



QUESTIONNAIRE
OKOTOKS NATURAL HEALTH CENTRE
 29C ELIZABETH STREET
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“TAKING THE TIME TO LISTEN & WORKING TOGETHER MAKES A DIFFERENCE!”

www.okotoksnaturalhealthcentre.info

MAKE SURE YOU HAVE ALL 15 PAGES OF THIS FORM

*******NOTICE: Page 14 needs to be faxed or emailed back to the office to confirm your visit within 48 hours of booking your appointment*******

Holistic Health is a state of well being in which an individual’s body, mind, emotions and spirit are in tune with the natural, cosmic and social environment.

Holistic Medicine 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 me to know the Total You, not just you as a collection of symptoms of an illness.

If, for any reason, you object to fill out any or all of it, you may leave that part blank and provide us with the information you feel comfortable sharing.

PLEASE NOTE: This is a confidential record of your medical history and will be kept in a locked and secure location. 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 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: _____

OCCUPATION: _____ 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 : _____

SYMPTOMS YOU PRESENTLY HAVE:

1. _____

2. _____

3. _____

4. _____

NO SYMPTOMS: I WOULD LIKE A ROUTINE CHECK – UP!

→ → → Have you been out of the country in the last 2 yrs? No Yes

If yes where? _____

LIST OF PHYSICANS YOU ARE PRESENTLY SEEING:

NAME	SPECIALTY	LOCATION
1: _____	_____	_____
2: _____	_____	_____

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

<u>NAME</u>	<u>DOSE</u>	<u>REGULARITY</u>	<u>HOW LONG HAVE YOU BEEN TAKING IT</u>
1: _____	_____	_____	_____
2: _____	_____	_____	_____
3: _____	_____	_____	_____
4: _____	_____	_____	_____

SUPPLEMENTS: Any vitamins, minerals or similar health products:

<u>NAME</u>	<u>DOSE</u>	<u>REGULARITY</u>	<u>HOW LONG HAVE YOU BEEN TAKING IT</u>
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			

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>	
Father	_____			
Mother	_____			
Brother or Sister				
1.	_____			
2.	_____			
3.	_____			
4.	_____			
Husband or Wife	_____			
Children				
1.	_____			
2.	_____			
3.	_____			

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

ALLERGIES: Are you allergic to

1. Any medicine or drug? **No** **Yes**

if yes, to which

ones: _____

2. Any kind of food? **No** **Yes**

if yes, to what kind

3. Anything carried in the air? **No** **Yes**

if yes, to what

4. Any other allergies, please list:

PERSONAL HISTORY:**ILLNESSES : Have you ever had:**

Measles	No	Yes	Migraine headaches	No	Yes
German measles	No	Yes	Tuberculosis	No	Yes
Mumps	No	Yes	Diabetes	No	Yes
Chicken pox	No	Yes	Cancer	No	Yes
Whooping cough	No	Yes	High or low blood pressure	No	Yes
Scarlet fever or Scarlentina	No	Yes	Colitis or other bowel diseases	No	Yes
Diphtheria	No	Yes	Hemorrhoids or any rectal dis.	No	Yes
Small pox	No	Yes	Nervous breakdown	No	Yes
Pneumonia	No	Yes	Food,chemical or drug poisoning	No	Yes
Influenza	No	Yes	Hayfever or asthma	No	Yes
Pleurisy	No	Yes	Hives or Eczema	No	Yes
Rheumatic fever or	No	Yes	frequent infections or boils	No	Yes
heart disease			Any other disease	No	Yes
Arthritis or Rheumatism	No	Yes			
Any bone or joint disease	No	Yes	INJURIES: have you had any		
Neuritis or neuralgia	No	Yes	Broken or cracked bones	No	Yes
Bursitis, Sciatica or			Sprains	No	Yes
Lumbago	No	Yes	Lacerations	No	Yes
Polio or Meningitis	No	Yes	Dislocations	No	Yes
Nephritis	No	Yes	Concussion, or head injuries	No	Yes
Gonorrhoea or Syphilis	No	Yes	Ever been knocked unconscious	No	Yes
Gallbladder disease	No	Yes			
Anemia	No	Yes	WEIGHT: now _____ one year ago _____		
Jaundice	No	Yes	Maximum _____ when _____		
Bladder disease	No	Yes	HEIGHT: _____ cm / ft.		
Epilepsy	No	Yes			

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.	_____	_____

Have you ever been advised to have any operations, which have not been done? No: _____ Yes: _____

How are your sleeping habits? Good _____ Bad _____
 If bad: are you waking at night _____ or having trouble falling asleep _____
 other _____

DO YOU HAVE OR HAVE YOU HAD DURING THE PAST YEAR?:

Frequent or severe headaches	No	Yes	ringing in ears	No	Yes
Fainting spells	No	Yes	Diminishing of hearing	No	Yes
Dizziness on movement	No	Yes	Recurrent nose bleed	No	Yes
Unconscious spells	No	Yes	Recurrent head colds	No	Yes
Blurred vision	No	Yes	Sinus trouble	No	Yes
Double vision	No	Yes	Hay fever	No	Yes
Spots in front of the eyes	No	Yes	Strange persistent odors	No	Yes
Infected eyes	No	Yes	Persistent hoarseness	No	Yes
Pain behind eyes	No	Yes	Difficulty on swallowing	No	Yes
Any change in vision	No	Yes	Enlarged glands	No	Yes
Do you wear glasses?	No	Yes	Recurrent sore throats	No	Yes
When was your last check up?	_____		Recurrent mouth sores	No	Yes
Earaches	No	Yes	Soreness or bleeding of		
Discharge from ears	No	Yes	gums during brushing	No	Yes

DO YOU HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR? (cont.)

Chest pain	No	Yes	Difficulty in starting urination	No	Yes
Angina pectoris	No	Yes	Urinate more than before	No	Yes
Coughed up blood	No	Yes	Urinate less than before	No	Yes
Pain in arm(s)	No	Yes	Any blood in urine	No	Yes
Night sweats	No	Yes	How much water do you drink a day?	_____ / litre	
Chronic or frequent cough	No	Yes	How many times per day do you urinate?	_____	
Chronic or frequent cough on lying down	No	Yes	Full feeling of bladder but only small amount of urination	No	Yes
Wake up short of breath	No	Yes	Lose urine on coughing or sneezing.	No	Yes
Shortness of breath on:			Discharge from penis	No	Yes
walking several blocks	No	Yes	Recurrent back pains	No	Yes
One flight of stairs	No	Yes	Backaches	No	Yes
On lying down	No	Yes	Joint pains	No	Yes
Purple lips or fingers	No	Yes	Swelling of any joints	No	Yes
Palpitations, fluttering of heart	No	Yes	Redness or heat of any joint	No	Yes
High blood pressure	No	Yes	Tingling or weakness of hands or feet	No	Yes
Swelling of hands, feet or ankles	No	Yes	Muscle spasm	No	Yes
At what time of day _____			Loss or change in sensation of hands or feet	No	Yes
Leg cramps on walking or at night	No	Yes	Trembling of any extremity	No	Yes
Enlarged veins in legs	No	Yes	Growth in neck or throat	No	Yes
Recurrent stomach pain	No	Yes	Hot flashes	No	Yes
Belching or heartburn	No	Yes	Tiredness without apparent reason	No	Yes
Relieved by food or medication	No	Yes	Brittleness of nails	No	Yes
Appetite good fair poor			Dryness of skin	No	Yes
Nausea or vomiting	No	Yes	Easy bruising	No	Yes
Avoid some foods	No	Yes	Inability to stand heat	No	Yes
What kinds _____			Inability to stand cold	No	Yes
Avoid spices	No	Yes	Change in hairtexture	No	Yes
Like some foods very much	No	Yes	Change in skintexture	No	Yes
What kinds? _____			Any skin rash	No	Yes
Abdominal cramping	No	Yes			
Color of bowel movement	_____				
Consistency of stools	_____				
Frequency of BM a day/week	_____				
Any blood in bowel movement	No	Yes	X - RAYS: have you ever had x rays of:		
Rectal pain with B.M.	No	Yes	Chest	No	Yes
Change in size shape or texture of B.M.	No	Yes	Stomach or colon	No	Yes
Describe _____			Gall bladder	No	Yes
Do you get up at night to urinate?	No	Yes	Extremities	No	Yes
How many times? _____			Back	No	Yes
Pain on urinating	No	Yes	Teeth	No	Yes
			Other	No	Yes

DO YOU HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR? (cont.)

WOMEN ONLY-MENSTRUAL HISTORY

EKG:

Have you ever had an
Electrocardiogram? No Yes

IMMUNIZATION:

Small pox vaccination
within last 7 years. No Yes

Tetanus shots-
(not antitoxin which
last only two weeks) No Yes

Polio shots within last
two years. No Yes

OTHER: _____

DRUGS:

Laxatives	never occ.	freq.	daily
Vitamins	never occ.	freq.	daily
Sedatives	never occ.	freq.	daily
Tranquilizers	never occ.	freq.	daily
Sleeping pills etc.	never occ,	freq.	daily
Aspirin etc.	never occ,	freq.	daily
Cortisone	never occ,	freq.	daily
Thyroid	never, yes, in past, now on _____gr. daily	none now daily	

Appetite

Depressants never occ freq daily

Have you ever been
treated for drug habits? No Yes

Have you ever taken
hormone tablets or
injections? No Yes

SEX:

Entirely Satisfactory No Yes

Age at onset _____
Regular No Yes

Varies
Cycle _____ days (from start to
start)

FLOW: Heavy Medium Light

Any clots passed No Yes
Pains or cramps No Yes

Date of last period _____

Date of last pelvic exam _____

Date of last Pap test _____

Results: Neg. Pos.

Any discharge from
vagina? No Yes

If so, color _____

Amount _____

Odor _____

Any itching of vaginal
Area? No Yes

Do you take
birthcontrol pills? No Yes

How long have you taken them? _____

Pregnancies:

How many children born alive? _____

How many stillbirths? _____

How many premature births? _____

How many cesarean sections? _____

How many miscarriages? _____

Any complications with
pregnancy? No Yes

Describe: _____

Other: _____

What things are worrying you at the moment?

How do worries affect you?

At what part of the day do you feel most tired?

How do you feel when you wake up in the morning?

What sort of things make you feel sad?

What sort of things make you afraid/anxious?

How do you feel about having to entertain people?

Under what sort of conditions do you become angry?

How do you express anger?

How do you like being alone?

How does time pass you by?

Do other people say that you do things quickly? If so what things?

When you are depressed, how would you look at death?

How do you tolerate waiting?

If you receive bad service in a shop or restaurant, how will you respond?

Are you hungry between or after meals, if yes, at what time?

How is your memory? (If weak, find out in what specific areas?)

How is your concentration?

How are you about making decisions?

Some people are suspicious and others aren't. How do you see yourself in this respect?

From your childhood, what memories do come up right away?

What about anxieties?

Do you remember any dreams? (If yes what are they like?)

If you could change one thing in your life what would it be?

IS THERE ANYTHING ELSE THAT YOU FEEL IS IMPORTANT; AND HAS NOT BEEN ASKED?

IF SO, PLEASE FEEL FREE TO SHARE IT WITH US:

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 “NONCOVERED” SERVICES AND NOT CONSIDERED REASONABLE AND NECESSARY UNDER YOUR INSURANCE PLAN. YOU ARE RESPONSIBLE FOR PAYMENT IN FULL, REGARDLESS OF YOUR INSURANCE COVERAGE.

NOTICE: 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 POLICY.
PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.
I HAVE READ THE FINANCIAL POLICY ABOVE.
I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.**

SIGNATURE PATIENT / RESPONSIBLE PARTY

DATE (m/d/y)

NOTICE

**We are by appointment only and other patients are waiting for the time with the practitioners. To reduce waiting times for you we try hard to be punctual and reserve lots of time just for your appointment. Thank you
Homeopathic and Herbal Medications are very sensitive to light, temperature influences, radiation's and so on.
This is why we are asking you to understand we cannot take back any medication even when it is still sealed.**

FOR YOUR INFORMATION
ABOUT THE VISIT

The Practitioner will have a short look at your questionnaire first to get some medical history and then it will be discussed together. After that, we will combine all findings with an iridology consultation, the Practitioner uses a microscope to get a three dimensional view of the eye to help locate where the problems are coming from originally.

During the visit you will be informed about the findings. The Practitioner will review everything and organize the right combination of herbs & homeopathies in a very exclusive plan prepared just for you. Normally the plan will only last 3-4 weeks, in which your problems generally should be solved, depending on how serious the issues are.

Each suggestion plan is a unique combination for your individual case, do not change it on your own, give part of the product to someone else, or use it later in other cases without talking to the Practitioner first.

After you start your plan you should come in 14 days for a follow-up visit, this includes another Iridology consultation to verify the healing process. We will then evaluate how everything is going and talk about the success of the plan.

IRIDOLOGY

Iridology identifies inherited predispositions that negatively or positively can affect one's health, as the iris shows, which systems of the body are the least and which are the most resilient.

Iridology is a diagnostic tool that helps the Practitioner see certain signs out of the iris, every bodily organ corresponds to a location on the iris, which then makes it possible to find out where the problems are originating.

Iridology is an invaluable tool for prevention; we need to identify our strongest functioning parts of the body, so we can depend upon them to carry us through periods of stress, and to keep the body balanced and in harmony!

Homeopathy: is a system of medicine that uses highly diluted doses from the plant, mineral and animal kingdoms to stimulate natural defenses in the body. Homeopathic remedies are based on the theory that "like cures like," and uses remedies that cause symptoms of a certain illness in one who is healthy in order to stimulate the body's natural defenses to heal those same symptoms in one who is ill. The word homeopathy comes from the Greek word 'homeos' meaning similar, and 'pathos' meaning suffering.

Herbal Medicine: is the therapeutic use of plants, and is the most ancient form of health care known to humankind. A herb is a plant or plant part valued for its medicinal, savory or aromatic qualities. Herb plants produce and contain a variety of chemical substances that act upon the body. Herbs have been used to treat virtually every disease and condition. The use of herbology ranges from pain relievers, hormone balancers, energizers, sleep aids, stomach soothers, skin soothers, and treatment of everything from allergies to cancer, from depression to hysteria. Herbs are used for both prevention and treatment.

Homotoxicology: In homotoxicology, homotoxins are all of those substances, which can cause ill health in humans. They can be introduced from the exterior or originate in the body itself. In Homotoxicology, homeopathically manufactured combination products are designed to work with the body's defense mechanisms and facilitate the body's elimination of toxic substances.