Catherine Isabelle DeVos, CNP, NNCP
Certified Nutritional Practitioner, Cancer Survivor, Lecturer

Confidential Health Inventory

Today's Date _____

Note

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us in writing to do so. Please complete the questionnaire as thoroughly as possible. Thank You!

Last Name _____ First Name _____

Address _____ City _____

Province _____ Postal Code _____ Birth Date _____

Mailing Address (if different) _____

Home Phone _____ Work Phone _____ Ext _____

Fax Number _____ Email _____

Call before Faxing ☐ Yes ☐ No

Martial Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Living Situation ☐ Alone ☐ Friend(s) ☐ Partner ☐ Spouse ☐ Parent(s)

Names of Ages of those living with you: _____

_____

_____

_____

_____

_____

Name of Partner/Spouse/Parent: _____

Occupation of Partner/Spouse/Parent: _____

Pets _____

Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Unemployed ☐ Other

Occupation _____

Support Activities/Pursuits/Groups: _____

_____

_____

What are the major health concerns that have brought you to this office today?

When did this condition begin?

Has anything recently changed or become worse?

Personal Health Habits

Height _____ Weight _____ Weight 1 year ago _____

Are you a Smoker? ☐ Yes ☐ No How many Years? _____ # per Day _____

Do you Drink Alcohol? ☐ Yes ☐ No What? _____ Frequency _____

Recreational Drugs? ☐ Yes ☐ No What? _____ Frequency _____

Do you Drink Coffee? ☐ Yes ☐ No Qty/Day _____ Tea? ☐ Yes ☐ No Qty/Day _____

Do you take regular exercise? ☐ Yes ☐ No Frequency _____

Type? _____

Duration? _____

Current/Recent Health Care Providers

Name	Dates	Care Provided

Supplements & Medications

(Please write a complete list on separate page if necessary)

Supplement/Herb Name _____ Brand _____
Potency (mg, IU, etc) _____ Dose _____ Frequency _____

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Potency (mg, IU, etc) _____ Dose _____ Frequency _____

Medication Name _____ What it's for _____
How long? _____ Strength _____ Dose _____ Frequency _____

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Allergies

Drug allergies (penicillin, etc) _____

Allergies to Foods, Pollens, etc _____

Hospitalizations/Surgery

Date	Hospital	Diagnosis/Operation	Doctor

Accidents/Injuries (Briefly Describe)

More than 5 Years ago _____

Less than 5 Years ago _____

Cancer Information

Have you ever been diagnosed with cancer, a mass or tumor? ☐ Yes ☐ No

When _____ Location _____

Type _____ Current Status _____ Stage _____

Type _____ Current Status _____ Stage _____

Current tumor markers _____

Date	Chemotherapy/Radiation/Other	Dose	Frequency	Duration

If you are in a clinical trial or experimental protocol please provide details _____

Please rate the following on a scale of 1 to 10 (10 being the best) & write any comments

Sleep ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Energy Level ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Appetite ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Digestion ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Diet and Lifestyle

Dietary preferences/restrictions _____

What is your favourite food? _____ Favourite Flavour _____

Sample of days menu (please fill out 3-day food chart if you have been asked to do so)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluids: _____

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? ☐ Yes ☐ No

If Yes, describe _____

Family History

Please include any of the following: Alcoholism, high blood pressure, cancer, diabetes, heart disease, osteoporosis, other addiction or illness.

Member	Living?	Age	Disease	Cause of Death	Year of Death
Mother					
Father					
Sibling(s)					
MGM*					
MGF*					
PGM*					
Aunts					
Uncles					

**M = Maternal; P = Paternal; GM = Grandmother; GF = Grandfather*

Personal

How do you feel about the following areas of your life? (Please check appropriate boxes & make any comments you would like)

Self	☐ Great	☐ Good	☐ Fair	☐ Poor	Comments _____
Work	☐ Great	☐ Good	☐ Fair	☐ Poor	Comments _____
Partner	☑ Great	☐ Good	☐ Fair	☐ Poor	Comments _____
Sex	☐ Great	☐ Good	☐ Fair	☐ Poor	Comments _____
Family	☐ Great	☐ Good	☐ Fair	☐ Poor	Comments _____
Diet	☐ Great	☐ Good	☐ Fair	☐ Poor	Comments _____

Please rate your stress on a scale of 0 to 10 (10 being the most) & write in any comments

Stress Level ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Personal Stress

1. I worry a great deal	☐ Yes	☐ No
2. I feel lonely	☐ Yes	☐ No
3. I am bored with my life	☐ Yes	☐ No
4. I think a lot about dying	☐ Yes	☐ No
5. I have particular concerns relating to my religion	☐ Yes	☐ No
6. I feel fearful or afraid	☐ Yes	☐ No
7. I feel nervous most of the time	☐ Yes	☐ No
8. I often feel depressed	☐ Yes	☐ No
9. I feel anxious often	☐ Yes	☐ No
10. I am ill frequently	☐ Yes	☐ No
11. I sometimes feel weak or light-headed	☐ Yes	☐ No
12. I often have pains in my shoulders, neck or back	☐ Yes	☐ No
13. I often feel like crying	☐ Yes	☐ No
14. I lose my temper more than I used to	☐ Yes	☐ No
15. Other personal concerns	☐ Yes	☐ No

Please Describe _____

_____

_____

_____

Please use this space to add any other information about yourself that you think will be of help to us:

_____

_____

_____

_____

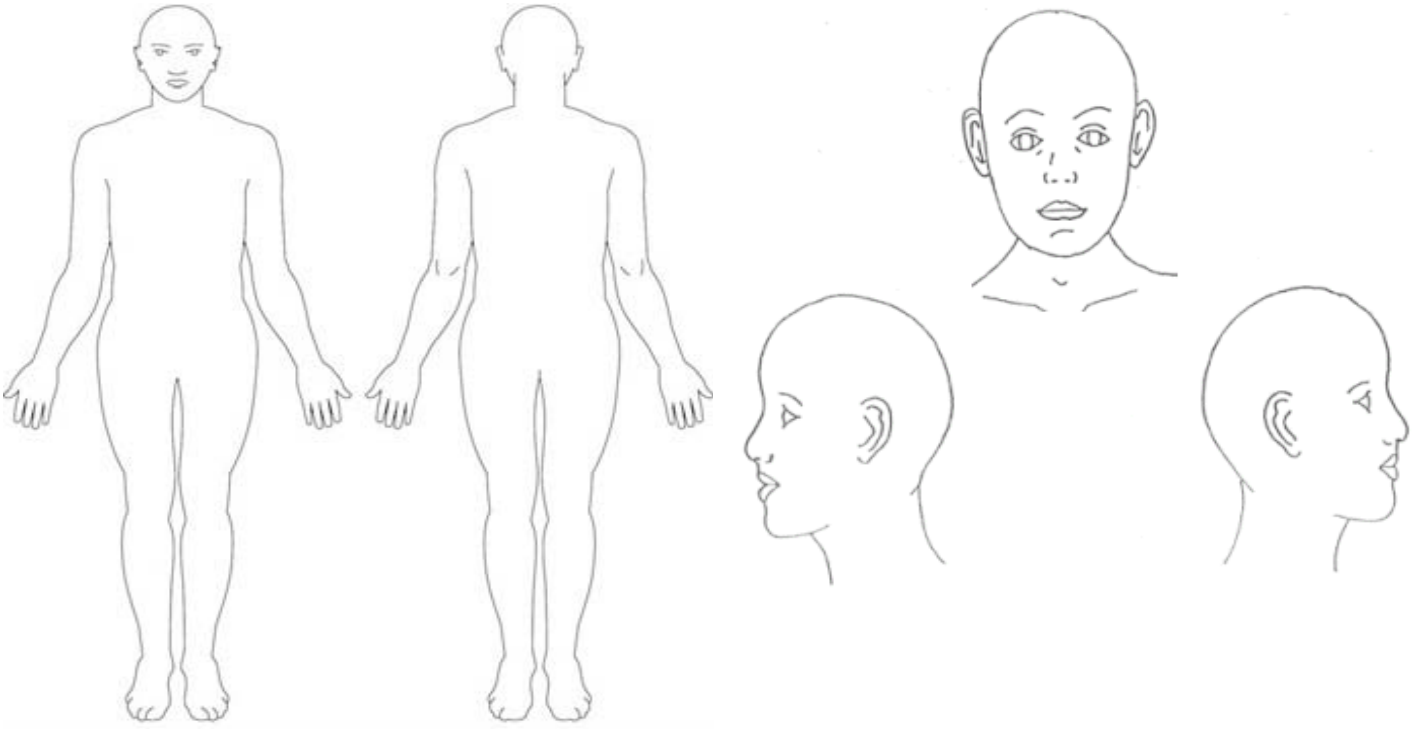
_____

_____

Pain

Do you have any Pain(s)? ☐ Yes ☐ No

Please indicate painful or distressed areas



Area/Description of Symptoms	Pain Level (0 to 10) (10 being the highest)	Frequency

For Women Only

Menstrual Periods

Please complete this section to the best of your quality even if you no longer menstruate. It provides valuable information for an accurate assessment.

Age Started _____ Length of Cycle _____ Flow lasts how many days? _____

Type of Flow ☐ Light ☐ Heavy Clots? ☐ Yes ☐ No Colour of Blood? _____

Menstrual Cramps? _____ Which Days? _____

Date of Last Menses _____ PMS? ☐ Yes ☐ No

Describe Symptoms: _____

History

Mark the following:

Hysterectomy	☐ Past	☐ Current	Breast Cancer	☐ Past	☐ Current
Irregular PAP Smear	☐ Past	☐ Current	Mastectomy	☐ Past	☐ Current
Tubal Ligation	☐ Past	☐ Current	Lumpectomy	☐ Past	☐ Current
Fibroids	☐ Past	☐ Current	Pain with Intercourse	☐ Past	☐ Current
Herpes	☐ Past	☐ Current	Dryness with Intercourse	☐ Past	☐ Current
Ablation	☐ Past	☐ Current	Infertility	☐ Past	☐ Current
D & C	☐ Past	☐ Current	Yeast Infections	☐ Past	☐ Current
Interstitial Cystitis	☐ Past	☐ Current	Irregular Bleeding	☐ Past	☐ Current

Vaginal Discharge ☐ Yes ☐ No Colour _____ Frequency _____
Amount _____

Do you have Breast Implants? ☐ Yes ☐ No If Yes, any problems? _____

Pregnancy/Birth Control

Are you pregnant? ☐ Yes ☐ No Do you think you may be? ☐ Yes ☐ No

# of Pregnancies _____ # of Children _____

# of Terminations _____ # of Miscarriages _____

# of Tubular Pregnancies _____ Difficulty in Conceiving? ☐ Yes ☐ No

Birth Control Methods Used: _____

Menopause

No Menses Since _____

Experiences/symptoms you are currently feeling/having? _____

Experiences/symptoms you had in the past during menopause? _____

Healthy Concerns

Please check if you have experienced any of these **in the last 3 months**.

Skin, Nails & Hair

- ☐ Rashes
- ☐ Poor Healing Sores
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of Hair
- ☐ Recent Moles
- ☐ Change in Texture

Any other problems with skin, nails or hair? _____

_____

_____

Head, Eyes, Ears, Nose & Throat

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Eye Pain
- ☐ Spots in Front of Eyes
- ☐ Earaches
- ☐ Poor Hearing
- ☐ Blurred Vision
- ☐ Ringing in Ears
- ☐ Ear Infections
- ☐ Sore Throats
- ☐ Canker Soars
- ☐ Cold Soars
- ☐ Grinding Teeth
- ☐ Nose Bleeds
- ☐ Clicking of Jaw
- ☐ Facial Pain
- ☐ Sinus Congestion
- ☐ Mucous in Throat
- ☐ Swollen Glands
- ☐ Frequent Colds

Any other problems with the head, eyes, ears, nose or throat? _____

_____

_____

Heart & Circulation

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Fainting
- ☐ Cold Hands or Feet
- ☐ Phlebitis
- ☐ Easy Bruising
- ☐ Blood Clots
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Difficulty Breathing
- ☐ Swelling of Hands
- ☐ Swelling of Feet

Any other problems with heart or circulation? _____

_____

_____

Breathing

- ☐ Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Pain in Breathing
- ☐ Shortness of Breath without exertion
- ☐ Difficulty Breathing lying down

Production of Phlegm? ☐ Yes ☐ No If Yes, what colour? _____

Any other problems with breathing? _____

Digestion

- ☐ Food Cravings
- ☐ Poor appetite
- ☐ Bad Breath
- ☐ Difficulty Swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Indigestion
- ☐ Heartburn
- ☐ Gas
- ☐ Bloating
- ☐ Blood in Stool
- ☐ Mucous in Stool
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black Stool

Number of Bowel Movements per day? _____ ☐ Loose ☐ Normal ☐ Hard ☐ Float ☐ Sink ☐ Bad Odor ☐ No Odor

Do you rely on any of the following for bowel eliminations? ☐ Enemas ☐ Laxatives ☐ Purgatives
What type/Brand? _____ How often? _____

Any other problems with digestion? _____

Urinary

- ☐ Pain in Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Urgency of Urination
- ☐ Kidney Stones
- ☐ Irregular Flow
- ☐ Impotency
- ☐ Inability to hold Urine
- ☐ Decrease in Urine flow
- ☐ Difficulty starting or stopping the flow

Any other problems with urination? _____

Musculoskeletal

- ☐ Neck Pain
- ☐ Muscle Pain
- ☐ Stiffness
- ☐ Back Pain
- ☐ Muscle Weakness
- ☐ Reduced range of Movement

Chiropractic or Massage Therapy? ☐ Yes ☐ No Frequency _____

Any other musculoskeletal problems? _____

General

- ☐ Fatigue
- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Excessive Thirst
- ☐ Sudden Energy Drops
- ☐ Slow Metabolism (Easy Weight Gain)
- ☐ Intolerance to Heat or Cold

Any other Health Concerns? _____

Neuropsychological

- ☐ Poor Sleep
- ☐ Poor Memory
- ☐ Numbness
- ☐ Depression
- ☐ Irritability
- ☐ Difficulty Concentrating
- ☐ Foggy or Spacy Feeling
- ☐ Lack of Coordination
- ☐ Loss of Balance
- ☐ Headaches
- ☐ Anxiety
- ☐ Seizures
- ☐ High Stress Levels
- ☐ Migraines

Hours of sleep per 24 hours _____ Naps? ☐ Yes ☐ No # of Hours _____

Stress Management Techniques _____

Any other Neurological or Mental Health Problems _____

Waiver of Liability

Catherine Isabelle Guyonne Marie DeVos, CNP, NNCP

I, the undersigned, hereby confirm that I understand that the above names individual is not a medical doctor nor is she licensed to practice medicine. I affirm that I am consulting with this practitioner for educational purposes, of my own free will. I understand that there will be no diagnoses made, nor prescription given, but that the practitioner will offer an assessment of my general state of health and will make dietary and stress regulation recommendations. She may also make several suggestions for herbal, mineral or vitamin supplements, all of which are safe when taken as suggested.

The above named practitioner also uses live cell microscopy and electrodermal screening to help determine nutritional deficits. These practices are used as a guide only and never meant to suggest a diagnoses.

_____

Print Name

_____

Signature

_____

Date