Thornhill Naturopathic HEALTH CLINIC

12A Centre Street
Thornhill, Ontario
L4J 1E9
www.thornhilllnaturopathic.ca

Telephone: 647-799-1078
Toll-free: 1-855-DrBetty (372-3889)
Fax: 647-799-1076

HEALTH ASSESSMENT QUESTIONNAIRE - SENIORS

This is a confidential health assessment questionnaire which is designed to provide insight into your health, family history and lifestyle. The following questions will assist me in providing you with the best possible care and in understanding the factors that may be playing a role in your health.

The questionnaire is **not** designed to give a medical diagnosis. It will identify current strengths of your health, and any risk factors that might be present.

This questionnaire will take about 30 minutes to complete. It is broken down into seven categories:

A. General Information
B. Family Medical History
C. Medications / Supplements
D. Nutrition
E. Exercise
F. Health Concerns
G. Review of Physical Symptoms

A. GENERAL INFORMATION

Please circle the response that is correct or fill in the blanks.

Current Date: _____

Name: _____

Date of Birth: _____

Occupation: _____

Number in household _____ Relationship to you _____

Current Health Concerns: _____

_____

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B. FAMILY MEDICAL HISTORY

Please indicate if any of your immediate family relatives has ever encountered the following health concerns:

Health Concern	Family Relative
Alzheimer's disease	
Arthritis	
Cancer *(indicate type)*	
Diabetes	
Glaucoma	
Heart disease	
Hypertension	
Osteoporosis	
Stroke	
Other	

C. MEDICATIONS / SUPPLEMENTS

Please circle any of the following medications that you are taking?

antacids diuretics (water pills) tranquillizers sleeping pills
Aspirin / Tylenol laxatives pain relievers

Any known allergies or drug sensitivities? _____

_____

Medications (if more space is needed please attach a separate sheet)

Listing of medications	Dosage	Reason for taking	Duration of use

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Vitamins, Supplements, Herbal or Homeopathic Remedies

Listing of Supplements	Dosage	Reason for taking	Duration of use

D. NUTRITION

What would you like to change about your diet? _____

_____

On average how many meals do you eat a day? ○1 ○2 ○3 ○4 ○5 ○+5

What is usually your largest meal?: ○ breakfast ○ lunch ○ dinner

Do you crave any specific foods?: ○ Yes ○ No

If yes, what food: _____

_____

Please list what you would typically have for:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

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Do you monitor your intake of FAT? ○ YES ○ NO

Do you add SALT to most meals? ○ YES ○ NO

Do you monitor your intake of FIBRE? ○ YES ○ NO

E. EXERCISE

Do you belong to a gym? ○ YES ○ NO

If yes, how often do you go? _____

What type of exercise(s) do you participate in and how frequently do you exercise?

_____

_____

F. HEALTH CONCERNS

Please list the injuries, hospitalizations, accidents, or medical concerns that you have had:

Event	When?	Treatments?

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G. REVIEW OF PHYSICAL SYMPTOMS

On a scale of 1 (low) to 10 (high) rate your energy level? _____

How is your sleep? _____

_____

How would you describe your breathing? _____

_____

What is your normal body temperature? _____

VASCULAR SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Hot hands / feet	☐		
Cold hands / feet	☐		
Deep leg pain	☐		
High blood pressure	☐		
Low blood pressure	☐		
Chest pain	☐		
Extremity swelling	☐		
Extremity numbness	☐		
Extremity ulcers	☐		
Angina	☐		
Other circulatory / heart concerns?	☐		

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SKIN	*Concern check if Yes*	*Number of years*	*Comments*
Rashes	☐		
Lumps / cysts	☐		
Dry / cracked skin	☐		
Jaundice (yellowing of skin)	☐ ☐		
Skin cancer	☐		
Other skin concerns	☐		

HEAD AND MOUTH	*Concern check if Yes*	*Number of years*	*Comments*
Frequent sore throats	☐		
Gum problems	☐		
Hoarseness	☐		
Swollen glands	☐		
Nose bleeds	☐		
Loss of smell	☐		
Dizziness / Vertigo	☐		
Headaches	☐		
Memory problems	☐		
Other problems	☐		

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EYES AND EARS	*Concern check if Yes*	*Number of years*	*Comments*
Eye-sight	☐		
Blurred vision	☐		
Dry eyes	☐		
Eye pain	☐		
Glaucoma	☐		
Cataracts	☐		
Diminished hearing	☐		
Ear aches/infections	☐		
Ringing in the ears	☐		

NERVOUS SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Fainting	☐		
Paralysis	☐		
Tingling	☐		
Numbness	☐		
Involuntary movement	☐		
Loss of balance	☐		
Speech problems	☐		
Other nervous system concerns	☐		

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DIGESTIVE SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Food intolerances / allergies	☐		
Trouble swallowing	☐		
Nausea	☐		
Vomiting	☐		
Gas or belching	☐		
Abdominal Bloating	☐		
Heartburn / Reflux	☐		
Constipation	☐		
Diarrhea	☐		
Liver Disease	☐		

RESPIRATORY SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Cough	☐		
Spitting up blood	☐		
Wheezing	☐		
Shortness of Breath	☐		
Bronchitis	☐		
Pneumonia	☐		
Tuberculosis	☐		
Smoking	☐		
Other concerns	☐		

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URINARY SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Urinary pain, burning	☐		
Difficult urination	☐		
Increased frequency	☐		
Inability to hold urine	☐		
Frequent infections	☐		
Blood in urine	☐		
Kidney Stones	☐		

MUSCLE / BONES	*Concern check if Yes*	*Number of years*	*Comments*
Bones break easily	☐		
Painful joints	☐		
Swollen joints	☐		
Muscle weakness	☐		
Prolonged stiffness	☐		
Low back pain	☐		
Weak, sore knees	☐		
Osteoporosis	☐		
Arthritis	☐		

FEMALE REPRODUCTIVE SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Pain during intercourse	☐		
Hot flashes	☐		
Night Sweats	☐		
Frequent fungal / yeast infections	☐		
Other concerns	☐		
MALE REPRODUCTIVE SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*

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Hernias	☐		
Testicular masses	☐		
Testicular pain	☐		
Sexual difficulties	☐		
Prostatitis / BPH	☐		

What are your health goals? _____

_____

_____

_____

_____

_____

_____

Please list any other relevant health / personal information that you feel is missing.

_____

_____

_____

_____

_____

_____

Thank you.