



**PERSONAL INFORMATION**

Name \_\_\_\_\_ Date of First Visit \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone # (home) \_\_\_\_\_ (work) \_\_\_\_\_

E-mail Address \_\_\_\_\_ Relationship Status \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth (M/D/Y) \_\_\_\_\_ Gender: female \_\_\_\_ male \_\_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_ Employer \_\_\_\_\_

Has any other family member already been a patient at the clinic? \_\_\_\_\_

Next of Kin or other to reach in an emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**HEALTH OVERVIEW**

Name of current general practitioner (MD) \_\_\_\_\_

GP's contact information \_\_\_\_\_

When was your last visit to your GP? \_\_\_\_\_

What was the reason? \_\_\_\_\_

Are you seeing a medical specialist?      Y      N

If yes, for what reason? \_\_\_\_\_

Name of medical specialist \_\_\_\_\_

Do you have any known contagious diseases at this time? Y N If yes, what? \_\_\_\_\_

What is the main reason for your visit today? \_\_\_\_\_

\_\_\_\_\_

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

**Consent and Cancellation Policy**

I hereby consent to receive treatment by the practitioners of Sage Clinic. I understand that I am responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

**Email Correspondence (we will not sell, rent, or share your email address)**

- Yes  No - I would like to receive Sage Clinic's free quarterly email newsletter, which contains information about clinic events, health conditions, current health news, and inspiring health quotes.
- Yes  No - Sage Clinic may correspond with me at the above email address.

Signature: \_\_\_\_\_ Today's date: \_\_\_\_\_  
(Parent or Guardian if a minor)

**HEALTH HISTORY QUESTIONNAIRE**

**FAMILY MEDICAL HISTORY (If Known)**

Mother's side: \_\_\_\_\_

Father's side: \_\_\_\_\_

What is your ethnic heritage? \_\_\_\_\_

**HOSPITALIZATIONS, SURGERIES, IMAGING**

What hospitalizations or surgeries, X-rays, CAT scans, EEG, EKG's have you had?

\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_

\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_

**ALLERGIES / SENSITIVITIES**

Are you hypersensitive or allergic to...

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental or chemicals? \_\_\_\_\_

Please list any prescription or over the counter medications you are currently taking:

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

Please list any naturopathic remedies (herbal, vitamin/mineral, nutritional, homeopathic, etc) you are currently taking:

1) \_\_\_\_\_ 5) \_\_\_\_\_

2) \_\_\_\_\_ 6) \_\_\_\_\_

3) \_\_\_\_\_ 7) \_\_\_\_\_

4) \_\_\_\_\_ 8) \_\_\_\_\_

**GENERAL**

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs. Weight 1 year ago \_\_\_\_\_ lbs.

Max Weight \_\_\_ lbs. When \_\_\_\_\_ Min Adult Weight \_\_\_\_\_ lbs When \_\_\_\_\_

When during the day is your energy the best? \_\_\_\_\_ worst? \_\_\_\_\_

**REVIEW OF SYSTEMS**

Check (✓) any of the following conditions you currently have (C), or have had in the past (P). Please also check if you feel any of the following are a significant part of your medical history.

**C P**

**LIFESTYLE**

		Alcohol
		Marijuana
		Other recreational drugs

		History of Smoking
		- How many packs per day?
		- How many years?

		Treated for drug dependence
		Stress

		Occupational hazards
		Any major traumas

**MENTAL/ EMOTIONAL**

		Treated for emotional issues
		Mood swings
		Considered/attempted suicide

		Depression
		Anxiety or nervousness
		Difficulty concentrating

**ENDOCRINE**

		Hypothyroid
		Hypoglycemia (low blood sugar)
		Excessive thirst
		Fatigue

		Heat or cold intolerance
		Diabetes
		Excessive hunger
		Seasonal depression

**IMMUNE**

		Reaction to vaccine
		Chronic swollen glands

		Chronic or recurrent infections
		Slow wound healing

**NEUROLOGIC**

		Seizures or tremors
		Muscle weakness
		Vertigo or dizziness

		Numbness/tingling of extremities
		Difficulty sleeping
		Loss of memory

**SKIN**

		Rashes
		Acne/boils
		Color change
		Lumps

		Eczema, Hives
		Itching
		Perpetual hair loss
		Night sweats

**HEAD**

		Headaches
		Migraines

		Head injury
		Jaw/TMJ problems

**MOUTH AND THROAT**

		Frequent sore throat
		Teeth grinding
		Gum problems
		Dental cavities

		Excessive or deficient saliva
		Sore tongue/lips
		Hoarseness
		Jaw clicks

### EYES

		Spots in eyes
		Impaired vision
		Blurriness
		Color blindness

		Cataracts
		Glasses or contacts
		Eye strain/pain
		Tearing or dryness

### EARS

		Impaired hearing
		Earaches

		Ringling in the ears (tinnitus)
		Impaired balance

### NOSE AND SINUSES

		Frequent colds
		Stiffness or post-nasal drip
		Sinus problems

		Nose bleeds
		Hayfever
		Loss of smell

### NECK

		Lumps
		Goiter

		Swollen glands
		Pain or stiffness

### RESPIRATORY

		Cough
		Spitting up blood
		Asthma
		Pneumonia
		Emphysema
		Pain on breathing
		Shortness of breath at night

		Sputum
		Wheezing
		Bronchitis
		Pleurisy
		Difficulty breathing
		Shortness of breath
		Shortness of breath lying down

### CARDIOVASCULAR

		Heart disease
		High/low blood pressure
		Blood clots
		Phlebitis
		Rheumatic fever
		Swelling in ankles

		Angina
		Murmurs
		Fainting
		Palpitations/Fluttering
		Chest pain
		High Cholesterol

### GASTROINTESTINAL

		Trouble swallowing
		Reflux

		Constipation
		Diarrhea

		<b>Heartburn</b>
		<b>Vomiting blood</b>
		<b>Nausea</b>
		<b>Change in appetite</b>
		<b>Vomiting</b>
		<b>Belching or passing gas</b>
		<b>Ulcer</b>
		<b>Hemorrhoids</b>

		<b>Blood with stool</b>
		<b>Change in bowel movements</b>
		<b>Abdominal pain or cramps</b>
		<b>Gallbladder disease</b>
		<b>Black stools</b>
		<b>Colon Polyps</b>
		<b>Jaundice</b>
		<b>Liver disease</b>

**URINARY**

		<b>Pain on urination</b>
		<b>Increased Frequency</b>
		<b>Frequent infections</b>

		<b>Frequency at night</b>
		<b>Inability to hold urine (urgency)</b>
		<b>Kidney stones</b>

**MUSCULOSKELETAL**

		<b>Joint pain or stiffness</b>
		<b>Broken bones</b>
		<b>Muscle spasms or cramps</b>

		<b>Arthritis</b>
		<b>Weakness</b>
		<b>Sciatica</b>

**BLOOD/PERIPHERAL VASCULAR**

		<b>Easy bleeding or bruising</b>
		<b>Deep leg pain</b>
		<b>Varicose veins</b>

		<b>Anemia</b>
		<b>Cold hands/feet</b>
		<b>Thrombophlebitis</b>

**FEMALE REPRODUCTION/BREASTS**

Age of first menses \_\_\_\_\_ Length of cycle \_\_\_\_\_

Duration of Menses \_\_\_\_\_ Age of last menses (if menopausal) \_\_\_\_\_

Date of last annual exam/ PAP (M/D/Y) \_\_\_\_\_

		<b>Irregular cycles</b>
		<b>Bleeding between cycles</b>
		<b>Cramping with menses</b>
		<b>Premenstrual Syndrome</b>
		<b>Clotting</b>
		<b>Heavy or excessive flow</b>
		<b>Vaginal Discharge</b>
		<b>Menopausal Symptoms</b>
		<b>Breast lumps</b>
		<b>Breast pain/tenderness</b>
		<b>Nipple discharge</b>

		<b>Abnormal PAP</b>
		<b>Cervical Dysplasia</b>
		<b>Endometriosis</b>
		<b>Ovarian cysts</b>
		<b>Uterine Fibroids</b>
		<b>Sexually Active</b>
		<b>Painful Intercourse</b>
		<b>Sexual difficulties</b>
		<b>Sexually Transmitted Disease</b>
		<b>Birth Control: type _____</b>
		<b>Difficulty conceiving</b>

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_ Number of abortions \_\_\_\_\_  
 Do you do breast self exam? \_\_\_\_\_ Have you had a hysterectomy? \_\_\_\_\_

**MALE REPRODUCTION**

		<b>Hernias</b>
		<b>Testicular masses</b>
		<b>Testicular pain</b>
		<b>Prostate disease</b>
		<b>Sexually Active</b>

		<b>Sexually Transmitted Disease</b>
		<b>Discharge or sores</b>
		<b>Impotence</b>
		<b>Premature ejaculation</b>
		<b>Birth Control: Type _____</b>

**CONTEXT OF CARE**

**What expectations do you have from this visit to our clinic?**

**What long-term expectations do you have from working with our clinic?**

**What expectations do you have of me as your physician?**

**Thank you for your time in providing this information.**



**487 Davie St.  
 Vancouver, BC  
 V6B 2G2**