

Chris Rolston BSc ND

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Building Health Naturally

INTAKE FORM

Name _____ Date _____ Gender: M F

Address _____

City _____ Prov _____ Postal Code _____

Telephone # (home) _____ (work) _____ (cell) _____

Age _____ Date of Birth _____ Place of birth* _____ Birth Time* _____

Email address _____ **Alberta Health Care #** _____

Married Separated Divorced Widowed Single Partnership

Live with: Spouse Partner Parents Children Friends Alone

Occupation _____ Hours per week _____ Retired _____

Employer _____ Work Address _____

Health insurance company (if any) _____

How did you hear about Dr. Rolston? _____

Has any other family member already been a patient at the clinic? _____

Next of Kin or other to reach in an emergency _____

Relationship _____ Phone _____

Address _____

Please list all other health care professionals you are currently seeing (alternative and conventional) and their contact numbers. For example - chiropractor, MD, herbalist, acupuncturist, massage therapist, physiotherapist, craniosacral practitioner etc.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If no, when and where did you last receive medical or health care?

What was the reason? _____

* optional - for looking at astrological information

What are your most important health problems? List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____

Which of the above problems are of most immediate concern to you? _____

How did these conditions develop? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify as having caused or clearly aggravated your health problems? If you prefer, feel free to list these in chronological flow chart form on a separate page.

What health problems have you had in the past? Give dates whenever possible.

Do you have any known contagious diseases at this time? Yes No

If yes, what? _____

PRIOR TREATMENTS AND RESPONSE:

Please list all of the former treatments you have used, both conventional and alternative and the degree of effectiveness of each treatment. Please be specific about the benefits you received (if any) from each treatment. This helps me develop an optimal treatment plan for you.

FAMILY HISTORY

	yourself	father	mother	brother	sister	child
Age (if living)						
Health (G=good P=poor)						
Age at death (if deceased)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hayfever/Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Alzheimers/Parkinsons						
Thyroid disorder						
Osteoporosis						
Chronic fatigue or Fibromyalgia						
Eczema or psoriasis						
Injury (serious)						
Liver disease or jaundice						
Hypoglycemia						
Ulcers						
Celiac disease						
Crohn's disease or ulcerative colitis						
Other: _____						

Have you traveled outside of Canada in the past 5 years? Yes No

Where, when and how long were you there?

Childhood Illnesses (Check those you have had)

- | | | |
|---|----------------------------------|---------------------------------------|
| <input type="radio"/> Scarlet fever | <input type="radio"/> Diphtheria | <input type="radio"/> Rheumatic fever |
| <input type="radio"/> Mumps | <input type="radio"/> Measles | <input type="radio"/> German measles |
| <input type="radio"/> Polio | <input type="radio"/> Roseola | <input type="radio"/> Asthma |
| <input type="radio"/> Rubella (german/3day measles) | <input type="radio"/> Chickenpox | <input type="radio"/> Whooping cough |

Other _____

Hospitalization and Surgery

What hospitalizations or surgeries have you had?

_____ year: _____ year: _____

_____ year: _____ year: _____

X-Rays and Special Studies

Type of X-ray or diagnostic procedure:	Date	Hospital/Clinic
_____	_____	_____
_____	_____	_____
_____	_____	_____

Electrocardiogram

Yes No

Electroencephalogram

Yes No

Immunizations

Polio

Pertussis

Hepatitis A

Yellow fever

Tetanus shot

Diphtheria

Influenza

Meningitis

Measles/Mumps/Rubella

Hepatitis B

encephalitis

Typhoid

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods or supplements? _____

Are you lactose intolerant? _____

Any environmental (ie animals, dust, pollens etc)? _____

What prior types of allergy testing have you had? (if yes – bring results with you to your appointment)

Intradermal skin scratch test Blood IgG food Blood IgE inhalant/food Cytotoxic

Electroacupuncture (VEGA, MORA) Kinesiology Food intolerance testing None

Medications

Do you take or use?

Laxatives

Pain relievers

Antacids

Weight loss pills

Cortisone

Appetite suppressants

Antibiotics

caffeine pills

Tranquilizers

Thyroid medication

Sleeping pills

Weight loss

Antibiotics. If you have had repeated rounds of antibiotics for any reason (ie. acne, urinary tract infections, sinusitis, ear infections) please give details. Antibiotic name: _____

Reason: _____

Duration: _____

How many rounds of antibiotics do you estimate you have had in total: _____

Please list all **MEDICATIONS** (**NOT** supplements which are in the **next** section!). Include both over-the-counter and prescription medications that you have taken in the past and all medications that you are currently taking (with doses if remember).

Past Medications

Present Medications

Snacks: _____

Desserts: _____

To drink: _____

What type of water do you drink? How much per day? _____

Distilled water Filtered Spring Well De-ionized Tap

How often do you eat out? _____. Where do you go? _____

What do you usually order? _____

How many meals do you generally eat each day? One Two Three More than three _____

Where do you usually buy your groceries/food? _____

Who cooks the food you eat? _____ What time do you eat your last meal of the day? _____

What time do you go to bed? _____ List the foods you exclude from your diet: _____

List any foods to which you have a bad reaction, and what the reaction is: _____

Are you satisfied with your diet the way it is now? Why or why not? _____

Are there any foods that you crave regularly? _____

Have you ever done any special diets that worked or didn't work for you? If so, describe the diet and the effects it had. _____

Meat, Dairy and wheat . How many times per week do you eat/drink;

Fish _____ times per week/month (circle one)

Pork _____ times per week/month (circle one)

Beef _____ times per week/month (circle one)

Chicken _____ times per week/month (circle one)

Wild game or bison _____ times per week/month (circle one)

Cheese _____ times per week/month (circle one)

Milk _____ times per week/month (circle one)

Bread/wheat/pasta _____ times per week/month (circle one)

HEALTH HABITS

How often do you drink: wine _____ beer _____ other alcohol _____

Do you use tobacco or have you in the past? Yes No.

If yes, then how many packs per day? _____ Years since quitting: _____

Do you now or have you in the past used marijuana or other drugs? Yes No

If yes, which drugs, how often and how long?

Have you ever been exposed to toxic chemicals, solvents or other possible toxins? Yes No

If yes, please explain:

Do you exercise? Yes No. What form(s)? _____

How often? _____ How long for? _____

Do you make time for rest, relaxation or meditation during the day and/or before bed? Yes No

How often? _____ How do you relax? _____

What are your interests and hobbies?

Which of the following do you do on a regular basis:

Jog Swim Walk Gardening Yoga Breathing exercises Meditation Weightlifting
Other _____

SLEEP - Do you have trouble falling asleep? Yes No. If yes, what keeps you up? _____

Do you sleep straight through the night? Yes No. Average hours of sleep per night _____

Do you wake feeling refreshed? Yes No

Do you have recurring dreams? Yes No. If yes, what is the theme? _____

Do you sleep well? Yes No. Explain _____

Enjoy your work? Yes No

Take vacations? Yes No

Spend time outside? Yes No

Watch television? Yes No

how many hours? _____

Read? Yes No

how many hours? _____

Have a history of abuse? Yes No

Any major traumas? Yes No

Been treated for drug dependence? Yes No

Do you go on diets often? Yes No

Do you drink coffee? Yes No

Cups per day _____

Do you drink black or green tea? Yes No

Do you drink cola or other sodas? Yes No

Do you eat refined sugar? Yes No

Do you add salt? Yes No

ENVIRONMENTAL EXPOSURES

Are your home and work environments well ventilated? Yes No

Are your home or work environments excessively Moist Dry

Are there unusual or unpleasant smells in your work/living environment? Yes No

When were the ducts in your home last cleaned? _____

Which of the following are bothersome to you or are known allergies?

Sunshine Dust Dampness Lack of sun

Mold Dryness New moon smoke

Perfume Cold Full moon Heat

Summer Car fumes Spring Summer

Dogs Cats Fall Winter

Seashore Grasses/weeds Mountains Tree pollens

Fluorescent lighting Approach of storms Poor air ventilation snow mold

Foods (specify) _____

Change of weather (specify) _____

Chemicals (specify) _____

Other _____

Do you have a religious or spiritual practice?

If yes, what? _____

How does your condition affect you? _____

What do you think is happening? _____

Why? _____

What do you feel needs to happen for you to get better? _____

What do you enjoy most in your life? _____

How much change are you willing to make at this time for improving your health?

MINIMAL SOME COMPLETE

Is there any information about your health you would like to add? _____

GENERAL

Weight _____ lbs. Weight 1 year ago _____ lbs.

Maximum Weight _____ When _____ Height _____

General energy level on a scale of 1-10 (0=can't get out of bed, 10=limitless energy): _____

When during the day is your energy level:

At its best? _____ at what energy level (number from 1-10) _____

At its worst? _____ at what energy level (number from 1-10) _____

REVIEW OF SYSTEMS

SYMPTOMS - Please mark (1)=mild, (2)=moderate, or (3)= severe next to the following symptoms which apply to you NOW or in the PAST.

MENTAL/ EMOTIONAL

	Now	Past		Now	Past
Treated for emotional problems?	___	___	Depression?	___	___
Mood Swings?	___	___	Anxiety or nervousness?	___	___
Considered/ Attempted suicide?	___	___	Tension?	___	___
Poor concentration?	___	___	Memory problems?	___	___

Details:

ENDOCRINE

Note: If you have had a history of thyroid or adrenal problems, then please fill out the **Thyroid Questionnaire**. Please contact my office to have the form sent to you by email or fax.

	Now	Past		Now	Past
Hypothyroid?	___	___	Heat or cold intolerance?	___	___

Hypoglycemia	___ ___	Diabetes?	___ ___
Excessive thirst?	___ ___	Excessive hunger?	___ ___
Fatigue?	___ ___	Seasonal depression?	___ ___

IMMUNE

	Now Past		Now Past
Vaccinations?	___ ___	Reactions to vaccinations?	___ ___
Chronic Fatigue Syndrome?	___ ___	Chronic infections?	___ ___
Chronically swollen glands?	___ ___	Slow wound healing?	___ ___

NEUROLOGIC

	Now Past		Now Past
Seizures?	___ ___	Paralysis?	___ ___
Muscle weakness?	___ ___	Loss of balance?	___ ___
Loss of memory?	___ ___	Numbness or tingling?	___ ___
Vertigo or dizziness?	___ ___	Easily stressed?	___ ___

SKIN

	Now Past		Now Past
Rashes?	___ ___	Eczema, Hives?	___ ___
Acne, Boils?	___ ___	Night Sweats?	___ ___
Color Change?	___ ___	Itching?	___ ___
Lumps?	___ ___	Perpetual Hair Loss?	___ ___
Psoriasis?	___ ___		___ ___

Details:

HEAD

	Now Past		Now Past
Headaches?	___ ___	Head Injury?	___ ___
Migraines?	___ ___	Jaw/TMJ problems	___ ___

EYES

	Now Past		Now Past
Spots in Eyes?	___ ___	Cataracts?	___ ___
Double Vision?	___ ___	Eye pain/strain?	___ ___
Impaired vision?	___ ___	Glasses or contacts?	___ ___
Blurriness?	___ ___	Tearing or dryness?	___ ___
Color blindness?	___ ___	Glaucoma?	___ ___

EARS

	Now Past		Now Past
Impaired hearing?	___ ___	Ringings?	___ ___
Earaches?	___ ___	Dizziness?	___ ___

NOSE AND SINUSES

	Now Past		Now Past
Frequent colds?	___ ___	Nose Bleeds?	___ ___
Stuffiness?	___ ___	Hayfever?	___ ___
Sinus problems?	___ ___	Loss of smell?	___ ___

MOUTH AND THROAT

	Now	Past		Now	Past
Frequent sore throat?	___	___	Copious saliva?	___	___
Teeth grinding?	___	___	Sore tongue/lips?	___	___
Gum problems?	___	___	Hoarseness?	___	___
Dental cavities?	___	___	Jaw clicks?	___	___
Do you have any root canals?	___	___		___	___

If yes, then how many? _____

How long have you had them? _____

NECK

	Now	Past		Now	Past
Lumps?	___	___	Swollen glands?	___	___
Goiter?	___	___	Pain or stiffness?	___	___

RESPIRATORY

	Now	Past		Now	Past
Cough?	___	___	Sputum?	___	___
Spitting up blood?	___	___	Wheezing	___	___
Asthma?	___	___	Bronchitis?	___	___
Pneumonia?	___	___	Pleurisy?	___	___
Emphysema?	___	___	Difficulty breathing?	___	___
Pain on breathing?	___	___	Shortness of breath?	___	___
Shortness of breath at night?	___	___	" " " " "lying down?	___	___
Tuberculosis?	___	___		___	___

CARDIOVASCULAR

	Now	Past		Now	Past
Heart disease?	___	___	Angina?	___	___
High/Low Blood Pressure?	___	___	Murmurs?	___	___
Blood clots?	___	___	Fainting?	___	___
Phlebitis?	___	___	Palpitations/Fluttering	___	___
Rheumatic Fever?	___	___	Elevated cholesterol or TG's?	___	___
Swelling in ankles?	___	___	Chest pain??	___	___

Give details of any relevant laboratory tests or symptoms;

GASTROINTESTINAL

Now	Past	Now	Past
___	Constipation	___	Indigestion immediately after eating a meal
___	Diarrhea	___	Indigestion 2-3 hrs after meals (bloating, pain, discomfort)
___	Alternating constipation/diarrhea	___	Stomach pain after eating
___	Straining at stool	___	Change in bowel movements
___	Hemorrhoids	___	Digestive symptoms worse with worry/stress
___	Black stools	___	Heavy, full feeling in stomach for hours after eating meat
___	Blood in stools	___	Nervous, shaky with headache - better with carbs or sweets
___	Ulcer	___	Irritable if late for a meal, miss meal or on waking
___	Cramps or colic	___	Sudden, strong cravings for sweets or alcohol
___	Vomiting blood	___	Diet but fail to lose weight
___	Trouble swallowing	___	Eat but fail to gain weight
___	Excessive belching	___	Insatiable appetite
___	Excessive lower bowel gas	___	Weight change - increase or decrease (circle)
___	Distress from fat/greasy food	___	Overweight

_____	Bad breath - chronic	_____	Underweight
_____	Strong body odor (incl. feet)	_____	Compulsive eating
_____	Stomach/abdominal pain	_____	Addictive eating
_____	Jaundice	_____	Anorexia
_____	Bad taste in mouth	_____	Bulimia
_____	Nausea/vomiting for any consistent period	_____	Intestinal parasites suspected
_____	Gall Bladder disease	_____	Appetite change - increase or decrease (circle)
_____	Gallstones	_____	Tasting beef or other meats hours after eating
_____	Gallbladder removed? <input type="radio"/> Yes <input type="radio"/> No	_____	Change in thirst
_____	Loss of appetite	_____	IBS
_____	Bloating that increases as the day goes on	_____	Nauseated in the morning with no appetite
_____	Waking in the night with stomach pain	_____	Diarrhea after eating
_____	Nausea after eating	_____	Bloating from eating sugar
_____	Constipation from eating cheese	_____	Hangover the morning after eating too much sugar

Heartburn ? Yes No. When do you get it (ie. after what foods, after meals etc)? _____

Nausea ? Yes No. When do you get it? _____

Abdominal bloating/distension? Yes No. When do you get it (ie. after what foods, after meals etc)? _____

Belching? What foods seem to cause? _____

Passing gas? What foods seem to cause? _____

Constipation? What foods seem to cause? _____

Does your gas smell particularly bad? Yes No. Details _____

Do you feel better when you don't eat or when fasting? Yes No. Details _____

Have you ever had an aggravation from probiotics? Yes No. Details _____

Bowel Movements:

How often? _____

Is this a change from before? _____

Bowel Studies

Date of last sigmoidoscopy. _____

Date of last endoscopy (if had one). _____

Stools

Do you see undigested food in your stools? If so, what foods do you see? _____

Mark below: **N** = never, **R** = rarely, **S** = sometimes, **M** = most of the time, **A** = all of the time.

- ___ narrow , skinny ___yellow ___gray ___normal brown solid logs ___with mucous
- ___green ___foul odor ___black. ___small, round pellets ___greasy – stick to bowl
- ___hard & dark ___bloody ___loose ___with lots of gas ___mushy pile

Have you ever done any Candida cleanses? yes no.

What did it consist of? _____

What changes did you notice from it? _____

Give details of any digestive trouble: _____

Have you ever done any digestive testing? Yes No. Details _____

Celiac Screen

	Now	Past		Now	Past
Recurring abdominal pain and bloating	_____	_____	Difficulty losing weight	_____	_____
Gas, intestinal difficulties	_____	_____	Muscle aching	_____	_____
Brain fog, memory problems, disorganized	_____	_____	Joint stiffness and pain, especially in hands, with	_____	_____

thinking		swelling	
Fatigue	_____	Burning sensations in the arms and legs	_____
Numbness and tingling in hands, arms and legs	_____	Painful skin rash on elbows, knees, and buttocks	_____
Sores inside the mouth	_____	Aggravated allergies	_____
Hives	_____	Thyroid condition	_____

URINARY

	Now Past		Now Past
Pain on urination?	_____	Increased frequency?	_____
Frequency at night?	_____	Inability to hold urine?	_____
Frequent bladder infections?	_____	Kidney stones?	_____

Does your urine ever smell especially strong, strange, or like anything you've eaten? yes no

If yes, give details _____

Have you ever had a series of repeat bladder infections? yes no.

Have you ever had a series of repeat bladder infections followed by yeast infections? yes no.

If yes to either, what were the circumstances and how was it treated? _____

MALE REPRODUCTION

	Now Past		Now Past
Hernias?	_____	Testicular masses?	_____
Testicular pain?	_____	Prostate disease?	_____
Venereal disease?	_____	Discharge or sores?	_____
Are you sexually active?	_____	Chlamydia?	_____
Birth control? Y N		Gonorrhea?	_____
Type? _____		NGU?	_____
Condyloma (warts)?		Herpes?	_____
Syphilis?			_____

FEMALE REPRODUCTION/BREASTS

Note: If you are seeing Dr. Rolston for hormonal issues, please fill out the **Hormonal Questionnaire** prior to your appointment. If you are post-menopausal, complete the **Postmenopausal Hormonal Questionnaire**. Contact my office to have the form sent to you by email or fax.

	Now Past		Now Past
Age of first menses?	_____	Are cycles regular?	_____
Age of last menses?	_____	Bleeding between cycles?	_____
Length of cycle?	_____ days	Pain during intercourse?	_____
Duration of bleeding with menses?	_____ days	Clotting?	_____
Painful menses?	_____	Discharge?	_____
Heavy or excessive flow?	_____	Birth control?	_____
PMS?	_____	What type? _____	
If yes, what are your symptoms?		Number of pregnancies	
_____		Number of live births	
_____		Number of miscarriages	
Do you do breast self exams	_____	Number of abortions	
Endometriosis?	_____	Menopausal symptoms?	_____
Ovarian cysts?	_____	Abnormal PAP?	_____
Difficulty conceiving?	_____	Chlamydia?	_____
Cervical Dysplasia?	_____	Condyloma?	_____
Sexual difficulties?	_____	Syphilis?	_____
Gonorrhea?	_____	Breast lumps?	_____
Herpes?	_____	Nipple discharge?	_____

Are you sexually active?	___ ___	Breast pain/tenderness?	___ ___
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Number of yeast infections in the last 2 years _____. What treatments have you used, and which have worked the best for you? _____

MUSCULOSKELETAL

	Now	Past		Now	Past
Joint pain or stiffness?	___	___	Arthritis?	___	___
Broken bones?	___	___	Weakness?	___	___
Muscle spasms or cramps?	___	___	Sciatica?	___	___

BLOOD/PERIPHERAL VASCULAR

	Now	Past		Now	Past
Easy bleeding or bruising?	___	___	Anemia?	___	___
Deep leg pain?	___	___	Cold hands/feet?	___	___
Varicose veins?	___	___	Thrombophlebitis?	___	___

Welcome!

We're glad to serve you!

Thank you for spending the time to fill out this questionnaire. It makes my time with you far more efficient.

Please remember to bring any laboratory test results (especially recent) with you to the appointment (if you have them).

Cancellation Policy:

Please keep track of your appointments. You are responsible for remembering the time and date of your consultation. For the consideration of other patients we would appreciate you understanding the following cancellation policy.

If you can't make your appointment, please give us 2 business days cancellation notice. This gives us time to fill that timeslot with those who might be waiting for a cancellation. It also helps us choose a new appointment time for you as soon as possible.

- Appointments changed or cancelled with less than 48 hours notice will be charged \$25.
- Appointments cancelled the same day will be charged \$40.
- Appointments missed completely will be charged \$50.

Exceptions will be given to unforeseeable circumstances at the clinic's discretion.

Please sign that you have read and agree to the cancellation policy as written above:

Signature: _____ Date: _____