

DR.CRISTINA COLOMA, ND
2888 GARDNER COURT
ABBOTSFORD, BC V2T 5H9
Phone/Fax (604) 556-4596
E-mail: abbynaturopath@gmail.com

Name: _____ Date: _____

Address: _____

City: _____ Province/State: _____ Zip/Postal Code: _____

Telephone # (home): _____ (cell): _____

E-mail address: _____

Age: _____ Date of Birth: _____ Gender: female ___ male ___

Level of Education: _____

Married: ___ Separated: ___ Divorced: ___ Widowed: ___ Single: ___ Partnership: ___

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___

Occupation: _____ Hours per week: _____ Retired: _____

CareCard#: _____ Work phone: _____

How did you hear about our clinic? _____

Next of Kin or other to reach in an emergency: _____

Relationship: _____ Phone: _____

Address: _____

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

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

- 1) Why did you choose to come to this clinic?

- 2) What do you love to do?

- 3) What health outcome(s) do you want from this visit to our clinic??

- 4) How do you see yourself 3 months from now?

- 5) How do you see yourself 6 months from now?

- 6) How do you see yourself one year from now?

- 7) 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%

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

- 9) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

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

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

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? _____ | | | |

What is your heritage: German _____ Nordic _____ Celtic _____ Other _____

Childhood Illnesses

Please circle whether you had any of these as a child:

- | | | |
|---------------|------------|-----------------|
| Scarlet fever | Diphtheria | Rheumatic fever |
| Mumps | Measles | German measles |

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

- | | |
|-------------------|-------------------|
| _____ year: _____ | _____ year: _____ |
| _____ year: _____ | _____ year: _____ |
| _____ year: _____ | _____ year: _____ |

Allergies

Are you hypersensitive or allergic to...

- Any drugs? _____
- Any foods? _____
- Any environmental or chemicals? _____

Current Medications

Do you take or use?

- | | | | | | |
|---------------|-----|-----------------------|-----|----------------|-----|
| Laxatives | Y N | Pain relievers | Y N | Antacids | Y N |
| Cortisone | Y N | Appetite suppressants | Y N | Antibiotics | Y N |
| Tranquilizers | Y N | Thyroid medication | Y N | Sleeping pills | Y N |

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

General

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum Weight : _____ When: _____

When during the day is your energy the best? _____ worst? _____

Y=a condition you have now

N=Never had

P=Significant problem in the past

Endocrine

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Skin

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P
Color Change?	Y N P	Perpetual Hair Loss?	Y N P
Lumps?	Y N P	Night Sweats?	Y N P

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P

Eyes

Spots in Eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

Ears

Impaired hearing?	Y N P	ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stiffness?	Y N P	Hayfever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Y=a condition you have now

N=Never had

P=Significant problem in the past

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Excessive Phlegm? Color _____?	Y N P	Itching in Chest?	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	“ “ “ lying down?	Y N P
Tuberculosis?	Y N P	Tight Chest?	Y N P

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic Fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Acid Reflux / Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? _____	
Gall Bladder disease?	Y N P	Is this a change? _____	
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Bedwetting?	Y N P	Incomplete urination?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Y=a condition you have now

N=Never had

P=Significant problem in the past

Male Reproduction

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Venereal disease?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N	Chlamydia?	Y N P
Sexual orientation: _____		Gonorrhea?	Y N P
Impotence?	Y N P	Condyloma?	Y N P
Premature ejaculation?	Y N P	Herpes?	Y N P
Birth control? Type? _____		Syphilis?	Y N P

Female Reproduction / Breasts

Age of first menses? _____		Date of last annual exam/ PAP _____	
Age of last menses? (if menopausal) _____		Are cycles regular?	Y N
Length of cycle? _____ days		Bleeding between cycles?	Y N P
Duration of menses? _____ days		Pain during intercourse?	Y N P
Painful menses?	Y N P	Clotting?	Y N P
Heavy or excessive flow?	Y N P	Discharge?	Y N P
PMS?	Y N P	Birth control?	Y N P
If yes, what are your symptoms? _____ _____		What type? _____	
Endometriosis?	Y N P	Number of pregnancies: _____	
Ovarian cysts?	Y N P	Number of live births: _____	
Difficulty conceiving?	Y N P	Number of miscarriages: _____	
Cervical Dysplasia?	Y N P	Number of abortions: _____	
Sexual difficulties?	Y N P	Menopausal symptoms?	Y N P
Gonorrhea?	Y N P	Abnormal PAP?	Y N P
Herpes?	Y N P	Chlamydia?	Y N P
Are you sexually active?	Y N	Condyloma?	Y N P
Do you do breast self exams?	Y N P	Syphilis?	Y N P
Breast pain/tenderness?	Y N P	Sexual orientation: _____	
		Breast lumps?	Y N P
		Nipple discharge?	Y N P

Is there anything else you would like to add or comment on?

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