EQUANIMOUS HEALTH
COMPLEMENTARY AND ALTERNATIVE MEDICINE

This confidential information of your medical record and health history will be kept in the office of our healthcare facility and will not be released to any individual except when you have authorized this release in writing or when it is required by law or permitted under legislation. Please complete this form by typing as thoroughly as possible to optimize your healthcare outcomes.

DEMOGRAPHIC INFORMATION

Patient name: _____ (Last Name) _____ (Given Name) Date: _____ (YYYY / MM / DD) File No.: _____

Date of birth: _____ (YYYY / MM / DD) Birth Place: _____ Age: _____ (YY / MM) Gender: Male/Female

Developmental state: _____ Culture: _____ Ability: _____

Marital Status: _____ Siblings: _____ Issues: _____

Education: _____ Occupation: _____

Address: Addressee: _____ (Last Name) _____ (Given Name)

Additional delivery information: _____

Post box number: _____ Station information: _____

Unit number: _____ Street: _____

Town/city: _____ Province: _____ Postal code: _____

Contact numbers: Cell phone: _____ Work phone: _____

Home phone: _____ Fax number: _____

E-mail ID: _____ Best way to contact: _____ Best time to contact: _____

Referred by: _____ Referrer contact number: _____

Duration of illness: _____ Provisional diagnosis: _____

EMERGENCY CONTACT INFORMATION

Full Name: _____ (Last Name) _____ (Given Name) Relation: _____

Contact numbers: Cell phone: _____ Work phone: _____

Home phone: _____ Fax number: _____

FAMILY DOCTOR INFORMATION

Full Name: _____ Designation: _____

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(Last Name) (Given Name)

Contact numbers: Cell phone: _____ Work phone: _____
Home phone: _____ Fax number: _____

CHIEF HEALTH CONCERN OR GOAL

What main health concern or goal brought you to the healthcare facility today?

_____
_____
_____

How long have you had it?

_____
_____
_____

Describe any factors you suspect may have played a role in the onset and perpetuation of your condition.

_____
_____
_____

Please name previous health practitioners consulted for this condition.

_____
_____
_____

What is previous health practitioner's diagnosis?

_____
_____
_____

What type of therapy have you tried for this condition?

_____
_____
_____

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What make it better?

_____
_____
_____

What make it worse?

_____
_____
_____

ASSOCIATED HEALTH CONCERNS OR GOALS IN ORDER OF THEIR IMPORTANCE

What are your other health concerns or goals?

1. _____
2. _____
3. _____

How long have you had them?

1. _____
2. _____
3. _____

Describe any factors you suspect may have played a role in the onset and perpetuation of your conditions.

1. _____
2. _____
3. _____

Please name previous health practitioners consulted for these conditions.

1. _____
2. _____

What is previous health practitioner's diagnosis?

1. _____
2. _____
3. _____

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What type of therapy have you tried for these conditions?

1. _____
2. _____
3. _____

What make them better?

1. _____
2. _____
3. _____

What make them worse?

1. _____
2. _____
3. _____

HEALTH AND LIFESTYLE REVIEW

The health and lifestyle assessment questionnaire is designed to provide insight into your personal health. When embarking on a personal health plan, it is important for you and your healthcare provider to have a benchmark of where you are, you're personal and family histories, and what your behaviours, concerns, and thoughts are with regards to your health.

The following lifestyle assessment questionnaire is not designed to give a medical diagnosis. It identifies your current strengths, risk factors that might be present, and it highlights key areas of concern. It also assists in uncovering the factors that may be contributing to your symptoms or current concerns.

- ✓ Use the last three months as a guide to current symptoms when answering the questions
- ✓ If you feel that something that pertains to you is missing in any section feel free to add it

GENERAL INFORMATION

Are you married, single, separated, widowed or with partner?_____

Number of Dependents:_____ Number of Children:_____

Number of pets:_____ What kind of pets?_____

Where did you grow up?_____

Where do you live? City_____ Suburbs _____Country_____ Farm _____

Please list any chemicals, toxins, or other factors in your environment that might be affecting your health:

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What are your hobbies?_____

How much time do you spend in nature?_____

Do you smoke?_____ In the past _____ How many pack a day? _____

Does anyone in your family smoke? _____ In the past _____

What do you want more of in life? _____

What do you want less of in life?_____

Have you experienced any major trauma, loss or life changing significant events?

A TYPICAL DAY

List the amount of time you spend doing the following activities during a typical day

Note: The total time will probably add up to more than 24 hours due to the nature of the question.

Activity	Hours	Activity	Hours
Sleeping		Exercising	
Personal hygiene		Relaxing/meditating	
Driving		Reading	
Public transit		Listening to music	
Working		Watching television	
In front of computer		Being outside	
House or yard work		Time alone	

SATISFACTION LEVEL ON DIFFERENT ASPECT OF YOUR LIFE

Using the scale provided identify your level of satisfaction with respect to the categories listed.

- ✓ Scale 1: not comfortable at all with current situation
- ✓ Scale 2: low level of comfort with current situation
- ✓ Scale 3: okay most of the time with current situation
- ✓ Scale 4: fairly comfortable with current situation
- ✓ Scale 5: high level of comfort with the current situation

Category	Comfort level with the situation					Changed in last 3 months		Changed in last 1 year	
Diet	1	2	3	4	5	Yes	No	Yes	No
Exercise	1	2	3	4	5	Yes	No	Yes	No
Wellness	1	2	3	4	5	Yes	No	Yes	No
Lifestyle	1	2	3	4	5	Yes	No	Yes	No
Environment	1	2	3	4	5	Yes	No	Yes	No

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Work	1	2	3	4	5	Yes	No	Yes	No
Family	1	2	3	4	5	Yes	No	Yes	No
Relationship	1	2	3	4	5	Yes	No	Yes	No

EXERCISE

How active is your day?_____

On average, how many hours do you exercise per week? _____

What kind of exercise do you do?_____

Do you belong to a gym? If so, how often do you go? _____

Do you prefer to exercise alone, with others or as part of a class?_____

What benefits have you found from exercising?_____

DIET

On a scale of 1 - 10 (low - high) how would you rate your diet? _____

Why?_____

Is there anything about your diet you would like to change?_____

_____

On average how many meals do you eat a day? _____

How much time do your spend preparing?_____

How much time you spend eating? _____

Are there any foods that you crave? _____ Avoid?_____

Do you follow any specific diet regime? (E.g. vegetarian, vegan etc…) _____

Do you usually eat alone or with others? _____

Do you pay attention to the quality of the food that you eat? _____

Are you aware of any differences in how you feel with different food? _____

How many times a week you eat; Proteins ____Carbohydrates_____ Fruit ____Vegetables ____Oils _____

Grains _____ Milk products ____Sweets/sweeteners ___Beverages __Herbs/spices __Other ____

Do you monitor your intake of fat, salt, fibre and sugar? _____

Do you add salt to most meals? _____

Do you eat according to the season?_____

Do you enjoy food? _____

Do you enjoy preparing food? _____

Do you look forward to meal time / eating? _____

Please describe an average:

Breakfast:_____

Lunch:_____

PATIENT NAME - FILE NO. - DATE

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Dinner: _____

STRESS

Using the scale provided circle the level of stress that you feel for the following aspects of your life and the duration of this stress.

Category	None	Low	Average	High	Duration
Personal	0	1	2	3	
Health	0	1	2	3	
Financial	0	1	2	3	
Unfulfilled expectations	0	1	2	3	
Relationships	0	1	2	3	
Marriage	0	1	2	3	
Career	0	1	2	3	
Family	0	1	2	3	
Spiritual	0	1	2	3	
Other	0	1	2	3	

Please specify other sources of stress that you have _____

What steps have you taken to deal with your stress? _____

Have you ever engaged in counselling or psychotherapy; if so for how long? _____

Do you take vacations regularly? _____ Date of last vacation: _____

SLEEP

How is your sleep? _____

Do you ever suffer from insomnia? _____ How often? _____

How many hours a day do you sleep? _____ Do you nap? _____

Are you a restful and sound sleeper? If not, please explain. _____

_____

Do you wake feeling rested? _____

Do you wake at night for any particular reason? If yes, please explain: _____

Is there any particular time? _____

How long does it take to fall back asleep? _____

Do you have frequent dreams and nightmares? _____

ENERGY LEVEL

On a scale of 1 (low) to 10 (high) rate your energy level? _____

What time of the day is your energy the highest? _____

What time of the day is your energy the lowest? _____

What affects your energy? _____

Work Environment

Do you enjoy your work? Please explain: _____
Describe your work load: _____
Do you work on shift? _____
On average how many hours do you work a day? _____ How many hours a week? _____
Do you bring your work home with you? If so, why? _____
How active is your work day? Please describe: _____
_____
How would you describe the dynamics at work? _____
_____

Appetite

Describe your appetite: _____
Describe your digestion: _____
What makes your digestion worse? _____
What happens if you skip a meal? _____
What type of foods do you prefer? _____
What temperature of food do you prefer? _____
Do you have any food allergies or intolerances? _____

Thirst

Describe your thirst: _____
What temperature of drinks do you prefer? _____
What do you prefer to drink? _____
How much water do you drink in a day? _____
What type of water you drink? _____

Sweat

How much you sweat? _____
On which location of your body you sweat much? _____
Is there any odour to your sweat? If yes, please describe: _____
Is there any stain because of sweat? If yes, please describe: _____

Urine

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Number of times a day you urinate? _____ Number of times you get up at night to urinate? _____
Is there any odour to your urine? If yes, please describe: _____

BOWEL MOVEMENTS

On average how many bowel movements do you have a day? _____
Do you strain to have a bowel movement? _____ What colour are your stools? _____
Describe the consistency / size of your bowel movements? _____

MENSTRUAL HISTORY

Age menses began: _____ Days flow lasts: _____ Days between periods: _____
Describe your flow: _____ When is it the heaviest? _____
What is the flow like (clots, colour)? _____
What symptoms are associated with your period? _____
Any pain with your menses; if so, when is it the worse? _____
Are you practising birth control; if so, what type and since when? _____
Number of pregnancies: _____ Number of live births: _____
Number of miscarriages: _____ Number of abortions: _____
Any problems conceiving; if yes, explain: _____

_____

Have you done any fertility treatments; if yes, explain: _____
Date of last PAP? _____ Last menstrual period? _____
Any menopausal symptoms; if yes, describe: _____

_____

WEATHER

Are you affected by the weather? _____
What is favourite type of weather? _____
What is your least favourite type of weather? _____

HABITS

Please check √ which of the following substances are you currently using?

SUBSTANCE	QUANTITY	SUBSTANCE	QUANTITY
Alcohol		Laxatives/purgatives	
Chewing tobacco		Painkillers	
Cigarettes		Recreational drugs	
Coffee/tea		Sleeping pills	

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Hours or day you spend: _____ Working: Driving: _____
Watching television: _____ Computer: _____

VITAL STATISTICS

Height: _____ Weight: _____
Blood Pressure: _____ Pulse: _____
Respiratory Rate: _____ Temperature: _____

BREATHING

How would you describe your breathing? _____
Do you have shortness of breath on exertion? _____
What affects your breathing? _____

BODY TEMPERATURE

Do you like to be warm or cool? _____
Do you become overly hot or cold throughout the day? _____

MEDICATIONS/SUPPLEMENTS AND OTHER TREATMENTS

Please check √ any of the following medications that you are taking or have taken in the last 2 years:

	Antacids		Appetite Suppressants		Aspirin/Tylenol		Birth Control Pills
	Chemotherapy		Diuretics (water pills)		Laxatives		Pain Relievers
	Radiation		Recreational Drugs		Sleeping Pills		Tranquilizers

How many times have you been on antibiotics in the last 10 years? _____
How many times have you been on corticosteroids in the last 10 years? Oral _____ Topical _____

CURRENT PRESCRIPTION OR OVER THE COUNTER MEDICATIONS BEING USED

MEDICINE	DOSAGE	FREQUENCY	TAKEN FIRST ON (YY/MM/DD)	TAKEN LAST ON (YY/MM/DD)	REGULARITY (Y/N)	SIDE EFFECTS	PRESCRIBED FOR

MEDICATIONS NOT BEING USED CURRENTLY, BUT USED ANYTIME DURING PAST 2 YEARS

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MEDICINE	DOSAGE	FREQUENCY	TAKEN FIRST ON (YY/MM/DD)	TAKEN LAST ON (YY/MM/DD)	SIDE EFFECTS	PRESCRIBED FOR	REASON FOR STOPPING

MAJOR SURGERIES

NAME OF SURGERY	DATE OPERATED (YYYY/MM/DD)	COMPLICATION

MAJOR INJURIES

INCIDENCE	INCIDENCE DATE (YYYY/MM/DD)	LONG-TERM EFFECT

PLEASE CHECK √ IF YOU HAVE EVER HAD ANY OF THESE CONDITIONS

	Abscesses		Emphysema		Liver disease		Strep throat
	Alcoholism		Gall stones		Malaria		Sinusitis
	Anaemia		Goitre		Measles		Stroke
	Appendicitis		Gonorrhoea		Mental illness		Gout
	Arthritis		Headaches		Mononucleosis		Syphilis
	Asthma		Heart trouble		Mumps		Tonsillitis
	Cancer		Hypertension		Nosebleeds		Tuberculosis
	Chicken pox		Hepatitis		Parasites		Venereal warts
	Cold sores		Herpes		Pelvic inflam. disease		Warts
	Depression		Influenza		Pneumonia		Whooping cough
	Diabetes		Jaundice		Prostate disease		Worms
	Eczema		Kidney disease		Rheumatic fever		Others*
	Epilepsy		Leukemia		Skin disease		

*Others: _____

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PLEASE CHECK √ WHICH CONDITIONS AFFECT(ED) YOUR FAMILY

Please indicate which family relatives (mother, father, grandparents, siblings, aunts or uncles) have ever encountered the following health concerns:

√	Health Concern	Family Relative	√	Health Concern	Family Relative
	Alcoholism			Infertility	
	Allergies			Intestinal disease	
	Alzheimer's disease			Learning disability	
	Arthritis			Mental illness	
	Asthma			Migraine	
	Cancer (indicate type)			Neurological disorders	
	Diabetes			Obesity	
	Depression			Osteoporosis	
	Drug addiction			Pneumonia	
	Eating disorder			Skin diseases	
	Epilepsy			Stroke	
	Genetic disorder			Syphilis	
	Gonorrhoea			Suicide	
	Heart disease			Tuberculosis	
	Hepatitis			Ulcers	
	Hypertension			Others	

FAMILY TABLE

RELATIONSHIP	CURRENT AGE	AGE AT DEATH	CAUSE OF DEATH	DISEASE(S)
Mother				
Maternal grandmother				
Maternal grandfather				
Father				
Paternal grandmother				
Paternal grandfather				
Sister(s)				
Brother(s)				

SYSTEM REVIEW

Please check with a √ if you are currently suffering from, or with a P if you have suffered from any of the following disorders in the past.

√	SKIN
	Rashes

	Boils
	Dryness

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	Eczema
	Itching
	Scaling
	Falling/Thinning of Hair
	Hives
	Lumps
	Moles
	Colour Changes
	Acne
	Dry Hair
	Warts
	Nail Changes
√	**HEAD**
	Headache
	Head Injuries
	Dizziness
	Vertigo
	Migraines

√	**EYES**
	Eye Pain
	Double Vision
	Redness
	Tearing
	Cataracts
	Discharge
	Dryness
	Blurring
	Impaired Vision
	Glaucoma
	Itching

√	**EARS**
	Ringing
	Buzzing
	Redness
	Earache
	Infection
	Discharge
	Impaired Hearing

√	**NOSE/SINUSES**
	Frequent Colds
	Stuffiness
	Hay Fever
	Nose Bleeds
	Obstruction
	Loss of Smell
	Nasal Discharge
	Sinus Problems

√	**MOUTH AND THROAT**
	Sore Throats
	Receding Gums
	Cankers
	Loss of Taste
	Dry Lips
	Dental Cavities
	Bleeding Gums

√	**NECK**
	Lumps
	Goitre
	Swollen Glands
	Pain or Stiffness
	Difficulty Swallowing

√	**RESPIRATORY SYSTEM**
	Cough
	Sputum
	Spitting Blood
	Wheezing
	Asthma
	Bronchitis
	Pneumonia
	Emphysema
	Difficulty Breathing
	Shortness of Breath
	Allergies

√	**CARDIOVASCULAR SYSTEM**
	Palpitations
	Chest Pain on Exertion
	Blueness of Lips

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	Swelling of Ankles
	High Blood Pressure
	Low Blood Pressure

√	GASTROINTESTINAL SYSTEM
	Heartburn
	Nausea
	Vomiting
	Constipation
	Diarrhoea
	Gas
	Belching
	Bloating
	Abdominal Pain
	Lack of Appetite
	Ineffectual Urging
	Haemorrhoids
	Indigestion
	Food Allergies

√	MUSCULOSKELETAL SYSTEM
	Pain in Joints
	Stiffness in Joints
	Swollen Joints
	Broken Bones
	Muscle Spasms
	Cramps
	Muscle Twitching

√	PERIPHERAL VASCULAR SYSTEM
	Deep Leg Pain
	Cold Hands
	Cold Feet
	Varicose Veins
	Ulcers
	Extremity Numbness
	Extremity Coldness
	Extremity Swelling

√	NEUROLOGICAL SYSTEM
	Fainting
	Convulsions
	Paralysis
	Tremors
	Numbness
	Tingling
	Weakness
	Involuntary Movements
	Loss of Memory
	Difficulty in Concentration
	Loss of Balance
	Difficulty Initiating Movements
	Speech Problems

√	ENDOCRINE SYSTEM
	Cold Intolerance
	Excess Thirst
	Excess Hunger
	Sudden Weight Gain
	Sudden Weight Loss
	Heat Intolerance
	Excess Sweating

√	FEMALE REPRODUCTIVE SYSTEM
	Menstrual Problems
	Sexual Difficulties
	Pain/Dryness during Intercourse
	Problems Achieving Orgasm
	Difficulties Conceiving or Carrying Pregnancy to Term
	Venereal Disease
	Age of First Menses
	Date of Last Menses

√	MALE REPRODUCTIVE SYSTEM
	Testicular Pain
	Testicular Masses
	Abnormal Penile Discharges
	Sexual Difficulties
	Erectile Difficulties
	Fertility Difficulties
	Enlarged Prostate
	Venereal Disease

PATIENT NAME - FILE NO. - DATE

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