NICOLE RUSH
NATUROPATHIC DOCTOR

Adult Patient Information Form

Last Name:		First Name:	
Date of Birth:	Age:	Sex:	Occupation:
Address:		City, Province:	
Postal Code:	Home Phone Number:	Cel Phone Number:	
Email Address:		May we leave a message regarding upcoming appointments? Y / N	
EMERGENCY CONTACT INFORMATION:			
Last Name:	First Name:	Relationship:	
Home Phone Number:		Cel Phone Number:	
OTHER HEALTHCARE PROVIDERS:			
Medical/Family Doctor:		Telephone:	
Other Health Care Provider:		Telephone:	
Date of last medical doctor visit:		Date of last complete physical exam:	

How did you discover the clinic and Dr. Nicole Rush? Please circle one of the following:

Family Friend Health Professional Yellow Pages Internet

Health Assessment Questionnaire

In your opinion, what are your most important health concerns?

1)
2)
3)
4)

Byron Natural Health Centre
(519) 601-5483
1288 Commissioners Rd. W. London ON

MEDICAL HISTORY:			
Height:	Weight:	Past Min. Weight:	Past Max. Weight:

Vaccination/Immunization Record: Check all that apply

Please note vaccinations in **bold** are routine as per the Ontario Childhood Immunization Schedule 2004.

- ☐ **DPT (Diptheria, Pertussis, Tetanus)**
- ☐ **MMR (Measles, Mumps, Rubella)**
- ☐ Gardasil/Cervarix (HPV Vaccine)
- ☐ Haemophilus Influenza B
- ☐ BCG (Tuberculosis)
- ☐ Hepatitis A
- ☐ **Hepatitis B**
- ☐ **Polio**
- ☐ Flu Vaccine
- ☐ **Pneumococcal Conjugate (Meningitis/Pneumonia)**
- ☐ **Meningococcal C Conjugate (Meningitis)**
- ☐ **Virivax/Varilrix (Chicken Pox)**

Did any of your vaccines cause adverse reactions? Y / N If yes, please specify:

List any previously diagnosed conditions:	Treatment Received:	Year:

List all allergies (medication, foods, environmental, etc.)	Reaction Type:

List all prescription drugs, herbs and natural supplements (vitamins, homeopathics, etc.) that you are taking:

Medication:	Dosage:	Start Date:

Please indicate if you have or have had any of the following:

Eczema/Psoriasis	Bowel Disease	Hepatitis	Arthritis	Anemia	High Blood Pressure
Asthma	Infertility	Kidney Disease	Osteoporosis	Eating Disorder	Parasites
Heart Disease	Miscarriage	Kidney Stones	Migraines	Alcoholism	Mono
Heart Attack	Diabetes	Bladder Infections	Epilepsy	Addiction	Depression
Stroke	Gallstones	Yeast Infections	Fainting	Cancer	Thyroid Disease

DIETARY AND LIFESTYLE HABITS:		
Exercise	How many times do you exercise per week? Never 1x 2x 3x 4x >5x	
	What type of exercise?	
Diet	Are you on a special diet? Y / N	Is it a physician prescribed diet? Y / N
	Do you have any dietary restrictions?	
Sexual Health	Are you currently sexually active? Y / N	
	List contraceptive method(s) used, if any:	
	Do you experience pain/discomfort during intercourse?	
	Do you have concerns about your sex drive?	

Do you use any of the following? (Check all those that apply):

- ☐ Aspirin/ASA
- ☐ Tylenol/Acetaminophen
- ☐ Advil/Ibuprofen
- ☐ Laxatives
- ☐ Antacids
- ☐ Diet Pills
- ☐ Oral Birth Control/Patch/IUD/Injection
- ☐ Tobacco Form, Amount per day, For how long _____.
- ☐ Alcohol Form, Amount per day/week _____.
- ☐ Recreational Drugs Form, how often _____.
- ☐ Caffeine Form, Amount per day _____.

Sleep	On average, how many hours of sleep do you get?	
	Do you have trouble falling asleep? Y / N	
	Do you typically wake up during the night? Y / N	If yes, how many times/night?
Energy	On a scale of 1 (lowest) to 10 (highest), rate your energy level:	
Stress	On a scale of 1 (lowest) to 10 (highest), rate your stress level: What are the 3 main stressors in your life? 1) 2) 3)	
Toxins	Are you regularly exposed to toxins or other hazards? Either at home or in the work environment? Please specify.	

Is there any other important information you would like me to know?