Optimum
Integrative Health Centre

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Redefine Your Health!

Confidential Adult Case History

Personal Information:

Name: _____ Date: _____ (mm/dd/yyyy)

Date of Birth: _____ Age: ____ Sex: _____ Marital Status: _____

# of Children: ____ Names and Ages of Children: _____

Health Card #: _____

Occupation: _____

How did you hear about us? _____

Contact Information:

Address: _____

Town/City: _____ Postal Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____ ☐ Check if you *do not* want our free newsletter.

Emergency Contact Information:

Name: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

Health Provider Information:

Family Doctor – _____

Naturopathic Doctor – _____

Chiropractor – _____

Specialist(s) – _____

Other(s) – _____

List Your Main Health Concerns in Order of Importance:

#1 _____ #4 _____

#2 _____ #5 _____

#3 _____ #6 _____

MEDICAL HISTORY:

Existing or Past Illnesses (*Check and date any that apply to you*):

- ☐ Anxiety _____ *year*
- ☐ Blood Clotting Disorder _____ *year*
- ☐ Cancer _____ *year*
- ☐ Depression _____ *year*
- ☐ Diabetes _____ *year*
- ☐ Eating Disorder _____ *year*
- ☐ Gastrointestinal Disease _____ *year*
- ☐ Heart Attack _____ *year*
- ☐ HIV/AIDS _____ *year*
- ☐ High Blood Pressure _____ *year*
- ☐ Liver Disease _____ *year*
- ☐ Seizures _____ *year*
- ☐ Sexually Transmitted Infections _____ *year*
- ☐ Stroke _____ *year*
- ☐ Suicide Attempt _____ *year*
- ☐ Thyroid Disease _____ *year*
- ☐ Other:

Vaccinations: ☐ *Check if up to date. Note any exceptions:* _____

Surgeries: _____

Significant Trauma *(car accidents, falls, etc.)*: _____

CURRENT HISTORY:

Height: _____ Weight: _____ Max Weight: _____

Do currently take any of the following more than once per week?

- ☐ Antacids
- ☐ Anti-Histamines
- ☐ Laxatives
- ☐ Pain Relievers (Aspirin, Tylenol, Ibuprofen)
- ☐ Sleep Aids
- ☐ Recreational drugs: Type and Frequency? _____
- ☐ Tobacco _____ pack(s)/day
- ☐ Alcohol _____ drink(s)/day
- ☐ Coffee _____ drink(s)/day

Exercise: Type – _____ Duration – _____ h Frequency – _____

Sleep: Average Duration – _____ h Describe Quality – _____

Energy: _____ ☐ Sudden Energy Drop? Time – _____

Mood: _____

Stress: Level – _____ Sources – _____ Outlets – _____

Sexual: ☐ Sexually Active? ☐ Actively Trying to Conceive? Contraception – _____

Allergies (Food, Drug, Environmental): _____

Foods you Avoid: _____

Supplements:
(include dose)

Medications:
(include dose)

FAMILY HISTORY: *Please check if any of these apply to your immediate family.*

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clotting Disorder
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Crohn's/Colitis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Heart Attack
- ☐ Hemochromatosis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mental Disease
- ☐ Liver Disease
- ☐ Obesity
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other:

REVIEW OF SYSTEMS: *Check and describe any body systems for which you have concern.*

- ☐ Skin/Hair: _____
- ☐ Head/Sinuses: _____
- ☐ Eyes: _____
- ☐ Ears: _____
- ☐ Nose: _____
- ☐ Throat: _____
- ☐ Cardiovascular: _____
- ☐ Respiratory: _____
- ☐ Digestive: _____
- ☐ Urinary: _____
- ☐ Neurologic: _____
- ☐ Genital/Reproductive: _____
- ☐ Bones: _____
- ☐ Muscles: _____
- ☐ Joints: _____

WOMEN'S HEALTH:

Menstruation: Age First Menses – ____ Cycle Length – ____ Date Last Menses – _____

Reproduction: Pregnancies – ____ Births – ____ Miscarriages – ____ Abortions – ____

Screening: Last PAP – _____ Last Mammogram – _____ ☐ Self-Breast Exams?

Existing or Past Issues (*Check and date any that apply to you)*:

- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lumps
- ☐ Difficulty Conceiving
- ☐ Menses – Heavy
- ☐ Menses – Light
- ☐ Menses – Short _____ days
- ☐ Menses – Long _____ days
- ☐ Nipple Discharge
- ☐ Periods are Irregular
- ☐ Vaginal Discharge
- ☐ Yeast Infections

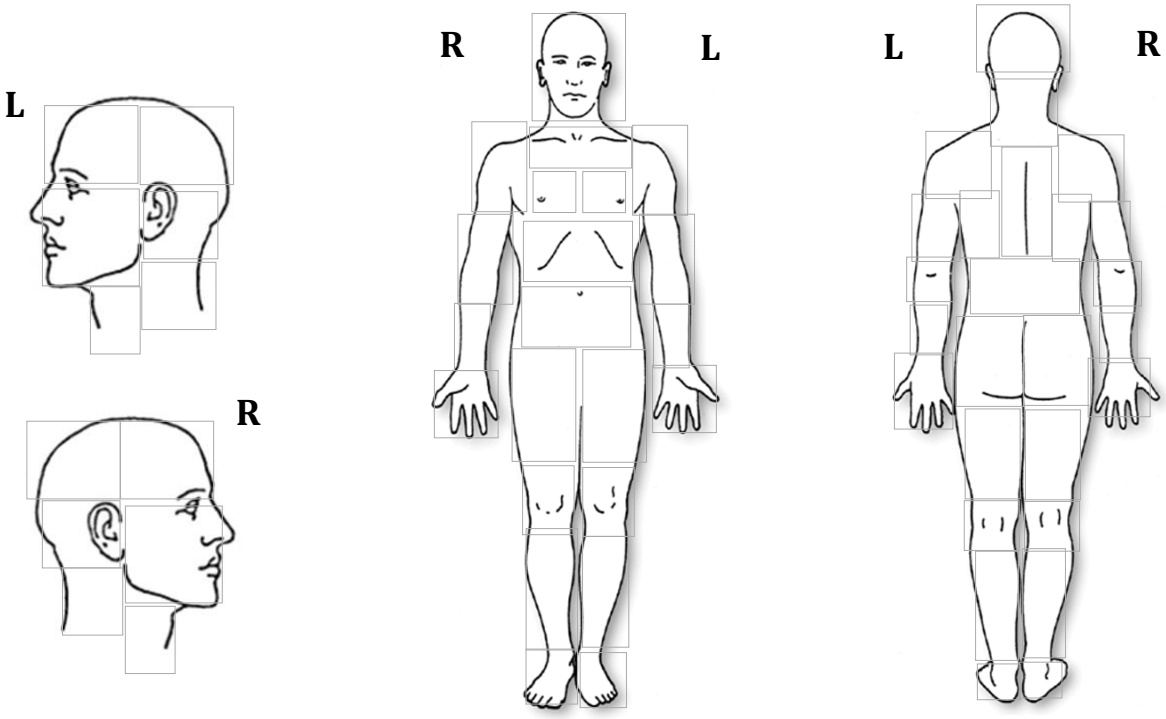
OTHER: *Please list anything else important that has not yet been covered*

Symptom Diagram:

How would you describe your pain(s) or sensation(s)? *(Choose all that apply)*:

- ☐ Burning
- ☐ Numbness
- ☐ Stabbing and Sharp
- ☐ Dull and Aching
- ☐ Pins and Needles
- ☐ Stiff and Tight

In the diagrams below, select the areas that best represent your pain *(Choose all that apply)*:



Visual Numeric Pain Scale:

Please mark the appropriate intensity that best represents your ***PAIN*** *(Scale from 1 – 10)*:

			1	2	3	4	5	6	7	8	9	10	
1.	As it is ***RIGHT NOW***	*Absence*	○	○	○	○	○	○	○	○	○	○	*Extreme*
2.	As it is ***ON AVERAGE***	*Absence*	○	○	○	○	○	○	○	○	○	○	*Extreme*
3.	At its ***WORST***	*Absence*	○	○	○	○	○	○	○	○	○	○	*Extreme*
4.	At its ***BEST***	*Absence*	○	○	○	○	○	○	○	○	○	○	*Extreme*

Form Submission - 3 Step Guide

1 **Save Form**: *save a copy to your computer for your personal records.*

Save Form

2 **Print Form**: *print and bring a copy of your completed form to your first appointment.*

Print Form

3 **Submit Form:** *if you use a desktop email client (i.e. Outlook) choose "Submit Form" below.*

Submit Form

If you use a web based email (i.e. Gmail), attach the form as a file, and send to info@ontariohealth.org