Health History Intake Form

Welcome to the Holistic Health Clinic. Please read and complete this form to the best of your ability. The following 13 page document outlines important information to help me best address your health and the required consent to be able to support you and protect your privacy. You will be required to sign the last page at the end of this form. If you have any questions do not hesitate to ask.

Thank you for completing this; your care is my priority.

Personal Information

Last name: _____ First name: _____ Age: ___

DOB: (DD/MM/YYYY) _____ /_____ /_____ How did you hear about us? _____

Address - Street _____

City: _____ Province: _____ Postal code: _____

Telephone: Home: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

E-mail address: _____ Occupation: _____

Emergency Contact: Name: _____ Relationship: _____Telephone: _____

Please list your other healthcare providers:

Family Doctor: _____ Medical Oncologist: _____

Radiation Oncologist: _____ Surgeon: _____

Other(s) (specialty): _____

Cancer Specific Information

I am dealing with cancer now ☐ I want to avoid cancer coming back ☐

If you have cancer now, what type is it (e.g. breast, colorectal, lung, lymphoma, etc): _____

Stage (if known): _____

Is this cancer a recurrence of the same cancer☐ Yes ☐ No

Have you ever had cancer before: ☐ Yes ☐ No If yes, what type was it: _____

What is your main reason for visiting the Holistic Health Centre?

_____

_____

_____

TREATMENTS	DATES	MAJOR COMPLICATIONS	SIGNIFICANT SIDE EFFECTS
☐ Biopsy		☐ Yes ☐ No	
☐ Surgery		☐ Yes ☐ No	
☐ Chemotherapy		☐ Yes ☐ No	
☐ Name of chemo (if known)		☐ Yes ☐ No	
☐ Radiation		☐ Yes ☐ No	
☐ Hormone therapy		☐ Yes ☐ No	
☐ Name of hormone therapy (if known)		☐ Yes ☐ No	
☐ Other		☐ Yes ☐ No	

Practitioner's notes:

In your opinion, what do you believe caused your cancer?

_____

_____

_____

_____

_____

MEDICAL INFORMATION

Allergies, if known (medical, environmental, foods):

_____

Do you have diabetes? If yes what type: _____ Do you use insulin: _____

Have you ever had a kidney stone? Yes ☐ No ☐ If yes, when was the last time you had this? _____

Dietary restrictions, if any (religious/ vegetarian/ vegan, celiac etc.): _____

Please list all medications and supplements/natural health products taken regularly:

NAME OF DRUG OR SUPPLEMENT	TAKEN FOR	DOSAGE	PRESCRIBED BY (OR SELF)

HOSPITALIZATIONS, SURGERIES, PROCEDURES, TRANSPLANTS AND/OR INJURIES (please include the dates, if known)

_____

_____

_____

FAMILY HISTORY Please describe your family's health, including current age or age at death, and major illness history (diabetes, heart disease, osteoporosis, cancer, allergies, mental illness, etc.)

MEMBER	LIVING YES/NO /AGE	MAJOR ILLNESS/CHRONIC CONDITIONS
Mother		
Father		
Sisters/brothers		
Children		
Maternal Grandmother		
Maternal Grandparent		
Paternal Grandparent		
Paternal Grandparent		

PLEASE CHECK ANY OF DISEASES OR SYMPTOMS THAT YOU HAVE EXPERIENCED:

☐ Alcoholism or substance abuse	☐ Allergies/Sensitivities (Medicines, skin, food)	☐ Mental Trouble/ Depression/ Anxiety, etc.
☐ Arthritis/Joint Disease	☐ Heart Attack, Heart Disease,	☐ Thyroid Disease
☐ Blood Clot/Phlebitis	☐ Urinary Difficulties (incontinence, infections, etc.)	☐ High Cholesterol
☐ Digestive (Ulcerative Colitis, Crohn's, etc.)	☐ High Blood Pressure	☐ Liver Disease
☐ Frequent Infections	☐ Lung Disease (Asthma, COPD) Pneumonia, Bronchitis	☐ Epstein Barr virus
☐ Human papilloma virus (HPV)	☐ Hepatitis B virus (HBV) and hepatitis C virus (HCV)	☐ Human immunodeficiency virus (HIV)
☐ Human herpes virus 8 (HHV-8)	☐ Human T-lymphotrophic virus-1 (HTLV-1)	☐ Merkel cell polyomavirus (MCV)
☐ Helicobacter pylori	☐ Parasites	☐ C. Difficile
☐ Mononucleosis (mono)	☐ E. Coli	☐ Meningitis
☐ Candida (yeast)	☐ Streptococcus	☐ Salmonella
☐ Shingles (herpes zooster)	☐ Ringworm	☐ Sexually transmitted diseases

YOUR STRESS LEVELS

Circle the level of stress you are presently experiencing in your life (10=highest): 1 2 3 4 5 6 7 8 9 10

Please list the major causes of stress for you (work, finances, relationship, health, etc.)

_____

_____

Have you experienced any major trauma, loss, or life changing significant events?

_____

Have you worked with a counsellor, psychologist, or psychiatrist? ☐ No ☐ Currently ☐ In the past

Do you feel you have an adequate support system? ☐ Yes ☐ No

Please explain: _____

Do you meditate? ☐ Yes ☐ No Do you practice Yoga/Pilates? ☐ Yes ☐ No Do you visualize? ☐ Yes ☐ No

YOUR DENTAL HEALTH

Do you have any amalgam or silver fillings? ☐ Yes ☐ No If yes, how many? _____

Have you had any removed? ☐Y ☐ N If yes, when? _____ Any side effects? _____

Any root canals? ☐ Yes ☐ No

YOUR ENVIRONMENT

Do you use any of the following?

☐ Microwave	☐ Aluminum Cookware	☐ Plastic Storage Containers
☐ Canned foods	☐ Plastic for Reheating Food	☐ Antiperspirants/ Perfume/Cologne/Hair products/nail polish/body lotion
☐ Make up	☐ Hair Dye	☐ Scented soaps/fabric softeners
☐ Plastic water bottles	☐ Air fresheners/candles	☐ Art supplies/epoxy glues/acrylic paints

Where have you lived? _____ How long? _____

How old is your home? _____ How is your home heated? _____ Remodeling /

construction / new carpets / paint? If yes, when? _____

Are there hydro lines or transformers near your home or work? _____ Are there any pets

in your home? ☐ Yes ☐ No Type: _____ Is there any smoking in your home?

☐Yes ☐ No Are there any other toxins you have been exposed to? _____

How would you describe the emotional climate of your home? _____

YOUR HABITS

Do you smoke? ☐ Yes ☐ No How long ago did you start? _____ Number of cigarettes per day: _____

Did you smoke in the past? ☐ Yes ☐ No For how long? _____ Number of cigarettes per day: _____

Do you drink alcohol? ☐ Yes ☐ No What type? _____How frequently?_____

Do you take recreational drugs? ☐ Yes ☐ No What type? _____How frequently? _____

Do you drink coffee? ☐ Yes ☐ No How many cups per day? ___ Do you think teas? ☐ Yes ☐ No
How many cups per day? _____

How often do you exercise? ☐ 5-7 days/week ☐ 3-4 days/week ☐ 1-2 days/week

What do you do for exercise/movement?

_____

HOW DO YOU SLEEP

How many hours of sleep do you receive in an average night? _____What time do you go to bed? _____

Do you have trouble falling asleep? ☐ Yes ☐ No If yes, how often? _____

Trouble staying asleep? ☐ Yes ☐ No If yes, how often? _____

What time do you wake in the morning? _____ Do you wake feeling rested? ☐ Yes ☐ No

If no, how often? _____

HOW/WHAT TO YOU FEED YOUR BODY

Do you consume:

☐ Canned foods ☐ Soda and sweetened beverages ☐ Aspartame (e.g. diet pop, gum)
☐ Deli meats ☐ Margarine ☐ Juice ☐ Frozen/Packaged meals ☐ Breads (whole wheat, white, bagels, wraps)
☐ Pasta noodles ☐ Convenience foods (Kraft dinner, fruit roll-ups, Pop tarts, prepared rice, packaged oatmeal)
☐ Breakfast cereals ☐ Snack cakes and cupcakes ☐ Microwave popcorn ☐ Chips and Cheetos
☐ Packaged muffins and breakfast bars ☐ Crackers ☐ Store-bought cookies ☐ Canned soups and instant noodle cups

Do you eat out in restaurants and fast food restaurants? ☐ Yes ☐ No How often? _____

Do you crave: ☐ Sugar ☐ Chocolate ☐ Salt ☐ Protein ☐ Fats What is your favourite food that you crave? _____

Are you an emotional eater? ☐ Yes ☐ No Do you overeat when you're sad, happy, stressed, entertaining, going out? ☐ Yes ☐ No

Please explain?

_____

_____

Do you eat more when under stress or feeling depressed? ☐ Yes ☐ No

Please provide examples of things you typically consume at the following meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you juice? ☐ Yes ☐ No How many glasses of water do you drink on an average day? _____

Do you drink purified water/filtered water? ☐ Yes ☐ No

Do you eat meals: ☐ With family ☐ Home alone ☐ On the run ☐ In front of the TV?

What are your greatest nutrition concerns?

_____

How many meals do you generally eat per day? _____ Do you skip meal? _____--_____

How many servings of fruit do you consume per day? _____

How many servings of vegetables do you consume per day? _____

Are you currently on a special diet? _____ What foods do you avoid? _____

Are you vegetarian or gluten-free? _____

Do you have a healthy appetite? ☐ Yes ☐ No

Do you experience sudden drops in energy? ☐ Yes ☐ No If yes, when? _____

What was your weight one year ago? _____

What is the most you have ever weighed? _____ When?_____

How often do you have a bowel movement? _____

WOMEN'S HEALTH

Age at First Menses _____Duration of Menses _____

Unusual Characters (clotting, heavy bleeding, spotting)

_____

Perimenopausal ☐ Yes ☐ No Breast lumps/soreness ☐ Yes ☐ No Menopausal ☐ Yes ☐ No

Number of pregnancies _____ Number of births _____ Number of miscarriages ____ Number of abortions _____
Difficult births ☐ Yes ☐ No Fertility problems ☐ Yes ☐ No Vaginal discharge or sores ☐ Yes ☐ No

Did you have any abnormal findings in your last tests or anytime in the past? ☐ Yes ☐ No Please give details:

_____

MEN'S HEALTH
What date was your last prostate exam? _____ PSA Test?_____ Colonoscopy? _____

Do you have: Prostate problems ☐ Yes ☐ No _____ Testicular cancer ☐ Yes ☐ No _____
Vasectomy☐ Yes ☐ No _____ Sexual dysfunction or impotence☐ Yes ☐ No _____

YOUR DIGESTIVE SYSTEM

Please check if symptoms apply. **Leave blank if system or activity does not apply.**

Underactive Stomach	Overactive Stomach
☐ Excessive gas, belching or burping after meals	☐ Stomach pain 1 hour after eating or at night
☐ Stomach bloated after eating	☐ Burning sensation in stomach
☐ Sleepy after eating	☐ Pain aggravated by worry/tension
☐ Longitudinal striations on fingernails	☐ Hiatal hernia
☐ Eat when rushed/in a hurry	☐ Gastritis, gastric ulcer
☐ Bad breath	☐ Nausea, vomiting
☐ Full feeling after heavy meat meal	☐ Sensation of acidity in abdominal area
☐ Heavy, tired feeling after eating	☐ Heartburn, indigestion
☐ Nausea after taking supplements	☐ Blood in stool
☐ Acne	☐ Lower back pain
☐ Undigested food in stool	☐ Long term aspirin use

Liver	Pancreas
☐ Yellow or pale fingernails	☐ Severe abdominal pain
☐ Skin oily on nose and forehead	☐ Nausea and vomiting
☐ Fats/greasy foods cause nausea, headaches	☐ Slow digestion; feel full for hours after eating
☐ Vertical white streaks on fingernails	☐ Fever
☐ Bad breath; bad taste in mouth	☐ Alcohol addiction
☐ Excess body odor	☐ Jaundice
☐ Onions, cabbage, radishes, cucumbers cause bloating or gas	**Hypoglycemia**
☐ Stiff, aching muscles	☐ Hungry up to 3 hours after eating
☐ Migraine headaches	☐ Strong, sudden cravings for sweets, starches, coffee or alcohol
☐ Discomfort underneath right ribcage	☐ Nervous/anxious feeling relieved by eating
☐ Food allergies	☐ Irritable if late for or skip a meal
☐ Irritable, easily angered	☐ Overweight
☐ Weight gain around abdomen	☐ Addicted to coffee with sugar and/or colas
☐ Yellow Palms	☐ Frequent “midnight snacks”
☐ Jaundice	☐ Family history of diabetes
☐ Poor concentration	☐ Fatigue
☐ Difficulty losing weight	☐ Frequent headaches
☐ Acne, boils, rashes, psoriasis or eczema	☐ Fainting spells
☐ Constipation	☐ Depression
☐ High cholesterol/high cholesterol diet (sugar)	☐ Lose temper easily

Gallbladder
☐ Gall stones; history of gall stones
☐ Stool appears clay-coloured, foul odour
☐ Constipation
☐ High cholesterol diet; high blood cholesterol levels
☐ Severe pain in right upper abdomen/gallbladder attack

The Lymphatic/Immune System:

Thymus (Immunity)	Allergies (Cont.)
☐ Excessive Sleep	☐ Muscle cramps or spasms
☐ Very susceptible to infections	☐ Abnormal body odor
☐ Swollen glands; tonsils, throat, armpits	☐ Excessive sweating, night sweats
☐ History of cancer, MS, Parkinson's arthritis	☐ Bowel disease: IBS, IBD, Crohn's, Colitis etc.
☐ Loss of appetite	☐ Joint pains or stiffness
☐ Headaches	☐ Frequent night urination
☐ Soreness on both sides of neck at shoulder	☐ Wheezing
☐ Feel puffiness in throat	☐ Pale face
☐ Look older than chronological age	☐ Hives
☐ Flu-like symptoms often occur	☐ Nose runs constantly
☐ Lupus	☐ Nosebleeds
	☐ Noticeable changes in writing throughout day
Allergies	☐ Bloating or gas after eating certain foods
☐ Frequent cravings for certain foods	☐ Canker sores
☐ Periods of blurred vision	☐ Dark circles under eyes
☐ Repeated ear problems	☐ Stuffy nose
☐ Hyperactivity	☐ Acne, psoriasis, dermatitis, eczema
☐ Dizzy spells	☐ Rapid pulse, heart irregularities
☐ Periods of confusion	☐ Frequent headaches
☐ Poor concentration	☐ Hay fever
☐ Epilepsy	

The Glandular/Endocrine System:

Underactive Thyroid/Hypothyroid	Overactive Thyroid /Parathyroid
☐ Lethargic, tiredness or sluggishness	☐ Losing weight without trying
☐ Cold hands or feet	☐ Heart races while at rest
☐ Mercury amalgams (fillings)	☐ Feel warm/flushed at room temperature
☐ Gain weight easily, fail to lose on diets	☐ Hands shake or tremble
☐ Constipation, less than one bowel movement/day	☐ Protruding tongue
☐ Low energy in the morning	☐ Heart palpitations
☐ Low pulse rate	☐ Nervous behaviour, hyperactivity
☐ Low body temperature, especially at bed rest	☐ Insomnia
☐ Hair dry, brittle, dull, lifeless, losing hair	☐ Increased appetite
☐ Flaky, dry, rough skin	☐ Frequent bowel movements, diarrhea
☐ Feel stiff after sitting still for some time	☐ Excessive sweating without exercising
☐ Mood swings	
☐ Square and wide fingernails/vertical ridges	
☐ High cholesterol	
☐ Diminished sex drive	

Pituitary	Adrenals
	☐ Stress or emotional upsets cause exhaustion
☐ Infertility or impotence	☐ Blood pressure decreases when going from lying position to standing position
☐ Headaches	☐ Perspire excessively
☐ Female: Loss of menstrual function	☐ Neck and/or shoulder tension
☐ Moody	☐ Frequent headaches
☐ Overweight from waist down	☐ Beau's lines (depressed furrows) on fingernails
☐ Overweight from waist up	☐ Occasional cold sweats
☐ Excessive urination	☐ Tightness or lump in throat, especially when emotionally disturbed
☐ Pain in little finger of left hand	☐ High or low blood pressure
☐ Swelling in ankles, fingers and feet	☐ Rapid pulse
☐ Cold hands or feet	☐ Short temper
☐ Pain in left side of upper neck	☐ Puffy face

When the world says give up.
Hope whispers...
Try it, one more time.

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CONSENT FOR CARE FORM

The Holistic Health Centre offers a range of nutritional strategies for managing cancer and cancer-related symptoms, improving quality of life, primary and secondary cancer prevention, augmenting the immune system, stimulating healing in the body and treating the underlying cause of disease. The Holistic Health Centre assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects related to health. We work to identify risk factors in order to make recommendations to prevent disease and help you optimize your physical, mental and emotional environment.

Because some therapies must be used with caution with certain conditions (such as pregnancy and breast feeding, liver disease, heart disease, kidney disease, autoimmune disease) it is very important that you inform us of any other disease(s) you are suffering from, as well as any medications, drugs, supplements and natural health products you are taking. It is also important to inform us of any allergies you may have.

We offers individualized, whole-person care and support in the support and prevention of cancer and cancer recurrence. We welcome patients seeking primary prevention; at initial diagnosis; during active conventional treatment including chemotherapy, radiation and surgery; prevention of recurrence; and in advanced cases. Please visit our website at www.holisticlifestyle.ca to learn more.

Please read and follow these policies and guidelines carefully in order to respect all patients, and practitioners within the Holistic Health Centre.

☐ A cancellation fee of **50% of the visit cost** is applied to all cancellations taking place within **24 hours** of the scheduled appointment. If you are not feeling too well, a home visit, scheduled telephone call, or a Skype appointment can also be arranged. How cool is that?

☐ Medical records of your nutritional and supplemental protocols provided will be kept confidential and not released unless so directed by you or as required by law. You may access your records at any time, and copies can be provided upon request.

☐ At this time, OHIP does not cover complementary and alternative medicine. Your consultation MAY be eligible for reimbursement by private insurance plans, however The Holistic Health Centre cannot accommodate third party billing. Service fees apply to all patients upon the date of their visit. Those experiencing financial difficulty that may prevent or inhibit their treatment options are encouraged to ask about subsidization.

☐ With your permission and with a signed consent form, the Holistic Health Centre can communicate on your behalf with other Healing Art Practitioners to inform and collaborate regarding your care. You are ultimately responsible for directing and choosing your integrative care plan.

Email Communications:

☐ The Holistic Health Centre will use reasonable means to protect the security and confidentiality of email information sent and received; The Holistic Health Centre cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct.

☐ The Holistic Health Centre will endeavor to read and respond promptly to your emails, within 24 hours. Accordingly, you should not use email for medical emergencies or other time-sensitive matters.

I acknowledge that I understand and agree to abide by the above policies and guidelines during the course of my treatment and support at The Holistic Health Centre.

Name (please print): _____

Patient Signature**:** _____ Date: _____

One thing is for sure…

→I will NOT show you a better way nor will I give you the answer.

→What I will do is guide you to YOUR BETTER WAY and I will nudge you to FIND your OWN ANSWER!

→**I HELP CANCER CONQUERORS**: I don't coach victims or people who believe that things happen to them. I am very selective with who I HELP. If you believe you are in charge of your life and in charge of the changes in your life, I CAN HELP YOU.

→You believe you can be a CANCER CONQUEROR through mind, body, spirit, nutrition and emotions.

→**I DO NOT USE TEMPLATES OR TECHNIQUES**: I work with you and I am devoted to what you need, not what I have read in a book or in my classes. My style of helping is not for everyone. But anyone that is ready to be helped will make big changes in their health and personal life.

→**YOU WILL BE VULNERABLE AND REALLY SCARED**: And I will also be vulnerable. I cannot HELP if you are not in the room; either physically, mentally, or emotionally. I cannot help you if you don't believe that food is your medicine, that supplementation and a well-designed health protocol will help you fight your cancer and get you better. I expect you to be transparent, REAL, and authentic. Your friends and your love ones will not always support your alternative cancer treatment. "Dr. Google" and your oncologist will challenge and scare you in thinking that you will die if you deviate from their plan and that your supplementation will interfere with your chemotherapy and radiation. If I see that you are not communicating your fears and googling about how alternatives cancer treatment have no scientific merit or can instantly give you nasty side effects and kill you on the spot, then you don't need my help.

→**MY NUMBER ONE PRIORITY IS YOU AND MAKING YOU BETTER**. I will share my ideas, my experience, my knowledge and will designed an individualized therapeutic protocol just for you. You will be challenged about your ideas about yourself, your health, your body and your mind. You will also know that I will be just as real and authentic as you will be with me. This is my promise.

CHEAP SUPPLEMENTATION, SYNTHETIC VITAMINS with no BIOAVAILABILITY WILL NOT HELP YOU. My supplements, antioxidants and vitamins are of the highest quality and of great value. I will not feed you synthetic products, just the real stuff. I work with the best companies that provide nanosphere and liposome technology. I might be too expensive for you, but the money you will invest with me will pay you back more than the session and the supplementation protocol.

My name is Joanne Groulx and I am your Cancer Health Coach.