTORY QUESTIONNAIRE

Please list the reasons for your visit in order of importance:

1.____

2.____

3.____

Please circle those items that apply to you.

Y=yes, currently N=never P=yes, in the past, list age and details

SKIN.

Y	N	P	Item	Y	N	P	Item
Y	**N**	**P**	**Please fill in reasons for your visit above**				
Y	N	P	Acne	Y	N	P	Boils
Y	N	P	Color changes	Y	N	P	Eczema/Psoriasis
Y	N	P	Hives	Y	N	P	Itching
Y	N	P	Lumps	Y	N	P	Moles
Y	N	P	Rashes	Y	N	P	Scaling, flaking
Y	N	P	Jaundice	Y	N	P	Tingling sensation

HEAD.

Y	N	P	Item	Y	N	P	Item
Y	N	P	Hair loss	Y	N	P	Headaches
Y	N	P	Head injury	Y	N	P	Skull fracture

EYES.

Y	N	P	Item	Y	N	P	Item
Y	N	P	Eye pain	Y	N	P	Cataracts
Y	N	P	Double vision	Y	N	P	Itchy, red
Y	N	P	Glasses	Y	N	P	Glaucoma
Y	N	P	Impaired vision	Y	N	P	Tearing, watery
Y	N	P	Sensitive to light	Y	N	P	Vision- flashes
Y	N	P	Vision- halos	Y	N	P	Other

EARS.

Y	N	P	Item	Y	N	P	Item
Y	N	P	Ear infections	Y	N	P	Earaches
Y	N	P	Discharges	Y	N	P	Hearing difficulty
Y	N	P	Ringing	Y	N	P	Ear trauma
Y	N	P	Itching	Y	N	P	Dizziness

NOSE AND SINUSES.

Y	N	P	Item	Y	N	P	Item
Y	N	P	Frequent colds	Y	N	P	Hay fever
Y	N	P	Nose bleeds	Y	N	P	Sinus pain
Y	N	P	Loss of smell	Y	N	P	Runny nose
Y	N	P	Stuffiness	Y	N	P	Other

MOUTH AND THROAT.

Y	N	P	Cavities	Y	N	P	Bleeding gums
Y	N	P	Hoarse	Y	N	P	Difficulty swallowing
Y	N	P	Canker sores	Y	N	P	Freq. sore throats
Y	N	P	Loss of taste	Y	N	P	Metal taste in mouth
Y	N	P	Sore tongue	Y	N	P	Speech problems

NECK.

Y	N	P	Goiter	Y	N	P	Swollen glands
Y	N	P	Pain, stiffness	Y	N	P	Lumps
Y	N	P	Trauma	Y	N	P	Other

MUSCLES AND BONES.

Y	N	P	Joint pain	Y	N	P	Broken bones
Y	N	P	Swollen joints	Y	N	P	Muscle cramps
Y	N	P	Arthritis	Y	N	P	Weakness
Y	N	P	Nerve pains	Y	N	P	Back injury
Y	N	P	Muscle pain	Y	N	P	Morning stiffness
Y	N	P	Bone loss	Y	N	P	Hip pain
Y	N	P	Back pain	Y	N	P	Fibromyalgia

EXTREMITIES.

Y	N	P	Deep leg pains	Y	N	P	Numbness or tingling
Y	N	P	Blood clot	Y	N	P	Cold hands, feet
Y	N	P	Leg, foot ulcers	Y	N	P	Vericose veins
Y	N	P	Restless legs	Y	N	P	Hair loss to ankles

GASTROINTESTINAL.

Y	N	P	Belching, bloating, gas	Y	N	P	Blood in stool
Y	N	P	Gall bladder troubles	Y	N	P	Mucus in stool
Y	N	P	Heartburn	Y	N	P	Change in thirst
Y	N	P	Indigestion	Y	N	P	Liver problem
Y	N	P	Constipation	Y	N	P	Diarrhea
Y	N	P	Alternating constip/ diarrhea	Y	N	P	Binge eating
Y	N	P	Hemorrhoids	Y	N	P	Pain in belly
Y	N	P	Vomiting	Y	N	P	

How many bowel movements do you have a day?

RESPIRATORY.

Y	N	P	Asthma	Y	N	P	Bronchitis
Y	N	P	Seasonal allergy	Y	N	P	Cough blood
Y	N	P	Emphysema	Y	N	P	Hard to breathe
Y	N	P	Pneumonia	Y	N	P	Short of breath
Y	N	P	Tuberculosis	Y	N	P	Wheezing
Y	N	P	Smoker	Y	N	P	Cough

CARDIOVASCULAR.

Y	N	P	Dizzy upon standing	Y	N	P	Chest pain
Y	N	P	Heart disease	Y	N	P	Angina
Y	N	P	Rheumatic fever	Y	N	P	Hypertension
Y	N	P	Palpitations	Y	N	P	Pain in legs.
Y	N	P	Racing heart	Y	N	P	Heart attacks
Y	N	P	Swollen ankles	Y	N	P	Murmurs

URINARY SYSTEM.

Y	N	P	Bladder infection	Y	N	P	Incontinence
Y	N	P	Dribbling at end of stream	Y	N	P	Cloudy urine
Y	N	P	Night frequency	Y	N	P	Kidney stone
Y	N	P	Difficulty initiating stream	Y	N	P	Painful urination
Y	N	P	Increased frequency	Y	N	P	Irritable bladder

How often do you urinate a day?_________________

FEMALE REPRODUCTIVE/HORMONAL.

Y	N	P	Tender breasts	Y	N	P	Weight gain in hips
Y	N	P	Fibrocystic breasts	Y	N	P	Menopause
Y	N	P	PMS	Y	N	P	Infertility
Y	N	P	Water retention	Y	N	P	Cold body temp
Y	N	P	Uterine fibroids	Y	N	P	Endometriosis
Y	N	P	Yeast infection	Y	N	P	Painful menses
Y	N	P	Irregular cycles	Y	N	P	Hot flashes
Y	N	P	Night sweats	Y	N	P	Painful intercourse
Y	N	P	Dry vagina	Y	N	P	Bloating
Y	N	P	Scanty menses	Y	N	P	Heavy periods
Y	N	P	Birth control, HRT	Y	N	P	V. D.
Y	N	P	Loss of scalp hair	Y	N	P	Facial hair

Age of first period___________________ Period begins every________ days______

# of days bleeding ______________.

Last period_____________________ Last Pap______________________

Last mammogram_______________ Bone density scan?_______________________

# of pregnancies________________ # of abortions_____________________________

Sexual desire: 1 2 3 4 5 6 7 8 9 10

Sexual desire: decreased, increased, same

MEN

Y	N	P	Erectile difficulties	Y	N	P	Lump in testicles
Y	N	P	Penis discharge	Y	N	P	Sore on penis

ENDOCRINE, BLOOD, IMMUNE SYSTEM

Y	N	P	Shaky before a meal	Y	N	P	Sugar cravings
Y	N	P	Irritable before meals	Y	N	P	Easy bleeding
Y	N	P	Headaches before meals	Y	N	P	Chronic fatigue
Y	N	P	Tired after lunch	Y	N	P	Weight gain in abdomen
Y	N	P	Excessive hunger	Y	N	P	Better after meal
Y	N	P	Excessive thirst	Y	N	P	Anemia
Y	N	P	Excessive urination	Y	N	P	Thyroid
Y	N	P	Morning fatigue	Y	N	P	Eve. fatigue
Y	N	P	Confusion before meals	Y	N	P	Easy bruising
Y	N	P	Seasonal depression	Y	N	P	Lupus
Y	N	P	Heat/ cold intolerant	Y	N	P	Mononucleosis

NEUROLOGICAL.

Y	N	P	Dizziness	Y	N	P	Numbness/tingling
Y	N	P	Fainting	Y	N	P	Memory loss
Y	N	P	Seizures	Y	N	P	Paralysis

MENTAL AND EMOTIONAL.

Y	N	P	Irritability	Y	N	P	Fatigue
Y	N	P	Impaired memory	Y	N	P	Suicidal
Y	N	P	Depression	Y	N	P	Mood swings
Y	N	P	Excessive anger	Y	N	P	Weeping
Y	N	P	Foggy thinking	Y	N	P	Compulsions
Y	N	P	Confusion	Y	N	P	Anxiety, panic

SLEEP AND DREAMS.

Y	N	P	Insomnia	Y	N	P	Drowsiness
Y	N	P	Troubles falling asleep	Y	N	P	Nightmares
Y	N	P	Frequent waking	Y	N	P	Grinding teeth
Y	N	P	Night sweats	Y	N	P	Unrefreshed in morning

How many hours do you sleep? ______

NUTRITION AND DIET.

Y	N	P	Gain weight easily	Y	N	P	Overweight
Y	N	P	Underweight	Y	N	P	

Heaviest adult weight________. When?______ Height__________

Lightest adult weight________. When?_______ **Weight in office: ________lbs.**

How much water do you drink? glasses/day ________kgs.___

DRINKS AND DRUGS.

Y	N	P	Soft drinks	How much?	
Y	N	P	Coffee How much?		
Y	N	P	Other liquids	How much?	
Y	N	P	Alcohol	How much?	
Y	N	P	Illicit drugs	Which ones?	How much?

Family history: Please list family member and details, eg. mother, skin cancer.

Y	N	Alcoholism	Y	N	Heart disease
Y	N	AIDS	Y	N	Herpes
Y	N	Allergies	Y	N	High blood pressure
Y	N	Arthritis	Y	N	Insomnia
Y	N	Asthma, hay fever	Y	N	Kidney problems
Y	N	Cancer	Y	N	Mental illness
Y	N	Chronic fatigue	Y	N	Osteoporosis
Y	N	Depression	Y	N	Stroke
Y	N	Diabetes	Y	N	Syphilis
Y	N	Drug addiction	Y	N	Tuberculosis
Y	N	Eczema, Psoriasis	Y	N	Thyroid problems
Y	N	Epilepsy	Y	N	Warts, severe
Y	N	Glaucoma	Y	N	Other
Y	N	Gonorrhea			

IMMUNIZATIONS.

Y	N	Mumps	Y	N	Measles	Y	N	Rubella
Y	N	Diphtheria	Y	N	Pertussis	Y	N	Tetanus
Y	N	Hepatitis	Y	N	Polio	Y	N	TB
Y	N	Rabies	Y	N	Smallpox	Y	N	Typhoid
Y	N	Flu	Y	N	Meningococcus	Y	N	Typhus

Was there a reaction to any of the above immunizations?

ALLERGIES.
What drugs are you allergic to?
What environmental allergies affect you?____
What foods are you allergic to?____

HOSPITALIZATION AND SURGERIES. Please list age, purpose and treatment:
____
____
____
____
____
____
____

CURRENT MEDICATIONS. Include medications, vitamins, supplements, herbs, over-the-counter drugs.
Also list the dosage or amount you use and when you began them:

Medicine:	Dose:	Began on:	Stopped on:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			

Number of courses of antibiotics taken in lifetime?_________
For what?____
When was your last course?___________________________
____
Have you ever traveled to a foreign country? If so, to where and when. Did you get ill?
____
____
____
____

HOMEOPATHY

Please circle:

I am: thirsty not thirsty

Prefer: ice cold cool warm hot drinks

Crave what foods?

Do you have any fears? Of what?

My body temperature is hot/ warm/ cool/ chilly (circle one)

Worst time of day or night for you?

What is the best time of day?

Dominant emotion:

Past homeopathic remedies taken:

Please list major occurrences in your life that affected your mental/ spiritual or physical health from the most recent occurrence:

Event:	Year:
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________