KAS-SKY
Wholistic Health Care Centre

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Dr. Darlene Bouchard, D.M.S. Doctor of Homoeopathy

ADULT PATIENT RECORD

CONTACT INFORMATION

Name (surname): _____ (given): _____

Address: _____

Phone (home): _____ (work): _____

Email: _____ Mobile: _____

How did you hear about us: ☐ Website ☐ Yellow Pages ☐ Signage ☐ Family ☐ Friend ☐ Co-worker ☐ Live in the area

Introduced by: _____ Case recorded by: _____

PERSONAL INFORMATION

Date of Birth (year/month/day): _____ Age: _____

Occupation: _____ Since: _____ Like your job?: _____

Religion: _____

Family Language: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Common Law ☐ Unmarried How Long?: _____

If unmarried, why?: _____

Number of Children: _____

Health of Children: _____

Sexual History (STD's, sexually transmitted diseases, herpes, mononucleosis, epstein-barr, gonorrhea, syphilis, HIV): _____

Marital Relations (if any problems): _____

Social Relations (prefer being in groups, alone, or both): _____

Domestic Relations (if any problems): _____

Morals, values (opinions on controversial issues): _____

Dwelling Place (any issues): _____

_____

Addiction (tobacco, alcohol, others): _____

Since: _____

Contraceptives (presently and in the past): _____

_____

Drug Use (prescription and or recreational drugs): _____

Since: _____

Supplements/Vitamins: _____

Cosmetics (how much and how often): _____

_____

Hobbies: _____

_____

Sports/Exercise (how often): _____

_____

_____

FAMILY HISTORY (family illnesses i.e. heart problems, kidney diseases etc.)

Grandfather - maternal (on mother's side): _____

Grandfather - paternal (on father's side): _____

Grandmother - maternal (on mother's side): _____

Grandmother - paternal (on father's side): _____

Father: _____

Mother: _____

Brothers & Sisters: _____

Maternal Uncles: _____

_____

PAST HISTORY

Your Mother's pregnancy with you, if any difficulties (if yes please explain): _____

_____

Your Birth (normal, operation, forceps): _____

_____

Milestones (if remembered): _____

_____

Dentition (teething): _____

_____

Walking: _____

Talking: _____

Menarche (periods): _____

Menopause: _____

Childhood: _____

Number of Brothers & Sisters: _____

Where do you fit in?: _____

Death in Family: _____

School Life: _____

College Life: _____

Accidents (falls, trauma, other injuries): _____

Surgical Operations: _____

Mental Traumas (when & what): _____

Diseases Suffered (age, period of suffering, treatment) If yes, were you hospitalized?: _____

Vaccination childhood history. Hepatitis A , B, C, flu, travel shots (any reactions or problems?): _____

Suppressions (examples: tylenol, aspirin, creams, medications from conventional doctors, insect repellent, sun screen etc.): _____

Animal Bite/Sting Reactions (hospitalization?): _____

Pregnancies (normal delivery, abortion, miscarriage? How far along in each case? Other difficulties?): _____

PRESENT COMPLAINT

Location (extension), Sensation (character), Modalities - means better by or worst by, (onset, durations, symptoms preceded by, symptoms followed by, or caused by) concomitant - means other physical ailments associated with another body part.

For example: headache, location left side, sensation pulsating, modalities better with pressure, worst with bright lights, onset sudden, duration one hour, symptoms preceded by hunger, symptoms followed by nausea, caused by empty stomach, concomitant associated with monthly period.

SPECIAL CHARACTERISTICS (about you)

Will (how difficult is it for you to make imp. decisions?): _____

Understanding (how quickly do you learn new concepts?): _____

Intellect (how do you see yourself - above average, average, below average?): _____

How were your academic grades while in school?: _____

Memory (long term, short term, give examples if any strength or difficulties?): _____

Appearance (what are your thoughts? Do you like what you see when you look in the mirror?): _____

Traits of Character (examples of your strengths, honesty, patience, sensitive, loyalty, kindness, compassion etc.): _____

Constitution (for Dr. Bouchard to fill in): _____

Diathesis (for Dr. Bouchard to fill in): _____

Temperament (how do you express your different types of emotions - anger, happy, sadness etc.?): _____

Relation to heat and cold (your body temperature). Do you sleep in P.J. and socks, lots of layers, or otherwise? How do you manage extreme temperatures, hot summers, cold winters? What season do you prefer, spring, summer, fall, or winter?: _____

Susceptibility (for Dr. Bouchard to fill in): _____

Appetite/Hunger (how many meals per day, snacks, or are you grazer?) Please explain your habits and give an example of your diet:

Desires/Cravings preferences to foods, tendencies of what you eat. Salty, sweet, sour, spicy? (please give an example of diet, breakfast, snacks, lunch, dinner):

Aversions/ Dislikes (foods, environment, weather, noises, sensitive to odors):

Intolerance to/or allergies:

Sleep - Nature of your sleep (sound, interrupted, restless, mind is busy). Sleep position (back, on your side left or right, stomach, curled up fetal position). Symptoms before sleep (difficulty falling asleep, staying asleep). Symptoms during sleep, after sleep. (do you wake up rested?)

What time do you go to bed, what time do you get up? How many hours are required to feel Rested? Do you snore?

Dreams (object, frequency, effect on the patient). Are your dreams pleasant or unpleasant, reoccurring, night mares. Do you ever try to interpret your dreams?

Tongue - color, moisture, fur coating, papillae, side & under surface, anything special (for Dr. Bouchard to fill in):

Taste, bad breath during the day (rotten, sour, metallic, sweet, salty):

Thirst - frequency, amount, kind of drink, effect on the patient (example how much water, coffee, tea, juice, soda pop, alcohol):

Thirsty often or thirst less. Preference in temperature, cold, hot, room temperature, do you like to crunch and chew on ice, do you sip or gulp your drinks?

Skin: color texture, tendencies - suppuration (healing quickly, within 1 or 2 weeks or more) scars:

Any ailments - psoriasis, eczema, shingles, herpes? (presently or in the past):

Skin types: rough, smooth, blemishes, complexion color, oily, greasy, dry, flakey:

Perspiration: Do you sweat? Can you sweat? Location, quantity, character, smell, consistency, color, stains clothing etc. Concomitant - (means other physical ailments associated with another body part) are aggravations, does the skin cause inflammation or become red and burn.

Discharge - location (nose, mouth drooling, eyes tearing, watery, ears, nipples, vagina,penis,rectum) character and causation from any orifice of the body? (sticky, slimy etc.)

Coition (sexual intercourse) sexual difficulty continence, desire, ejaculation, symptoms before, during and after coition, perversion if any, increased,or decreased libido. (Example: Men - difficulty with erections, flaccid, or premature? Women - dryness, lack of desire, painful, burning?)

Stool & Defecation - frequency, aggravation & amelioration (relief) character, consistency (of the stool, size) color (dark, medium, light) odor, aggravation, amelioration, symptoms before, during and after stool. Effect on the patient. Do you pass stool at least once a day?

Urine & Urination - frequency, aggravation & amelioration, flow, impeded, interrupted, aggravation, quantity, character, odor, color etc. Sediment if any, symptoms before, during and after urination, history of any urinary tract infections, bladder, kidneys, yeast, herpes breakouts etc.

If you know - how old before completely potty trained? Did you have any problems with bed wetting? If yes how old, how often, how long?

Menses - menarche - age, premature, delayed cycle - regular, irregular, early, late, duration, character of discharge, color, consistency, odor, stain, quantity, profuse scanty, character of flow, flow increased by, flow decreased by, flow suppressed, if any symptoms before, during and after menses, with no menstruation.

Leucorrhoea (vaginal discharge) - character, frequency, aggravation, symptoms before, during, and after, alternation, concomitant (means other physical ailments associated with another body part) relation to menses.

Hair - character - dry, moist, split, tangled, falling out, oily etc.? Do you color your hair? If yes, how long and how often do you color your hair? What product do you use?

Nails - healthy, strong or weak, brittle, spots on the nails, ridges, spoon shape? Do you wear nail polish regularly (toe nails, or finger nails)? History of fungal or bacterial infection? _____

_____

PHYSICAL EXAMINATION

Respiratory System: _____

Circulatory System: _____

Alimentary System: _____

Lips (cold sores, dry, cracked): _____

Teeth (cavities, bridge work, caps, root canals): _____

Mouth: _____

Tongue: _____

Throat: _____

Abdomen: _____

Epigastrium: _____

Liver: _____

Gall Bladder: _____

Spleen: _____

Navel: _____

Appendix: _____

Colon: _____

Inguinal: _____

Anus/Rectum: _____

Back: _____

Locomotor System: _____

Genitor/Urinary System: _____

Nails: _____

Skin: _____

Special Organs: _____

Eyes: _____

Nose: _____

Ears: _____

Rubrics: _____