Erika Nabuurs, Medicine Woman
Erika@MECA.Life • www.MECA.Life
604.388.MECA • 778.834.5204
Merville, BC

Health History Questionnaire
Holistic health care and preventive medicine are only possible when the practitioner has complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. This information will remain confidential. Please mark anything you do not understand with a question mark.

PERSONAL INFORMATION – please print

Last Name: _____ First Name: _____ Age: _____

Address: _____ Date of birth: _____

City: _____ Province: _____ Postal Code: _____ Sex: M F

Telephone: (Home) _____ Telephone: (Work) _____

Occupation: _____ Email address: _____

Are you: __ Married __ Separated __ Divorced __ Widowed __ Single

Live with: __Spouse __ Partner __ Friends __ Other Children: Y N How many? ____

How did you hear about Erika Nabuurs or Nature's Revival Clinic?

_____

What health concerns brought you to this office today?

_____

_____

Has anything recently changed or become worse?

_____

_____

CURRENT MEDICATIONS & SUPPLEMENTS
Please list all your prescription medications (such as sleeping pills, birth control pills), non-prescription medications, (such as aspirin, antacids, laxatives, antihistamines), vitamins, minerals, herbs, etc, that you take more than occasionally.

_____

_____

KNOWN ALLERGIES
Please list any known allergies to medicines, (such as penicillin, sulpha drugs, aspirin), or other substances (such as pollens, ragweed), foods, chemicals, etc.

_____

_____

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HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES

Date	Injury or Reason for Hospitalization

PERSONAL HEALTH HABITS

Height: _____ Current Weight: _____lbs. Weight 1 year ago: _____lbs. Maximum weight: _____lbs.

Smoker: Y N Smoked for ___ years Amount per day:_____Year stopped, if applicable: _____

Alcohol Use: Y N Type of Alcohol Preferred: _____ Frequency: _____

Recreational Drug Use: Y N Type: _____ Frequency: _____

Coffee: Y N Cups per day ___ Tea: Y N Cups per day ___

Diet: Are there any food groups that you avoid? Y N If yes, what? _____

Do you exercise regularly? Y N Type: _____ Duration: _____ Frequency: _____

Hobbies: _____

Blood Type (if known): A B AB O Additional Information: _____

Women: Are you currently pregnant? Y N

PERSONAL MEDICAL HISTORY

Please check only those that pertain to you personally. Please specify (**P**) Past or (**C**) Current.

___ Alcohol Abuse
___ Asthma
___ Depression
___ Female Gynecological Problems
___ Heart Problems
___ Lung Problems
___ Skin Problems
___ Tuberculosis
___ Allergies
___ Back, Muscle, Joint Pain
___ Thyroid Problems
___ Gallstones
___ High Blood Pressure
___ Overweight
___ Liver Problems
___ Heart Attack
___ Anemia
___ Bladder/Urinary Problems
___ Epilepsy
___ Gum/Teeth Problem
___ Kidney Problems
___ Psychological Difficulties
___ Rheumatoid Fever
___ Venereal Diseases (AIDS, herpes, syphillis,etc)
___ Arthritis
___ Colitis
___ Fatigue
___ Ulcers
___ Suicide
___ Stroke
___ Diabetes
___ Other

GENERAL HEALTH REVIEW: Check any that apply

Male

☐Hernia ☐Testicular pain ☐Testicular mass ☐Herpes ☐Discharge/Sores ☐Impotency
☐Prostate disease ☐Other reproductive concerns_____

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Female

☐Heavy menses ☐Painful periods ☐Irregular periods ☐Light menses ☐Clots
☐Abnormal pap ☐Painful intercourse ☐Bleeding between periods ☐Vaginal sores ☐Ovarian cysts
☐Endometriosis ☐Vaginal discharge ☐Nipple discharge ☐Abnormal menses ☐Mood swings
☐Breast lumps ☐Sexual difficulties ☐Menopausal Sx_____
☐Other reproductive concerns _____

General

☐Low appetite ☐Strong thirst ☐Chills ☐Tremors ☐Sudden energy drop ☐Localized weakness
☐Poor balance ☐Fever ☐Fatigue ☐Weight loss ☐Weight gain ☐Sweat easily
☐Cravings ☐Night sweats ☐Poor sleep ☐Bleed/Bruise easily

Skin and Hair

☐Rashes ☐Ulcers ☐Hives ☐Itching ☐Eczema ☐Pimples ☐Pigment changes
☐Hair loss ☐New moles ☐Dandruff ☐Dry skin ☐Other skin/hair concerns_____

Head, Eyes, Ears, Nose, Throat,

☐Sinuses ☐Swollen glands ☐Excess saliva ☐Dizziness ☐Concussions ☐Headaches
☐Migraines ☐Sore throat ☐Poor vision ☐Contacts ☐Cataracts ☐Eye strain ☐Eye pain
☐Night blindness ☐Poor hearing ☐Earaches ☐Ringing ears ☐Grinding jaw ☐Cavities
☐Jaw clicks ☐Nose bleeds ☐Loss of smell ☐Facial pain ☐Sore lips ☐Sore tongue
☐Other head/neck concerns _____

Cardiovascular

☐Chest pain ☐Palpitations ☐Fainting ☐Irregular beat ☐Swollen feet/ankles ☐Blood pressure
☐Murmurs ☐Blood clots ☐Phlebitis ☐Cold hands/feet ☐Rheumatic fevers ☐Varicose veins
☐Other heart or blood vessel concerns _____

Respiratory

☐Cough ☐Phlegm ☐Shortness of breath ☐Pleurisy ☐Coughing blood ☐Asthma
☐Wheezing ☐Bronchitis ☐Pneumonia ☐Other breathing concerns_____

Gastrointestinal

☐Nausea ☐Indigestion ☐Chronic laxative use ☐Diarrhea ☐Constipation ☐Vomiting ☐Ulcer
☐Belching ☐Abdominal pain ☐Bad breath ☐Black stools ☐Gas ☐Rectal pain ☐Liver disease
☐Hemorrhoids ☐Gallbladder disease ☐Pale stools ☐Other digestive concerns_____

Genitourinary

☐Hurts to urinate ☐Blood in urine ☐Frequent urination ☐Bladder urgency ☐Unable to hold urine
☐Unable to void completely ☐Kidney stones ☐Decreased in flow ☐Wake to urinate at night? How Often _____
☐Other urinary concerns_____

Musculoskeletal

Pain: ☐Neck ☐Shoulder ☐Elbow ☐Wrist ☐Rib ☐Back ☐Hip ☐Pelvis ☐Knee
☐Ankle ☐Foot
Other bone or muscular concerns_____

Neurological

☐Seizures ☐Depression ☐Tingling ☐Loss of balance ☐Concussions ☐Anxiety
☐Poor memory ☐Prone to stress ☐Irritable ☐Numbness ☐Nervousness ☐Lack of coordination
Have you ever been treated for emotional concerns _____

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Have you ever considered or attempted suicide_____
Other neurological or psychological concerns_____

FAMILY MEDICAL HISTORY

	Age	Health Problems	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Brother and sisters				
Children				

MISCELLANEOUS

What questions do you have that you would like answered?

_____

_____

_____

_____

_____

_____

What kind of help do you want or expect to be provided?

_____

_____

_____

_____

_____

_____

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INFORMED CONSENT

I would like to take this opportunity to welcome you to MECA.Life. This clinic utilizes the principles and practices of holistic health care techniques to stimulate and guide the body's innate ability to heal, and to improve on one's quality of life and health, through natural therapies.

Your practitioner will conduct a thorough case history, including verbal inquiry and physical exam, and may request urinary analyses and specific blood work. Erika Nabuurs is the sole practitioner who will have access to view or review the contents of your file, and she is held to the highest standard of patient-practitioner confidentiality.

I understand that Erika Nabuurs is a BSc. degree graduate and medically trained in post-graduate naturopathic medicine. I understand that Erika holds additional certifications in TBM Therapy, Bowen Therapy, and Birth Attendance; and that she now walks and learns among the elders of traditional lineage medicine. _____ **(Initial)**
I understand that Erika is a **sovereign** Medicine Woman. _____ **(Initial)**
I understand that Erika chooses NOT to be a licensed physician. _____ **(Initial)**
I understand that Erika is NOT a member of any association or college of physicians. _____ **(Initial)**
I understand that this means **I am 100% responsible for advocating on my own behalf**, and must ask for clarification of the risks & benefits of every treatment procedure – for which I am uncertain – before agreeing to proceed. ____**(Initial)**

STATEMENT of ACKNOWLEDGEMENT

Printed Name_____

As a patient of this clinic I have read the information and understand that this form of medical care is based on holistic health care principles, practices, and therapies. As MECA.Life is a private practice, I recognize that only Erika Nabuurs will have access to my file. I also recognize that even the gentlest therapies may present risks or complications, and that I have a right to be informed of these risks and complications, prior to accepting treatment. I understand that in certain physiological conditions or in very young children or those on multiple medications, the chance of these risks may be higher and hence, the information I have provided in my intake form is complete and inclusive of all health concerns and all medications. Minimal risks of some holistic health care treatments include, but are not limited to, allergic reaction to supplements or herbs; aggravation of pre-existing symptoms; pain; fainting; bruising; muscle strains/sprains; spinal disk injuries; vascular events from manual therapies.

I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial, or federal agency attempting to gather information without so stating.
I accept full responsibility for any fees incurred during care and treatment.

_____ _____/_____/_____
Signature **Date** (Day/Month/Year)

Parental Consent (if applicable)
If you are under the age of 19, parent consent is required for holistic health care treatment.

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_____ _____/_____/_____
Signature of Parent/Guardian **Date** (Day/Month/Year)