DR. CRISTINA M. COLOMA
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Abbotsford, BC V2T 5H9
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Name: ____ Date: __________________

Date of Birth: _______________________ Age: _______ Gender: o Male o Female

Mailing Address: _____________________________________ City: _______________________

Province: _____ Postal Code: _________ Phone (H): ________________ Phone (C): ___________

Email: __________________________________ Occupation: _____________________________

Care Card Number # _______________________ Level of education: ______________________

Marital Status: o Single o Partnered o Married o Divorced o Widowed

Live With: Spouse___ Partner___ Parents___ Children___ Friends___ Alone___

Number of Children (list age):

____

____

How did you hear about our clinic?____

QUESTIONNAIRE

What are your three most important current health concerns?

1. ____
2. ____
3. ____

List any medical problems currently being managed by a physician: _______________________

____

List any surgeries with dates: ____

____

List allergies to any food, drugs or other known allergies: _______________________________

____

List all supplements you are taking on a routine (daily - monthly) basis, include dose: _________

____

____

List all prescription and over-the-counter drugs you are taking on a routine (daily - monthly) basis:

____

____

PHYSICAL HEALTH

Height:_________________________ Weight :________________________

What is your activity level on a scale from 1-10? (10 being very active) _____________________

What is your average energy level on a scale of 1-10 (10 being the optimal energy level you think you should have)? ____

Have you ever been hospitalized or had surgery? Yes No

If yes, list with dates:

Have you ever been in a motor vehicle accident? ♦Yes ♦No If yes, what kind and when?

____

Have you had any imaging performed in the last year? ♦No ♦X-ray ♦MRI♦Ultrasound ♦PET/CT

Have you had blood work done in the last year? ♦Yes ♦No

Were your test results in medically normal ranges? ♦Yes ♦No

If not, which results were abnormal? ____

Bowel Movements/day _______ Any blood in the stools? ♦Yes ♦No

Do you feel you get adequate sleep? ♦Yes ♦No How many hours do you sleep/night?____

Do you wake rested? ♦Yes ♦No _________________________

Do you wake during the night? At what time? ♦Yes ♦No _________________________

Do you sleep next to any electronic devices? ♦Yes ♦No _________________________

Do you exercise? ♦Yes ♦No _________________________

Do you follow any particular diet? ♦Yes ♦No _________________________

Do you consume caffeine daily? ♦Yes ♦No _________________________

Do you use tobacco? ♦Yes ♦No _________________________

Do you consume alcohol? ♦Yes ♦No _________________________

Do you feel you've ever had a problem with overuse of drugs or alcohol? ♦Yes ♦No

Do you have a good support system? ♦Yes ♦No _________________________

Do you have a spiritual practice? ♦Yes ♦No _________________________

What are the main stresses in your life? ____

Have you experienced any particularly life-changing stressful events? ______________________
____

What do you do to de-stress?____

What are your some of your hobbies? ____

CHEMICAL HEALTH

Do you choose to get annual flu shots? ♦Yes ♦No

Have you used antibiotics in the last year? ♦Yes ♦No

How many cups of water do you drink per day? ____

How many cups of coffee/energy drinks do you drink per day? ____

How many glasses of juice/soda/sports drinks do you drink per day? ____

Do you eat wheat products (bread/pasta/crackers/baked goods)? ♦Yes ♦No

If yes, how many servings? ____

Do you eat refined sugars? ♦Yes ♦No

Do you eat artificial sweeteners (Splenda, Aspartame, Equal, diet drinks, gum)? ♦Yes ♦No

Do you smoke? ♦Yes ♦No I used to for: ___ years

Do you take probiotics? ♦Yes ♦No

Do you take vitamin D? ♦Yes ♦No

Do you take omega-3? ♦Yes ♦No

SYMPTOMS

Please circle the symptoms that you are currently experiencing, or have experienced in the past 6 months:

Wood:

♦ Back pain ♦ Gallbladder problems ♦ Muscle cramps ♦ Brittle nails ♦ Gout ♦ Neck pain ♦ Bursitis/Tendonitis ♦ Irritable/Angry ♦ Muscle weakness ♦ Headaches/Migraines ♦ Hepatitis/Liver disease ♦ Paralysis

Fire:

♦ Anxiety ♦ Heart disease ♦ Palpitations ♦ Bleed or bruise easily ♦ Heart murmur ♦ Memory loss ♦ Chest pain/pressure ♦ High blood pressure ♦ Nose bleeds ♦ Depression ♦ Hot/Cold intolerance ♦ Numbness/Tingling ♦ Environmental sensitivities ♦ Hyperthyroid ♦ Seizures/Epilepsy ♦ Fainting/Dizziness ♦ Hypothyroid ♦ Tremors ♦ Food intolerances ♦ Insomnia ♦ Varicose veins

Earth:

♦ Acid reflux ♦ Gas/Bloating ♦ Irritable when hungry ♦ Abdominal Pain ♦ Hemorrhoids ♦ Nausea/Vomiting ♦ Cold/Canker sores ♦ Hypoglycemia ♦ Tired after eating ♦ Diabetes ♦ Indigestion ♦ Ulcers ♦ Excessive thirst/hunger ♦ Insulin resistance ♦ Worrisome

Metal:

♦ Acne ♦ Eczema ♦ Rashes/Itchiness ♦ Asthma ♦ Emphysema ♦ Respiratory infections ♦ Constipation ♦ Gingivitis ♦ Shortness of breath ♦ Cough ♦ Hay fever ♦ Sinus problems ♦ Despair/Apathy ♦ Hives ♦ Skin tags ♦ Diarrhea ♦ Psoriasis ♦ Wheezing/Hoarseness

Water:

♦ Arthritis ♦ Frequent ear infections ♦ Kidney stones ♦ Chronic urinary tract infections ♦ Hair loss ♦ Low blood pressure ♦ Dentures ♦ Hearing loss ♦ Low libido ♦ Edema ♦ Incontinence ♦ PMS ♦ Excess libido ♦ Infertility ♦ Prostate issues ♦ Fearful ♦ Joint pain ♦ Ringing in ears

For Women: (Please Circle)

♦ Breast masses ♦ Lack of periods ♦ Menopause (age) _______ ♦ Hysterectomy ♦ Painful/Heavy periods ♦ Vaginal discharge ♦ Irregular periods ♦ Spotting ♦ Yeast infections ♦

Pregnancies #_________ ♦ Miscarriage #/date ____________♦ C-section #____________

Length of cycle ___ daysNumber of days of bleeding ____

Are you/Do you plan to become pregnant? ♦Yes ♦No _______________________

Are you breastfeeding? ♦Yes ♦No ________________________

Are you taking birth control? What kind? ♦Yes ♦No ________________________

Are you on hormone replacement therapy? ♦Yes ♦No ________________________

Other: ♦ Autoimmune disease ♦ Hernia ♦ Relationship problems ♦ Bleeding gums ♦ History of abuse ♦ Restless legs ♦ Employment difficulties ♦ History of antibiotic use ♦ Schizophrenia ♦ Erectile dysfunction ♦ History of vaccine reactions ♦ Serious head injury

FOOD HEALTH

Please list the foods you commonly eat for:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

How many cups of vegetables do you eat per day? _____

How many fruits do you eat per day? _____

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

____

____

If you have recent blood work (within the last 6 months), please include a copy with this form or provide a copy to us. It is not required but can be extremely helpful in understanding your full health picture.

Please write down below any relevant health history that you may have experienced that may help us assist you with your current health issue(s):

____
____
____
____
____

INFORMED CONSENT:

I, _________________________, hereby acknowledge that I have been informed of and understand the diagnostic and therapeutic procedure(s) with respect to the expected benefits, potential risk(s) or side effects, and financial costs of the treatment/health program(s) available to me. I understand any medications I am currently taking may need dosage adjustment and I agree to notify my prescribing physician that I am working with Dr. Cristina M. Coloma, ND.

I have read the above consent and have had the opportunity to ask questions and to clarify anything that was not clear to me. As a result, I hereby consent to the diagnostic, and therapeutic procedure(s) discussed with Dr. Cristina M. Coloma, ND. I intend this consent to cover the entire course of the treatment/program.

Signature (patient/parent/guardian): ____

FINANCIAL AGREEMENT

I, ___________________________, agree to full financial responsibility for services rendered and products purchased. Notice of **24 HOURS** is necessary for **cancelled appointments.** I may be charged a **$60 fee** for a missed appointment.

Unopened supplements and other items or products may be returned for a full refund or exchange within **14 days of the purchase ONLY.**

Signature (patient/parent/guardian): ____

Thank you for your support and we look forward to being part of your healthcare team!