

The Lilac Naturopathic Clinic

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When did you last visit an optometrist? _____
 (Month) (Year)

Who is your regular optometrist? _____
 (Name) (City)

Are you under the care of any specialists? **Yes/No** _____
 (Name) (Specialty) (City)

Are you receiving other health care? Yes/No: _____

Please List your major concerns in order of importance

Complaint	Since	Possible Cause(s)

What medications/supplements are you currently taking (prescription/over-the-counter/supplements/vitamins/minerals etc)?

Medication/Supplement	Since	Adverse Effects

List all surgeries you have had:

Procedure	Year	Complications?

List any major injuries you have sustained:

Injury	Year	Long Term Effects

Which of the following conditions have you had? (Check all that apply)

- | | | | |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sunstroke |
| <input type="checkbox"/> Amnesia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Parasites | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Influenza | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rubella | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Yellow Fever |

Which of the following do you currently use? (Amount, how often, how much, how long)

Alcohol	_____	Tobacco	_____
Hormones	_____	Coffee	_____
Cortisone	_____	Laxatives	_____
Sedatives	_____	Antacids	_____
Recreational Drugs	_____		

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc) while at work, home, or traveling?

Yes/No _____

List the primary foods included in your diet for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

List the foods you exclude from your diet: _____

Why are these foods excluded? _____

List any foods that you crave (e.g.: chocolate, sweets, salty, sour, breads, rich/fatty or spicy foods): _____

Have you had a bad reaction to any foods? _____

Are you satisfied with your diet as it is now? **Yes/No**

Do you tend to be thirsty: **Yes/No**

How much **water** do you drink each day: _____

Do you prefer beverages: ____ Hot ____ Cold ____ Room Temperature

How many times do you urinate each day?: _____

Do you get up a night to urinate? **Yes/No**

How often do you have a bowel movement? _____

On average, how many hours of sleep do you get per night? _____ hrs

Women Only

Age of first period: _____

Number of pregnancies: _____

Number of Children: _____

Length of Cycle: _____

Length of Menses (period): _____

Have you had any adverse effects from a vaccination? **Yes/No**

If Yes, describe the effect(s): _____

Has your weight changed lately? **Lost / Gained / No Change**

How many pounds? _____

Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? **Yes/No**

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

4. _____ Date: _____

5. _____ Date: _____

Is there anything else I need to know about you personally, about your health condition, or about the circumstances relating to you or your condition?

**Thank you for taking the time to complete these forms and welcome to The Lilac Naturopathic Clinic
If you have any questions please feel free to ask.**