PATIENT HISTORY QUESTIONNAIRE

Name: ____

BC Care Card #: ____________________ Date: ____________________

Address: ____

City: ________________ Province: ________ Postal Code: ______________

Telephone # (Home): ______________ Alt. #: ____________________

E-mail Address: ____

Date of Birth: (day) / (month) / (year) Age: ____ Gender: Female ____ Male____

Marital Status: S M W D (circle one) # of Children: ______________

Occupation: ________________ Retired: ____________________

Employer: ________________ Work #: ____________________

Work Address: ____

Next of kin or other to reach in case of an emergency: ____________________

Relationship: ________________ Phone #: ____________________

Please Note: Your appointment time has been reserved for you. In courtesy of your practitioner and fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated practitioners to collect my personal information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any time using the contact numbers I have provided above. In addition, I authorize the clinic and its associated practitioners to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Patient Signature: ____________________ Date Signed: ____________________

MEDICAL DOCTOR:

Name: ____________________ Telephone: ____________________

Address: ____

Date of last appointment: ____________ Date of last physical: ______________

Date of last dental examination: ______________________________

How did you hear about our clinic? ______________________________

____

Who referred you to us? ______________________________

Has any other family member been a patient at the clinic? ______________

2306 St. Johns Street | Port Moody, BC | V3H 2A9
TEL 604.931.2225 | FAX 604.931.2143 | www.integratedhealth.ca

CONTEXT OF CARE REVIEW

Successful healthcare and preventative medicine are possible only when we have a complete understanding of the patient physically, mentally, and emotionally. The nature of your responses to the following questions will go a long way in assisting our understanding of your truest desires. Your time, thoughtfulness, and honesty in completing this overview will greatly aid us in assisting you with your health needs.

1) What is your primary health concern (why are you here)?

2) Why did you choose to come to Port Moody Integrated Health?

   - Do you know anything about our approach?

3) What short term expectations do you have from this visit to Port Moody Integrated Health?

   - What long term expectations do you have, if any, from working with Port Moody Integrated Health?

4) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

   0% 0 1 2 3 4 5 6 7 8 9 10 100%

5) What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

   - What behaviours or lifestyle habits do you currently engage in regularly that you believe are less constructive lifestyle habits? (please list)

6) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that we will be sharing with you?

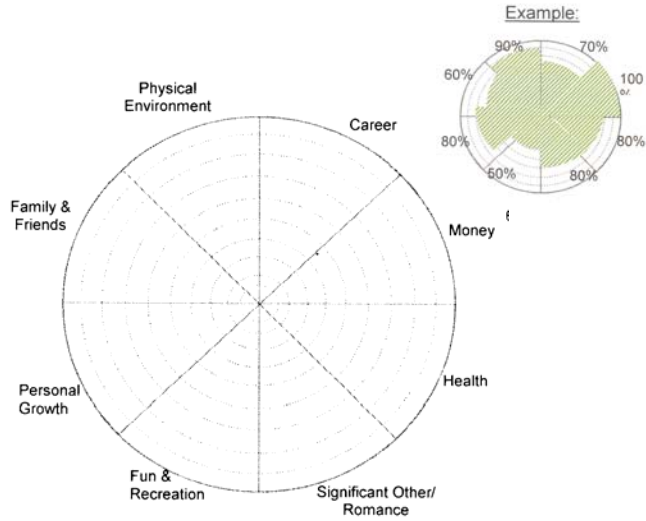
7) Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for the career section.

Do the same for each area, starting from the center point radiating outwards.



What are your most important health problems? List as many as you can in order of importance:

1) ______
2) ______
3) ______
4) ______
5) ______
6) ______
7) ______

FAMILY HISTORY

Do you have a family history of any of the following? (please circle)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma/Hayfever/Hives			

Any other relevant family history? ______

______

Allergies

Are you hypersensitive or allergic to:

Drugs? ______

Foods? ______

Environmental or chemical? ______

Hospitalization, Surgery, Imaging

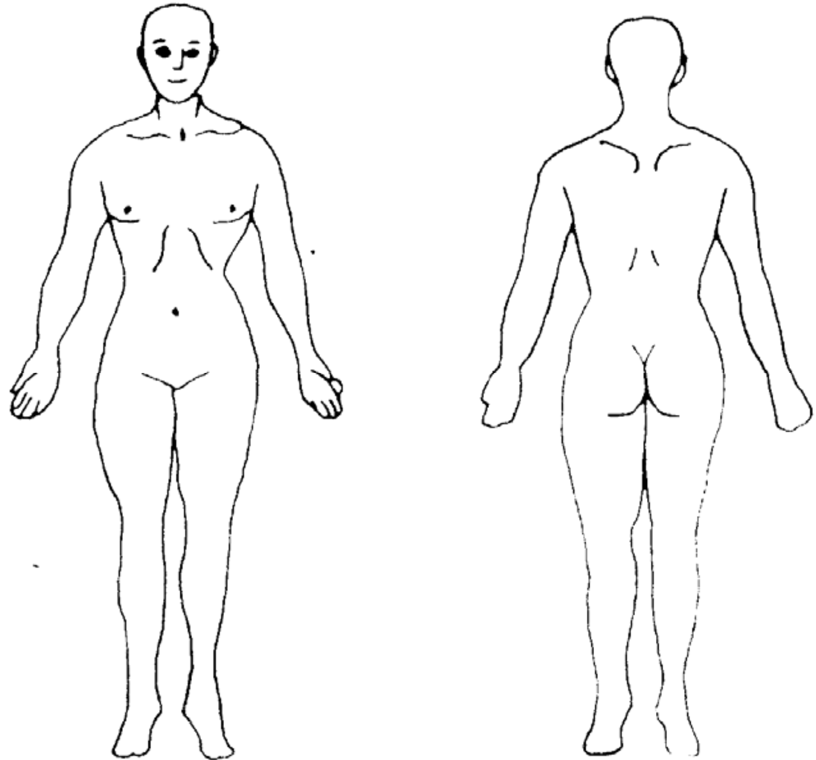
What hospitalizations, surgeries, X-Rays, CT scans, EEG, and EKG's have you had?

______ **year:** ______ ______ **year:** ______

______ **year:** ______ ______ **year:** ______

______ **year:** ______ ______ **year:** ______

Show area(s) of pain or unusual feeling. Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Include all affected areas.



Numbness	* * * * * * * * * * * *
Pins and Needles	0 0 0 0 0 0 0 0 0 0 0 0
Burning	# # # # # # # # # # # #
Aching	^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^
Stabbing	/ / / / / / / / / / / /

FOR THE FOLLOWING, PLEASE CIRCLE

Y = A condition you have now **N = Never had** **P = Significant problem in the past**

HABITS

Main exercise and hobbies ____________________

Do you exercise	Y N		
If yes, what kind ____________________		Enjoy your work	Y N
→ How often ____________________		Take vacations	Y N
Average 6-8 hrs. sleep	Y N	Spend time outside	Y N
Sleep well	Y N	Watch television	Y N
Awaken rested	Y N	→ How many hours ____________	
Have a supportive relationship	Y N	Read	Y N
Have a history of abuse	Y N	→ How many hours ____________	
Any major traumas	Y N P	Do you eat 3 meals a day	Y N
Use recreational drugs	Y N P	Do you go on diets often	Y N
Been treated for drug dependence	Y N P	Do you eat out often	Y N
Use alcoholic beverages	Y N P	Do you drink coffee	Y N P
Treated for alcoholism	Y N P	Drink black/green tea	Y N P
Use tobacco	Y N P	Do you drink soda	Y N P
Smoked previously	Y N P	Do you eat refined sugar	Y N P
→ How many years	________	Do you add salt	Y N P
→ How many packs per day	________	→ table/sea salt ______________	

Thank you for your time and effort.
Our team looks forward to providing you with the best possible care.