THRIVE
Chiropractic & Wellness Centre

Woman's Wellness Visit Health Questionnaire

PERSONAL INFORMATION

Name: _____ Today's Date: _____
Date of Birth:_____(d/m/y) Age:_____ Gender: M☐ F ☐ Non-binary/Other ☐
AB health care #: _____
Home Address:_____ _____
City: _____ Prov: _____ Postal Code:_____
Phone (home):_____ Phone (work):_____ Phone (cell):_____
E-mail Address: _____ Occupation: _____full time☐ part time ☐
Ethnicity: _____ *(for genetic health risk assessment purposes only)*
Emergency Contact: _____ Relation:_____ Phone: _____

I consent to receiving free ongoing support and guidance via email to help me achieve better results in my health: Yes ☐ No ☐

How did you hear about Dr. Haarsma?
Dr. Haarsma's website ☐ Clinic website ☐ Referral/Recommended ☐ Internet reviews ☐
Facebook ☐ Instagram ☐ Other Social Media ☐ Other ☐ (please specify):_____

CURRENT HEALTH HISTORY

What are your goals for this visit? _____
_____
_____
What is the outcome/solution/result you are hoping for? Why?
_____
_____

How many times have you been treated with antibiotics? _____ When was the last time? _____

Medication	Date started [m/y]	Dose	Effectiveness
1)			
2)			
3)			
4)			
5)			
Supplement / Vitamin (Brand Name)	**Date started [m/y]**	**Dose**	**Effectiveness**
1)			
2)			
3)			
4)			
5)			

Do you have any **allergies** to medications, foods, animals, other? If so please list. _____
_____
_____
How would you rate your general state of health? Excellent ☐Good☐ Average☐ Fair☐ Poor ☐
Current Weight: _____ Weight 1 year ago_____
Current Height: _____

LIFESTYLE

Are you: Married☐ Separated ☐ Divorced ☐Widowed ☐ Single ☐

What is your current level of stress (reflecting over the past 1 month)? (10 being highest)
1 2 3 4 5 6 7 8 9 10

How often do you exercise per week? _____ For how long and what kind? _____

How often do you use any of the following **per day**?
Alcohol _____ Tobacco _____ Coffee_____ Black Tea _____
Soft Drinks_____ Laxatives _____ Pain Medication _____ Antacids_____
Sleeping Medication _____Marijuana _____ Other Recreational Drugs_____

Do you have any dietary restrictions, religious, ethical or other? _____
_____

PAST MEDICAL HISTORY

Please list any major **traumas, surgeries and/or hospitalizations** not previously mentioned above (include dates):
_____
_____
_____

Please Check and **Date** each of the following conditions that **you** have or have had in the past:

- ☐ Allergies
- ☐ Diverticulosis/ Diverticulitis
- ☐ Gall Bladder Disease
- ☐ Liver Disease/ Jaundice/ Hepatitis
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Anemia (any type)
- ☐ Angina
- ☐ Heart Disease/ Heart Attack
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Surgeries
- ☐ Depression
- ☐ Arthritis
- ☐ Osteoporosis or Osteopenia
- ☐ Other Major Illness (specify)_____

FAMILY HISTORY

	Age	Health Problems	If deceased:	
			Age at death	Cause of Death
Father				
Mother				
Siblings				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				

REVIEW OF SYMPTOMS

Please check all of the following symptoms you are **currently experiencing** or experience as a recurring issue.

GENERAL

- ☐ Night Sweats
- ☐ Sweat Easily
- ☐ Fatigue
- ☐ Chills
- ☐ Fevers
- ☐ Poor Appetite
- ☐ Change in Appetite
- ☐ Cravings
- ☐ Weight Gain
- ☐ Easy Weight Gain
- ☐ Heat or Cold Intolerance
- ☐ Weight Loss
- ☐ Sudden Drop in Energy (time?)_____
- ☐ Bleed or Bruise Easily
- ☐ Strange Tastes or Smells

SLEEP

- ☐ Problems Sleeping anytime during Life
- ☐ Difficulty Falling Asleep
- ☐ Nightmares
- ☐ Difficulty Staying Asleep
- ☐ Grind Teeth
- ☐ Snoring
- ☐ Sleep Apnea

SKIN, HAIR AND NAILS

- ☐ Rashes or Hives
- ☐ Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Pimples
- ☐ Loss of Hair
- ☐ Dandruff
- ☐ Changes in Hair or Skin Texture
- ☐ Recent Moles
- ☐ Lumps
- ☐ Ulcerations
- ☐ Peeling Nails
- ☐ Ridges in Nails
- ☐ Other _____

HEAD, EYES, EARS, NOSE AND THROAT

- ☐ Headaches
- ☐ Neck Pain
- ☐ Concussion(s)
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Blurred/ Double Vision
- ☐ Tearing or Dryness
- ☐ Use of Glasses

_____Date of last eye exam

- ☐ Night Blindness
- ☐ Color Blindness
- ☐ Blind Spots
- ☐ Cataracts
- ☐ Earaches
- ☐ Poor Hearing
- ☐ Ringing in the Ears (Tinnitus)
- ☐ Use of Hearing Aid
- ☐ Facial Pain
- ☐ Sinus Issues
- ☐ Nose Bleeds
- ☐ Jaw Pain or Clicking
- ☐ Tooth Pain
- ☐ Gingivitis
- ☐ Amalgam (silver colored metal) fillings

Date of last dental exam_____

- ☐ Recurrent Sore Throats
- ☐ Sores on Lips, Tongue or inside of Cheeks

HEART AND CIRCULATION

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Palpitations / Fluttering
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fainting
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Cold Hands and Feet
- ☐ Swelling of Hands
- ☐ Swelling of Feet

BREATHING AND LUNGS

- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Pain with a Deep Breath
- ☐ Cough (Blood?)
- ☐ Bronchitis
- ☐ Asthma
- ☐ Phlegm (colour and consistency?)
- ☐ Pneumonia
- ☐ Other Issues not listed

DIGESTION AND ELIMINATION

- ☐ Issues swallowing
- ☐ Bad Breath
- ☐ Heartburn
- ☐ Abdominal Pain or
- ☐ Cramping
- ☐ Bloating
- ☐ Nausea
- ☐ Vomiting
- ☐ Gas
- ☐ Constipation
- ☐ Chronic Laxative Use
- ☐ Rectal Pain
- ☐ Rectal Sores
- ☐ Hemorrhoids
- ☐ Diarrhea or Loose Stools

How many bowel movements do you have per day?_____

GENITO- URINARY

- ☐ Frequent Urination
- ☐ Urinary Urgency
- ☐ Pain on Urination
- ☐ Waking to Urinate
- ☐ Inability to Hold Urine
- ☐ Decreased Urine Flow
- ☐ Distinctive Color
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Other Issues?_____

REPRODUCTIVE

FEMALE

Age at 1st Period:_____
Duration of Period (Days): _____
Duration of One Cycle (From first day of period until the start of the next period): _____
Date of Last Period:_____
Period: Heavy ☐ Light ☐ Clots ☐
Date of Last PAP Exam:_____
☐ History of Abnormal PAP(s)
☐ Irregular Periods
☐ Bleeding Between Periods
☐ Painful Periods
☐ Vaginal Discharge
☐ Vaginal Sores
☐ Breast Lumps
☐ Breast Tenderness
☐ Nipple Discharge
☐ Sexual Difficulties
☐ Low Libido
☐ Changes in body or emotions prior to menstruation (Describe)_____
_____
☐ History of a Sexually Transmitted Infection (Which, Date and Treatment)_____
_____
Are you pregnant? Yes ☐ No ☐ Maybe ☐ Are you currently breast feeding? Yes ☐ No ☐
Are you trying to conceive? Yes ☐ No ☐
Number of Pregnancies_____, Number of Live Births _____, Miscarriages _____, Abortions_____
Are you sexually active? Yes ☐ No ☐
If so do you practice birth control? Yes ☐ No ☐ What type and for how long?_____
Do you practice regular Self Breast Exams? Yes ☐ No ☐ How Often?_____
Date of Last Mammogram:_____

MUSCLES, JOINTS AND BONES

☐ Neck Pain
☐ Back Pain
☐ Hand/ Wrist Pain
☐ Shoulder Pain
☐ Knee Pain
☐ Foot/ Ankle Pain
☐ Hip Pain
☐ Other Joint or Bone Problems?
☐ Muscle Pain
☐ Muscle Weakness

BRAIN, NERVES AND EMOTIONS

☐ Loss of Balance
☐ Lack of Coordination
☐ Dizziness
☐ Seizures
☐ Areas of Numbness/ Tingling/ Paralysis
☐ History of Concussion
☐ Poor Memory
☐ Quick Temper
☐ Irritability
☐ Anxiety/ Nervousness
☐ Depression
☐ Susceptible to Stress

CONSENT FORM

Naturopathic medicine is a style of medicine which approaches individual health, condition treatment and disease prevention primarily by natural means. Naturopathic doctors consider the whole person taking into account physical, biochemical, mental and emotional aspects of each person and work to find the root cause of disease and to stimulate the innate healing ability of the body.

There is a slight potential for risk involved in naturopathic medical care. These risks include but are not limited to the following:

- Allergic reaction to supplements, herbs, topical products or injectable components
- Aggravation of pre-existing symptoms or condition(s)
- Mild pain, bruising or minor bleeding following acupuncture, injection therapies or venipuncture

I _____understand that my identity will be protected at all times and that a health record will be kept detailing health services provided to me. This record will be kept confidential and will only be released under my specific direction or as required by law. I understand that I may see my medical record at any time during regular business hours and that a copy can be requested for a fee. I also consent to the use of information in my medical record for research purposes and understand that my identity will always be protected and kept absolutely confidential.

I commit to informing my Naturopathic Doctor immediately of any disease or condition I am suffering from and will continue to update my Naturopathic Doctor with all pertinent changes in my health. I will also inform my Naturopathic Doctor immediately if I become pregnant or suspect that I am pregnant or if I am breast feeding.

I understand that the Naturopathic Doctor will answer any of my questions to the best of her ability. I understand that results are not guaranteed. I do not expect the Naturopathic Doctor to anticipate and explain all risks and potential complications involved in naturopathic care. With this knowledge, I voluntarily consent to diagnostic and treatment procedures by my Naturopathic Doctor. I understand that my consent, as indicated on this form, will cover the entire duration of my clinical relationship with my naturopathic doctor. I also understand that I am free to withdraw this consent through written notification and may discontinue participation in any procedure at any time.

Patient Name: (please print) _____

Signature of Patient or Guardian: _____

Date: _____

PAP TEST CONSENT FORM

PLEASE NOTE THAT THIS FORM MUST BE READ AND SIGNED PRIOR TO YOUR APPOINTMENT

What is a PAP test?

A PAP test or smear is a screening test that checks the cells of the cervix to ensure no abnormal changes. Abnormal cells can change over time and become cancer.

Your Naturopathic Doctor will take a sample of cells from your cervix. This involves inserting a speculum into your vagina to view the cervix and then using a small broom to collect cells from the cervix itself.

What are the benefits of cervical screening? What are the limitations?

Benefits

- 90% of cervical cancer can be prevented by having regular pap tests.
- It can detect abnormal cell changes in the cervix at an earlier stage when they are easier to treat.

Limitations

- Cervical screening will not prevent all cases of cervical cancer. Some women will still develop cervical cancer despite regular screening. Some abnormal cell changes may still be missed.

Are all abnormal cells found?

Unfortunately, no. A pap test can miss abnormal cell changes.

What causes laboratory error?

Sometimes abnormal cells are missed because they do not look very different from normal cells, there may be very few abnormal cells in the sample or the laboratory technician reading your sample may miss the abnormality.

What should I do?

After your first pap test, plan to have a repeat test every three years. Be sure to inform your healthcare provider if you experience any changes, such as abnormal bleeding between periods, after sexual intercourse or after menopause.

What is reflexive HPV testing?

If you are 30 years old or older and the lab sees cell changes in your pap test that are difficult to interpret, your pap test sample will be **automatically** tested for Human Papillomavirus (HPV) – the main cause of cervical cancer. When women in this age group have high-risk HPV, their infections are more likely to last longer and cause serious cell changes.

<u>References</u>

Cervical Cancer Screening. 2019. Alberta Health Services Cancer Screening Programs. http://screeningforlife.ca/cervical-cancer-at-a-glance/

PATIENT CONSENT (PLEASE INITIAL)
_____ I HAVE READ ALL OF THE ABOVE and any questions were discussed with my ND and answered
to my satisfaction.

I UNDERSTAND THAT MY IDENTITY WILL BE PROTECTED AT ALL TIMES, AND THAT A HEALTH RECORD WILL BE KEPT DETAILING HEALTH SERVICES PROVIDED TO ME. THIS RECORD WILL BE KEPT CONFIDENTIAL AND WILL ONLY BE RELEASED UNDER MY SPECIFIC DIRECTION OR AS REQUIRED BY LAW. I UNDERSTAND THAT I MAY SEE MY MEDICAL RECORD AT ANY TIME DURING REGULAR BUSINESS HOURS AND THAT A COPY CAN BE REQUESTED FOR A FEE.

By signing below, I consent to evaluation and/or treatment of my condition. I understand the nature and the purpose of the procedures, evaluation, and course of treatment. I have been given the opportunity to ask questions, and my questions have been answered to my satisfaction. I certify that I have read, fully understand, and agree to the terms of this consent form.

PATIENT NAME: (PLEASE PRINT) _____

DATE: _____

SIGNATURE OF PATIENT: _____