Open to Wellness: *Whole Life Health*
Dr. Monika A. Herwig BSc ND (403) 609-8385
 # 205 - 1205 - Bow Valley Trail Canmore, Alberta

CONFIDENTIAL HEALTH HISTORY SUMMARY

DATE ____________________

NAME ____ **AGE** _______ **BIRTHDATE** _________________

ADDRESS ____________________________________ **CITY** ___________ **POSTAL CODE** ____________

PHONE NUMBERS: (TO LEAVE MESSAGES AT): (Home) ______________ **(Work)** __________________

OCCUPATION ____

EMERGENCY CONTACT: NAME ___________________________ **PHONE** _________________________

CHILDREN (NAMES, AGES): ____

E-MAIL ADDRESS ____

YOUR CURRENT WELLNESS SUPPORT TEAM (MD, RMT, etc.)

Name	Profession	Nature of Support

Main Health Concerns

Health Concern	Past treatment	Biggest Challenge with it

Review of Systems Summary (please leave blank for Dr. Herwig's notes)

____

____

____

____

Current Wellness Overview

GENERAL

How would you describe your general state of health? **Excellent** **Good** **Fair** **Poor**

What do you feel is your weakest body system and why? (e.g. digestive, cardiovascular, immune, hormonal, nervous etc.)____

On a scale of 1-10, how would you rate your energy level? ______________________________________

Where would you like your energy to be ?____

When is your energy highest? ____________ When is your energy lowest? __________________________

What brings your energy up? ____

What brings your energy down? ____

Height: _________ Weight: _________ In your mind, what is your ideal weight?_________________

What kind of physical activity do you do on a regular basis? _____________________________________

How often?

☐1x per week
☐2-4 x per week
☐5+ per week
☐Less than 1x per week

What do you believe is the right amount for you? ____

MENTAL-EMOTIONAL WELL-BEING

List current stresses affecting your wellness

1. ____
2. ____

What do you do that helps build your resilience to stress is fun or supports your mental/emotional health?

____

Do you feel like you have a community (friends, family and professionals) that you can lean into for support? If ________ yes, describe ____

If no, what type of support do you feel you would most benefit from? ______________________________

SLEEP QUALITY

On a scale of 1-10, how would you rate your sleep (10 = Excellent, 1 = Poor) ____________________

Average number of hours of sleep/night? ________

Do you fall asleep easily? ________ Do you generally wake refreshed? _________

Has your sleep pattern changed lately and if yes, how? ____

What changes would you like to make with your sleep?____

SEXUAL HEALTH

Are you sexually active? ______

Is your sex drive where you would like it to be right now? ______

Do you practice birth control? ______ If yes, what type and for how long?________________________________

NUTRITION

Blood type ____________ Do you have any dietary restrictions (religious, vegetarian, vegan?) ______________

List any foods that you avoid ____

Do you have any allergies or sensitivities? (drugs, food, chemicals) _____________________________________

Are you interested in identifying your food sensitivities? ______

TYPICAL DAILY FOOD INTAKE:

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Drinks ____

How much water do you drink daily ____

MEDICATIONS:

Please list current supplements and medications in the chart including dose and frequency

Name	Waking	Breakfast	Lunch	Supper	Bedtime	Reason for taking it
Example:. B100complex		1 capsule	1 capsule			Adrenal support, stress

Do you frequently use any of the following? (D-daily, W-weekly, R-rarely)

☐ laxatives
☐ antacids
☐ sleeping pills
☐ alcohol
☐ anti-inflammatories
☐ thyroidmedications
☐ birth control pills
☐ coffee
☐ anti-depressants
☐ recreationaldrugs

Other (including over the counter) ____

How many times have you been treated with antibiotics in the last 5 years?_____________________________

Do you take probiotics when you take antibiotics? _______

ENVIRONMENT

What makes your home a healthy place to be in? ____

What are some changes you'd like to make to have your home support your life/health even more?

____

List any fumes/toxic chemicals you are exposed to at home or work:

____

DIGESTION

How many bowel movements/day? __________ Are your stools **Formed** or **Loose?**

In the stool, do you notice any : **Blood** **Mucus** **Undigested food** **Black colour**

Do your stools have a strong disagreeable odour? ________ Are your stools **Formed** or **Loose**?

Have you had any bladder infections? _______ How often? __________ How did you treat them? __________

Female Wellness

Are you currently pregnant? _______

Are you peri-menopausal? _______If yes, any symptoms? ____

____

Are you still menstruating? _________ Are your cycles regular? ________

Periods begin every _________days, and last _______days. Last menstrual period _____________________

Do you experience any spotting or bleeding between your periods? ________ If yes **Before** **After** **During**

Is the flow of your periods: **Heavy** **Medium** **Light** What color is the blood? ________________

Are there any clots? ______ **Other comments**: ____

# of pregnancies _______ # of live births ______ # of miscarriages ______ # of abortions_______

Are you familiar with healthy breast practices? ________

If yes, which do you include in your daily wellness practice? ______________________________________

Do you ever lose urine unintentionally with jumping, sneezing or running? _________

If yes, have you ever been to a pelvic floor physiotherapist? ________

Do you experience any premenstrual symptoms? _______ If yes, please check all that apply:

☐ Water retention ☐ Breast tenderness ☐ Acne ☐ Irritability

☐ Depression ☐ Headaches ☐ Anger ☐ Mood swings

☐ Crying ☐ Bloating ☐ Food cravings ☐ Other: _________ If you checked Yes to PMS is this something you would like to improve?________

If yes, have you tried anything naturally for this yet?________

If yes, what have you tried and what have you noticed? ____

Additional Information

Additional Concerns

Additional Questions

Additional Comments

Thank you for taking the time to fill out this questionnaire! The information gives us the big picture view of your whole life health so we can better support you in feeling great and living your best life.

HEALTH CARE AGREEMENT

Naturopathic medicine supports individuals in restoring and maintaining wellness. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects.

My signature acknowledges that:

1. I have been informed of and understand that:
    a. The treatments offered at this office are different from those usually offered by a medical doctor or other licensed health care provider.
    b. I am at liberty to begin/continue receiving medical care from a physician, surgeon or other licensed health care provider throughout the duration of my naturopathic care.

2. **Informed consent**: I authorize and consent to treatment with Dr. Monika Herwig ND. I am informed that, as in all health care, in the practice of naturopathic medicine, there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all the risks and complications.

3. **Payment options and policy**: I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Therefore, all services rendered to me are charged to me directly and that I am personally responsible for payment.

4. **Missed appointments**: I agree that missed appointments not canceled within 24 hours will result in a $90.00 fee billed to me.

5. **Phone consultations**: In the event that a phone/zoom consultation is needed the fee will be based on Dr. Herwig's hourly rate of $165.00.

I understand that results are not guaranteed. I do not expect Dr. Monika Herwig to be able to anticipate and explain all possible risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures. I intend this consent form to cover the entire course of care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient's or Guardian's signature X ______________________________ Date ________________