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## Health History Summary for Women

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Blood type \_\_\_\_\_

Address \_\_\_\_\_ City/Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone (work) \_\_\_\_\_ daytime or evening? (home) \_\_\_\_\_

Fax \_\_\_\_\_ E-mail address \_\_\_\_\_

If we need to contact you, messages can be left at (check all that apply):  work  home  e-mail

Would you like to receive our clinic newsletter via e-mail? (yes/no)

Occupation \_\_\_\_\_ (full/part time?) Employer \_\_\_\_\_

Nearest Relative \_\_\_\_\_ Phone \_\_\_\_\_

what is his/her relationship to you

Who else can we reach in case of emergency? \_\_\_\_\_ Phone \_\_\_\_\_

what is his/her relationship to you

How did you hear about my office? \_\_\_\_\_

If referred, please provide name of referee (so we can thank them): \_\_\_\_\_

When was your last blood test? \_\_\_\_\_ What kind? \_\_\_\_\_

**Your Current Health Concerns**

What is your **main** reason for coming in today? If you have a specific health condition, please describe in detail. When was the very first time you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are you willing to do to change this situation? \_\_\_\_\_  
How long are you willing to work at it? \_\_\_\_\_

List in order of importance other health concerns that are troubling you:

- 1. \_\_\_\_\_ & length of time \_\_\_\_\_
- 2. \_\_\_\_\_ & length of time \_\_\_\_\_
- 3. \_\_\_\_\_ & length of time \_\_\_\_\_
- 4. \_\_\_\_\_ & length of time \_\_\_\_\_
- 5. \_\_\_\_\_ & length of time \_\_\_\_\_
- 6. \_\_\_\_\_ & length of time \_\_\_\_\_

Other problems: \_\_\_\_\_

How long has your main concern been troubling you? \_\_\_\_\_

Is your current "main problem" getting (*better, worse, same*) and for how long? \_\_\_\_\_

What kind of treatment have you received and from whom? \_\_\_\_\_

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current main health concern? (*yes/no*) or for any problem? (*yes/no*)

What was the therapy and what were the results? \_\_\_\_\_

**Your Health History**

The general state of your health is (check one): excellent \_\_\_\_\_ good \_\_\_\_\_ avg \_\_\_\_\_ fair \_\_\_\_\_ poor \_\_\_\_\_

and on average, your energy level is best described on a scale of 1 to 10 (10 is highest, 1 is lowest) as \_\_\_\_\_

When during the day is your energy best? \_\_\_\_\_ worst? \_\_\_\_\_

What is your current approximate weight? \_\_\_\_\_ One year ago? \_\_\_\_\_ Ideal weight? \_\_\_\_\_ Height? \_\_\_\_\_

As an adult what has been your maximum \_\_\_\_\_ and minimum weight (excluding pregnancy) \_\_\_\_\_

Please list the 5 most significant stressful events in your life, from the most recent to the most distant

1. \_\_\_\_\_ Date \_\_\_\_\_
2. \_\_\_\_\_ Date \_\_\_\_\_
3. \_\_\_\_\_ Date \_\_\_\_\_
4. \_\_\_\_\_ Date \_\_\_\_\_
5. \_\_\_\_\_ Date \_\_\_\_\_

Are any of these situations continuing to impact your life? (yes/no) Please circle number

Are you currently working with a professional counsellor, psychologist, social worker, pastor or other therapist? Y/N

Have you in the past? \_\_\_\_\_ If so, when? (please give dates) \_\_\_\_\_

Are you currently working with a Doctor of conventional medicine (M.D.)? (yes/no) If so, whom? \_\_\_\_\_

Which of the following illnesses have you had? Please indicate "n" for now or "p" for past

	N	P		N	P		N	P		N	P
Allergies			Weight problems			Stroke			Venereal disease		
Asthma			Gallstones			Cancer			Syphilis		
Eczema			Gout			Epilepsy			Gonorrhea		
Psoriasis			Arthritis			Migraine			HIV		
Ear infections			Thyroid problems			Pneumonia			Varicose veins		
Strep throat			Anemia			Diabetes			Broken bones		
Hay fever			High blood press.			Malaria			Numbness/tingling		
Measles			Rheumatic fever			Tuberculosis			Cold hands/feet		
Mumps			Fainting			Small pox			Visual problems		
Chicken pox			Poor memory			Polio			Miscarriage		
Whooping cough			Balance problems			Gas/bloating			Mono		
Diphtheria			Speech problems			Hemorrhoids			Depression		
Scarlet fever			Ringling in ears			Parasites			Child abuse		
Sinusitis			Jaundice			Rectal bleeding			Physical abuse		
Canker sores			Hepatitis			Herpes			Sexual abuse		
Acne			Heart disease			Headaches			Emotional abuse		
Tonsillitis			Alcoholism			Warts			Rape		

Other Conditions: \_\_\_\_\_

Are there any of these from which you feel you have never been well since? \_\_\_\_\_

Previous surgeries and hospitalizations (please give dates) \_\_\_\_\_

Have you had any major injuries? If so, what happened and when? \_\_\_\_\_

Do you have any allergies to any drugs, herbs, foods, animals or other? (yes/no) If so, what? \_\_\_\_\_

**Which of the following do you currently use?**

	Amount (how often, how much & how long)		Amount (how often, how much & how long)
alcohol	_____	tobacco	_____
hormones	_____	coffee	_____
cortisone	_____	laxatives	_____
sedatives	_____	antacids	_____

other medications (please give full name and dosage and how long you have been taking the medication)

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

vitamins/herbs : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Family History**

Please indicate which of the following is found in your family with date of diagnosis if possible.

	Mother	Father	Sister/Brother	Grandparents
Cancer				
Tuberculosis				
Heart Disease				
Arthritis				
Diabetes				
High blood				
Asthma				
Kidney disease				
Depression				
Anemia				
Stroke				
Heart attack				
Ulcers				
Other				

When did you last use antibiotics? \_\_\_\_\_  
When was your last vaccination? \_\_\_\_\_ Did you have any adverse reactions (e.g. fever)? (yes/no)  
Your currently live with? spouse \_\_\_ partner \_\_\_ parents \_\_\_ friends \_\_\_ children \_\_\_ alone \_\_\_  
Are you? married \_\_\_ separated \_\_\_ divorced \_\_\_ widowed \_\_\_ single \_\_\_ in a supportive relationship \_\_\_  
What is your current level of education? \_\_\_\_\_ Are you satisfied with this? (yes/no)  
Do you have any children? (yes/no) If so, how many? \_\_\_\_\_ Ever have toxemia during pregnancy? (yes/no)  
Do they have any health problems? \_\_\_\_\_  
What is your weakest organ system and why? \_\_\_\_\_

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### **Kidneys and Bladder**

How much water do you drink daily? \_\_\_\_\_  
Have you had recurrent bladder infections? (yes/no) How were they treated? \_\_\_\_\_  
How many bladder infections have you had in the last 3 years? \_\_\_\_\_  
Do you have any burning sensation during or after urination? (yes/no, past or present)  
Is your urine (dark yellow, bright yellow, cloudy, pale or clear)?  
Does your urine have a strong odor to it? (yes/no)  
Do you have difficulty starting or stopping when urinating? (yes/no)  
Do you have difficulty perspiring? (yes/no) Do you perspire when you exercise? (lightly, moderately, heavily)  
Do you perspire at times other than when exercising? (yes/no) If yes, when? \_\_\_\_\_  
Does your perspiration have a strong smell? (yes/no)

### **Digestion and Elimination**

Do you have any problems with gas, bloating or fullness after eating? (yes/no)  
If so, how often? (often, sometimes, never) How severe? \_\_\_\_\_  
Do you have gas in (the upper part of the abdomen, the lower part, or both)? How long have you had this problem?  
\_\_\_\_\_ How often do you have bowel movements? \_\_\_\_\_  
Do you ever have any (blood, mucus, undigested food, black) stools? Any rectal itching? (yes/no)  
Do your stools tend to be (formed or loose)? How often do you have diarrhea? \_\_\_\_\_  
Do you ever have alternating constipation and diarrhea? (yes/no)  
Do you ever have yellow or light colored stools? (often, sometimes, never)  
How often do your stools have a strong disagreeable odor? (often, sometimes, never)  
Have you ever fasted? (yes/no, juice or water) If yes, how long have you fasted? \_\_\_\_\_  
How did you feel while you were fasting? \_\_\_\_\_  
Have you traveled outside Canada in the last 5 years? (yes/no) If yes, where did you go? \_\_\_\_\_

### **Reproductive Health**

Are you currently sexually active? (yes/no) How often? \_\_\_\_\_ Is this (more or less) than 1 year ago?  
Sexual preference: Heterosexual \_\_\_ Bisexual \_\_\_ Homosexual \_\_\_ Transexual \_\_\_  
Do you use birth control? (yes/no) What type of birth control do you currently use? \_\_\_\_\_  
Age of first menses \_\_\_ If periods have stopped, at what age did they stop? \_\_\_\_\_  
Are your cycles regular? (yes/no) Periods begin every \_\_\_\_\_ days and last for \_\_\_\_\_ days.

Are your periods (heavy, medium, light) and what color is the blood? (light red, dark red, medium, clots)

Do you have any spotting or bleeding between periods? (yes/no) Any cramps with your period? (yes/no)

Please rate the following symptoms you experience premenstrually from 1 to 6 (1 is no change, 6 is extreme change)

- |  |                                     |
|--|-------------------------------------|
| 1. Pain, tenderness, enlargement or swelling of breasts _____      | 2. Feeling under stress _____       |
| 3. Feeling unable to cope or overwhelmed by ordinary demands _____ | 4. Feeling sad or blue _____        |
| 5. Edema, swelling, puffiness, or water retention _____            | 6. Weight gain _____                |
| 7. Backaches, joint and muscle pain, or joint stiffness _____      | 8. Irritability or bad temper _____ |
| 9. Relatively steady abdominal heaviness, discomfort or pain _____ | 10. Feeling bloated _____           |

Do you have any abnormal discharge from the vagina? (yes/no)

No. of pregnancies \_\_\_ abortions \_\_\_ miscarriages \_\_\_ live births \_\_\_ Any problems getting pregnant? (yes/no)

Do you get yearly PAP smears? (yes/no) Any abnormal PAPs? (yes/no)

Do you do regular breast self exam? (yes/no) Have you noticed any breast lumps? (yes/no)

### Personal Habits

What do you enjoy most in your life? \_\_\_\_\_

Please rate your satisfaction with the following areas of your life on a scale of 1 to 10: (10 is highest, 1 is lowest)

Fun & recreation \_\_\_\_\_ Personal growth \_\_\_\_\_ Significant other/romance \_\_\_\_\_ Friends & Family \_\_\_\_\_

Health \_\_\_\_\_ Money \_\_\_\_\_ Physical Environment \_\_\_\_\_ Career \_\_\_\_\_

What are your main interests or hobbies? \_\_\_\_\_

What do you worry most about in your life? \_\_\_\_\_

Do you have any dietary restrictions? (yes/no) If yes, what? \_\_\_\_\_

Do you exercise? (yes/no) If yes, what kind, how much & how often? \_\_\_\_\_

Do you have a religious or spiritual practice? (yes/no) If yes, what? \_\_\_\_\_

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) \_\_\_\_\_

Do you have problems (*falling or staying*) asleep? \_\_\_\_\_ How many hours do you sleep at night? \_\_\_\_\_

Do you awaken at night? (yes/no) If yes, at what time(s) do you usually wake up? \_\_\_\_\_

Do you ever sweat at night while sleeping? (yes/no) How frequently and how much do you sweat? \_\_\_\_\_

Do you wake up feeling refreshed? (yes/no) Do you nap or rest horizontally throughout the day? (yes/no)

If yes, how long and at what time usually? \_\_\_\_\_

What do you normally feel like temperature wise, compared to others? (*warmer, cooler, or average*)

What are the temperatures of your hands and feet generally? (*warmer, cooler, or average*)

Do you enjoy your work? (yes/no) Do you take vacations? (yes/no)

Are you currently in a happy satisfying relationship with someone? (*very, mostly, somewhat, not*)

How often do you get colds, flus, sore throat, yeast infections during the year? \_\_\_\_\_

When you rise quickly from a sitting or lying position do you ever get dizzy? (yes/no)

If yes, how often? (*daily, few times per week, once a week, twice a month, once a month, rarely*)

How do you learn best? *I read*     *I listen (lectures)*     *Television*     *Through stories*     *Very visual*

### Occupational/Household

How long have you lived at your present address? \_\_\_\_\_ Where have you lived previously?

(*please describe location, if old or new place, if damp, moldy, etc.*) \_\_\_\_\_

Do you have specialized air filtration at home? (yes/no) Do you live in a city? (yes/no)

Do you work in an office building? (yes/no) Do the windows open? (yes/no)

Do you have specialized air filtration at your work place? (yes/no)

Do you work in the presence of toxic fumes or chemicals? (yes/no)

Do any of your hobbies involve toxic materials? (yes/no)

Do you smoke? *(yes/no)* If yes, what and how much and how often? \_\_\_\_\_

Are you currently exposed to second hand smoke? *(yes/no)*

What do you use for your drinking water? *(bottled, filtered, or tap water)*

Is there anything else you feel I should know about you? \_\_\_\_\_

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## CARE AGREEMENT

Naturopathic medicine uses non-invasive methods for the assessment of bodily dysfunction and natural therapeutics for correction. The methods used in this clinic for assessment and therapeutics include clinical nutrition, homeopathy, botanical medicine, hydrotherapy, detoxification, acupuncture and lifestyle counseling.

Each person must sign this document before any treatment is rendered.

My signature acknowledges that:

- 1) I have been informed of and I understand that:
  - i) The treatments that I receive at this office are different from those usually offered by a medical doctor or other licensed health care practitioner.
  - ii) I understand that I am at liberty to seek or continue to seek medical care from a physician or surgeon or other licensed health care provider.
  - iii) I confirm that Tasleem Kassam, N.D. nor anyone else has suggested that or recommended that I refrain from seeking or following the advice of another licensed health care provider.
- 2) I declare that I authorize and consent to treatment. I further understand and am informed that, as in all health care, in the practice of naturopathy, there are some very slight risks to treatment. I do not expect the doctor(s) to be able to anticipate and explain all the risks and complications; I wish to rely on the doctor's judgment during the course of treatment, based upon the facts then known, is in my best interest.
- 3) I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Therefore, all services rendered to me are charged to me directly and that I am personally responsible for payment. I am aware that these fees are not covered by provincial health care plans. I also understand that if I suspend or terminate my naturopathic care, any outstanding charges for consultation, labwork, supplements or other incidental fees arising from my treatment will be immediately due and payable.

**Patient's Name:** \_\_\_\_\_

**Patient's signature X** \_\_\_\_\_

**Date** \_\_\_\_\_

OR

**Guardian's signature X** \_\_\_\_\_

**Date** \_\_\_\_\_