



**QUESTIONNAIRE**  
**OKOTOKS NATURAL HEALTH CENTRE**  
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**“TAKING THE TIME TO LISTEN & WORKING TOGETHER MAKES A DIFFERENCE!”**

**PLEASE MAKE SURE YOU HAVE ALL 15 PAGES OF THIS FORM**

**OUR MISSION**

**TO HELP WITH PREVENTION IN THE GROWING NUMBER OF CHILDHOOD ILLNESSES WITH USING THE HOLISTIC HEALTH APPROACH. THIS INCLUDES A VARIETY OF INTERVENTIONS, CUSTOMIZED ON AN INDIVIDUAL BASIS, WHICH HAVE BEEN SHOWN TO PRODUCE DRAMATIC RESULTS IN SOME PATIENTS, THE FOCUS BEING ON THE WHOLE PERSON TO RESTORE OPTIMAL HEALTH.**

**Holistic Health** is defined as a system of health care which emphasizes on personal responsibility, and care, a cooperative relationship among all those involved, leading toward optimal harmony of body, mind, emotions and spirit.

The following questionnaire, although somewhat long and detailed, is an invaluable source of information about you as a unique person. It will allow us to know the Total You, not just you as a collection of symptoms of an illness.

**PLEASE NOTE:** This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization.

Would you be willing to sign a release to obtain medical records from your previous doctor(s) and hospital(s), if this information would be helpful for your treatment?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, then sign below.

**AUTHORIZATION FOR MEDICAL INFORMATION**

This will authorize (Dr.) \_\_\_\_\_ of

(Clinic) \_\_\_\_\_

to provide Dr. KURT HARTMANN ND, or his/her representative, with any and all information in regards to any form of treatment applied to me, including blood tests, X - rays, findings and diagnoses. A copy of this authorization is valid as well as an original.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

REFERRAL THROUGH: \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_

DATE OF LAST CHEST X - RAY: \_\_\_\_\_

DATE OF LAST EKG: \_\_\_\_\_

DATE OF LAST LAB WORK (BLOOD, URINE): \_\_\_\_\_

LIST ANY ABNORMAL RESULTS : \_\_\_\_\_

**List diagnoses and explanations (including dates) given for your child's condition:  
ANY SYMPTOMS YOUR CHILD PRESENTLY HAS:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**NO SYMPTOMS: DESIRE ROUTINE CHECK - UP FOR PREVENTATIVE HEALTH.**

**LIST OF PHYSICIANS YOUR CHILD IS PRESENTLY SEEING:**

NAME	SPECIALTY	LOCATION

**MEDICINES/DRUGS: List all chemical substances your child is taking, even if they are nonprescription (over the counter).**

NAME	DOSE	REGULARITY/HOW LONG TAKING IT

**SUPPLEMENTS: Any vitamins, minerals or similar health products:**

NAME	DOSE	REGULARITY/HOW

		<b>LONG TAKING IT</b>

**FAMILY MEDICAL HISTORY**

	<u>If living.</u>	<u>Health</u>	<u>If passed away.</u>	<u>Cause</u>
	<u>Age</u>		<u>Age at death</u>	
<b>Father</b>	_____			
<b>Mother</b>	_____			
<b>Brother or Sister</b>	_____			
	1.	_____		
	2.	_____		
	3.	_____		
	4.	_____		
<b>Husband or Wife</b>	_____			
<b>Children</b>	_____			
	1.	_____		
	2.	_____		
	3.	_____		

<b>Has any blood relative ever had</b>	<b>( please circle )</b>		<b><u>Who?</u></b>
<b>Cancer</b>	No	Yes	_____
<b>Tuberculosis</b>	No	Yes	_____
<b>Diabetes</b>	No	Yes	_____
<b>Heart trouble</b>	No	Yes	_____
<b>High blood pressure</b>	No	Yes	_____
<b>Stroke</b>	No	Yes	_____
<b>Epilepsy</b>	No	Yes	_____
<b>Mental illness</b>	No	Yes	_____
<b>Suicide</b>	No	Yes	_____

<b>PRENATAL HISTORY</b>	
<b>MATERNAL AGE AT DELIVERY:</b>	<b>#OF PREGNANCIES / BIRTHS PRIOR _____ AFTER THIS CHILD</b>
<b>ILLNESSES DURING PREGNANCY:</b>	
<b>MEDICATION DURING PREGNANCY:</b>	
<b>HEAVY METAL EXPOSURE DURING PREGNANCY (INCREASED TUNA/SWORDSFISH/SEA BASS CONSUMPTION; DENTAL WORK: ROOT CANAL, AMALGAMS; FLUVAX; RHOGAN INJECTION)</b>	
<b>OTHER COMPLICATIONS DURING PREGNANCY:</b>	
<b>COMPLICATIONS DURING LABOR AND DELIVERY:</b>	
<b>MODE OF DELIVERY: C-SECTION/VAGINAL? IF C-SECTION, EXPLAIN WHY?</b>	
<b>IF VAGINAL DELIVERY, DID YOU HAVE FORCEPS/VACUUM?</b>	
<b>MEDICATION(S) DURING LABOUR AND DELIVERY?</b>	
<b>FULL TERM/PREATURE?</b>	<b>HOW MANY WEEKS?</b>
<b>COMPLICATION AFTER DELIVERY?</b>	
<b>MEDICATIONS GIVEN TO CHILD DURING HOSPITAL STAY? (INCLUDING IMUNIZATIONS)</b>	

<b>DIETARY / NUTRITIONAL HISTORY</b>		
<b>BREAST-FED?</b>	<b>IF YES, HOW LONG?</b>	<b>MONTHS</b>
<b>BOTTLE-FED?</b>	<b>IF YES, BRAND OF FORMULA?</b>	
<b>BOTTLE FED BEGINNING AT WHAT AGE?</b>	<b>HOW LONG?</b>	
<b>FOODS? BEGUN AT WHAT AGE?</b>	<b>FIRST FOODS?</b>	
<b>What age was your child introduced to whole milk?</b>		
<b>What does your child take now:</b>		
<b>IS YOUR CHILD ALLERGIC TO ANY TYPE OF: FOOD-MEDICINES-ANYTHING CARRIED IN THE AIR - OR OTHER? (PLEASE LIST)</b>		
<b>ANY FOOD CRAVINGS?</b>		
<b>OTHER COMMENTS:</b>		

<b>IMMUNIZATIONS FOR YOUR CHILD: PLEASE LIST DATES AND ANY COMPLICATIONS:</b>		
<b>NAME</b>	<b>DATE(S)</b>	<b>COMPLICATIONS IF ANY</b>
<b>DTP/DTaP</b>		
<b>HIB (HEMOPHILUS)</b>		
<b>HEPATITIS B</b>		
<b>OPV/IPV (POLIO)</b>		
<b>VARIVAX (CHICKEN POX)</b>		
<b>MMR (MEASLES)</b>		
<b>ROTAVIRUS VACCINE</b>		
<b>PREVNAR:</b>		
<b>OTHER:</b>		
<b>OTHER:</b>		
<b>OTHER:</b>		
<b>OTHER:</b>		
<b>OTHER:</b>		
<b>ANY OTHER COMMENTS:</b>		

**HOSPITALIZATIONS:**

	<u>List all surgeries/operations</u>	<u>Year</u>	<u>Reason for it</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

**ANY OTHER HOSPITALIZATIONS:**

	<u>Reason</u>	<u>Year</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

<b>Has your child ever been advised to have any operations which have not been done?</b>
No: _____
Yes: _____
Other comments: _____

<b>YOUR CHILD'S SLEEPING HABITS:</b>
How are your child's sleeping habits? Good ____ Bad ____
If bad: Is your child waking at night? ____ or
Having trouble falling asleep? ____ Both ____
Other comments: _____

<b>CHILD ILLNESSES – PLEASE LIST APPROPRIATE DATES AND ANY COMPLICATIONS:</b>		
<b>ILLNESS</b>	<b>DATE(S)</b>	<b>COMPLICATIONS</b>
<b>EAR INFECTIONS</b>		
<b>SINUS INFECTIONS</b>		
<b>BRONCHITIS</b>		
<b>PNEUMONIA</b>		
<b>THRUSH</b>		
<b>CHICKEN POX</b>		
<b>SEIZURES</b>		
<b>MONO</b>		
<b>OTHER:</b>		
<b>OTHER:</b>		

<b>Has your child ever had?</b>			
<b>Please check yes or no.</b>	<b>YES</b>	<b>NO</b>	<b>OTHER COMMENTS</b>
Measles			
German measles			
Mumps			
Chicken pox			
Whooping cough			
Scarlet fever or Scarlentina			
Diphtheria			
Small pox			
Pneumonia			
Influenza			
Pleurisy			
Rheumatic Fever			
Any bone or joint disease			
Neuritis or neuralgia			
Bursitis			
Sciatica			
Lumbago			
Polio or Meningitis			
Nephritis			
Gallbladder disease			
Anemia			
Jaundice			
Bladder disease			
Epilepsy			
Migraine headaches			
Tuberculosis			
Diabetes			
Cancer			
High or low blood pressure			
Colitis or other bowel diseases			
Hemorrhoids or any rectal dis.			
Food, chemical or drug poisoning			
Hay fever or asthma			
Hives or Eczema			
Frequent infections or boils			

<b>Has your child ever had? Continued.</b>			
<b>Please check yes or no.</b>	<b>YES</b>	<b>NO</b>	<b>OTHER COMMENTS</b>
<b>INJURIES: has your child had any?</b>			
<b>Broken or cracked bones</b>			
<b>Sprains</b>			
<b>Lacerations</b>			
<b>Dislocations</b>			
<b>Concussion, or head injuries</b>			
<b>Ever been knocked unconscious</b>			
<b>Frequent or severe headaches</b>			
<b>Fainting spells</b>			
<b>Dizziness on movement</b>			
<b>Unconscious spells</b>			
<b>Blurred vision</b>			
<b>Double vision</b>			
<b>Spots in front of the eyes</b>			
<b>Infected eyes</b>			
<b>Pain behind eyes</b>			
<b>Any change in vision</b>			
<b>Do you wear glasses? When was your last check up?</b>			
<b>Earaches</b>			
<b>Discharge from ears</b>			
<b>Ringling in ears</b>			
<b>Diminishing of hearing</b>			
<b>Recurrent nose bleed</b>			
<b>Recurrent head colds</b>			
<b>Sinus trouble</b>			
<b>Hay fever</b>			
<b>Strange persistent odors</b>			
<b>Persistent hoarseness</b>			
<b>Difficulty on swallowing</b>			
<b>Enlarged glands</b>			
<b>Recurrent sore throats</b>			
<b>Recurrent mouth sores</b>			
<b>Soreness or bleeding of gums during brushing.</b>			

<b>Has your child ever had in the last year? Please check yes or no.</b>			
<b>PROBLEM</b>	<b>YES</b>	<b>NO</b>	<b>OTHER COMMENTS</b>
Chest pain			
Angina pectoris			
Coughed up blood			
Pain in arm(s)			
Night sweats			
Chronic or frequent cough			
Chronic or frequent cough on lying down			
Wake up short of breath			
Shortness of breath on:			
Walking several blocks			
One flight of stairs			
On lying down			
Purple lips or fingers			
Palpitations, fluttering of heart			
High blood pressure			
Swelling of hands, feet or ankles.			
At what time of day			
Leg cramps on walking or at night			
Enlarged veins in legs			
Recurrent stomach pain			
Belching or heartburn Relieved by food or medication.			
Appetite: good fair poor			
Nausea or vomiting			
Avoid some foods			
What kinds?			
Avoid spices			
Like some foods very much			
What kinds?			
Abdominal cramping			

<b>Has your child ever had in the last year? Please check yes or no. Continued.</b>			
<b>PROBLEM</b>	<b>YES</b>	<b>NO</b>	<b>OTHER COMMENTS</b>
Color of bowel movement.			
Consistency of stools			
Frequency of BM a day/week			
Any blood in bowel movement			
Rectal pain with B.M.			
Change in size shape or texture of B.M.			
Does your child get up at night to urinate?			
How many times?			
Pain on urinating?			
Difficulty in starting urination? Urinate more than before?			
Urinate less than before			
Any blood in urine			
How much water does your child drink a day?			
How many times per day does your child urinate?			
Full feeling of bladder but only small amount of urination			
Lose urine on coughing or sneezing			
Discharge from penis			

<b>Has your child ever had in the last year? Please check yes or no. Continued.</b>			
<b>PROBLEM</b>	<b>YES</b>	<b>NO</b>	<b>OTHER COMMENTS</b>
Recurrent back pains			
Backaches			
Joint pains			
Swelling of any joints			
Redness or heat of any joint			
Tingling or weakness of hands or feet			
Muscle spasm			
Loss or change in sensation of hands or feet			
Trembling of any extremity			
Growth in neck or throat			
Hot flashes			
Tiredness without apparent reason?			
Brittleness of nails			
Dryness of skin			
Easy bruising			
Inability to stand heat			
Inability to stand cold			
Change in hair texture			
Change in skin texture			
Any skin rash			

<b>OTHER QUESTIONS WE FEEL ARE IMPORTANT TO ASK?</b>		
<b>PLEASE LIST ANY HOBBIES YOUR CHILD HAS, RECREATIONAL OR LEISURE ACTIVITIES / EXERCISE HE/SHE PERFORMS:</b>		
<b>DOES YOUR CHILD MEDITATE OR DO RELAXATION EXERCISES REGULARLY? NO YES</b>		
<b>Does your child have any pets?</b>	<b>No</b>	<b>Yes</b>
<b>IF YES, WHAT TYPE OF PETS DO YOU HAVE?</b>		
<b>IS YOUR CHILD A VEGETARIAN? NO ____ YES ____</b>		
<b>DIET: Is your CHILD'S diet primarily of typical North American food NO ____ YES ____</b>		
If no, please list anything unusual about your diet _____		
<b>Does your child have any Religious Affiliations to food?</b>		
NO ____ YES ____ If yes, what? _____		
OR		
<b>Medical Procedures?</b>		
NO ____ YES ____ If yes, what? _____		
<b>DOES YOUR CHILD PREFER DIET DRINKS OR POP WITH ARTIFICIAL SWEETENERS?</b>		
NO YES If yes, what sort of sweeteners?		
<b>IS THERE ANYTHING ELSE THAT YOU FEEL IS IMPORTANT; AND HAS NOT BEEN ASKED?</b>		
<b>IF SO, PLEASE FEEL FREE TO SHARE IT WITH US:</b>		

**VERY IMPORTANT NOTICE:**

**WE WOULD LIKE TO HEAR HOW YOU FEEL DURING THE TREATMENT, PLEASE CALL US A WEEK AFTER YOU HAVE STARTED THE TREATMENT.**

**THIS SUGGESTION PLAN IS NOT INTENDED TO REPLACE YOUR MEDICATION FROM YOUR GENERAL MEDICAL PRACTITIONER.**

**DO NOT TAKE ANY OTHER SUPPLEMENTS OR DO NOT CHANGE THE RECOMMENDED DOSAGE IN OUR PROGRAM UNLESS DISCUSSED WITH THE PRACTITIONER(S).**

**FINANCIAL POLICY**

**THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, WHICH WE REQUIRE THAT YOU READ AND SIGN PRIOR TO ANY SUGGESTIONS. ALL PATIENTS MUST COMPLETE OUR “QUESTIONNAIRE” BEFORE BEING SEEN AT OUR OFFICE(S). FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, DEBIT, VISA OR MASTERCARD.**

**PLEASE NOTE THAT WE DO NOT FILE FOR INSURANCE. THE BILL IS YOUR RESPONSIBILITY, WHETHER YOUR INSURANCE COMPANY PAYS OR NOT. PLEASE BE AWARE THAT SOME, PERHAPS ALL, OF THESE SERVICES PROVIDED MAY BE “NON-COVERED” SERVICES AND NOT CONSIDERED REASONABLE AND NECESSARY UNDER YOUR INSURANCE PLAN. YOU ARE RESPONSIBLE FOR PAYMENT IN FULL, REGARDLESS OF YOUR INSURANCE COVERAGE.**

**CANCELLATION POLICY**

**UNLESS APPOINTMENTS ARE CANCELLED AT LEAST 72 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENTS AT NORMAL OFFICE RATES. IF CANCELLED ON A FRIDAY AFTER 1:00 PM OR OVER THE WEEKEND YOU WILL ALSO BE CHARGED AT NORMAL OFFICE RATES.**

**THANK YOU FOR UNDERSTANDING OUR FINANCIAL/CANCELLATION POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS. I HAVE READ THE FINANCIAL/CANCELLATION POLICY ABOVE. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.**

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**SIGNATURE PATIENT/RESPONSIBLE PARTY**

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**DATE (m/d/y)**