

Kawartha Natural Health Clinic

Your Health Matters To Us!



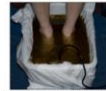
Chiropractic



Acupuncture



Laser Therapy



Ionic Defox Foot Bath



Massage Therapy



Infrared Sauna



Naturopathy



Orthotics



Grafen Technique



Customized Kinesiology



Health is what you do!

Welcome To Our Office!

Date: _____

Mr. Mrs. Ms. Miss

Name: _____
(Please Print) First Last

Address: _____ Postal Code: _____
Street

City: _____ Province: _____ Country: _____

Telephone: _____ Email: _____
Home Business

Occupation: _____ Birth Date: _____

Referred by: _____

Name of Family Physician: _____

Are you currently seeing a Chiropractor? Yes or No Name: _____

Are you currently seeing a Naturopath? Yes or No Name: _____

Health Concerns

Primary Complaints:

1. _____
2. _____
3. _____

List Prescription Medication: _____

Would you like our office to provide a team member to present a health and wellness talk such as ergonomics, lifting, sleep troubles, stress busters, herbal solutions, detoxing or weight loss to your sports team/ workplace/community group?

Yes, I'm interested and would like more information _____

No thank you. _____

Patient Questionnaire

Never Rarely Sometimes Frequently Daily

	Never	Rarely	Sometimes	Frequently	Daily
1) Do you experience recurrent infections, sinusitis, postnasal drip, or swollen lymph nodes, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you experience bouts of diarrhea or constipation gas, bloating, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you have cold fingers or toes, blood pressure problems, varicose veins, arteriosclerosis, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Do you have slow metabolism, are you always hungry, have low energy at specific times of day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Do you experience palpitations, arrhythmia, impairments from prior infections, weak valves, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Do you experience spinal stiffness or pain, headaches, mental confusion, depression, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Do you experience chronic fatigue, recurring infections, lowered immune response, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Do you experience recurrent respiratory infections, coughs, bronchitis, pneumonia, asthma, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Do you experience irritability, nervousness, trembling, anxiety, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) Do you react to pollens, molds, foods, seasonal irritants, perfumes, animal dander, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11) Do you have mood swings, problems sleeping, are you always cold, have chemical imbalances, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12) Do you have recurrent yeast infections, frequent antibiotic use, poor diet, gas, bloating, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13) Do you have diabetes, hypoglycemia, irritability, shaking if you skip a meal, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) Do you experience jaundice, high cholesterol, discomfort in the liver region, blood disorder, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15) Do you have arthritis, back pain, discomfort when moving, weather triggered ailments, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16) Do you have Fibromyalgia, rheumatism, carpal tunnel, slow recovery after exercise, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17) Do you have lymphomas, degenerative liver disease, breast tumors, problems burning fat, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18) Do you experience impotence, miscarriages, sterility, gynecologic or genital disorders, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19) Do you have recurring infections, itching or yeast problems, painful urination, "leaking", etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20) Do you experience digestive disturbances, high acidity, bloating or gas after meals, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21) Do you have rashes, dryness or cracking, scaly patches, eczema, acne psoriasis, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22) Do you have a history of gallstones, discomfort after eating rich foods, low fat metabolism, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23) Do you experience edema, gout, pain in the lower back, burning urination, kidney stones, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovary & Uterus: Do you have PMS, menstrual pains or discomfort, irregular periods, mood swings, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate: Do you experience urinary discomfort, frequency of urination, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth: Do you have sensitive teeth or experience pain or discomfort in the teeth, gums or jaw region?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress: Do you experience stress from work, finances, society, or relationships that you feel cause physical ailments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy: Do you lack motivation, drive, perseverance, stamina, or endurance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of Well-being: Do you lack a sense of happiness, joy, feelings of fulfillment, a positive outlook on life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune System: Are you susceptible to infections, allergies, or sensitive to pollution, or work environment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State of Health: Do you experience symptoms affecting your emotions, mental focus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>