



Wellness Detoxification Program

Welcome to DOWNTOWN INTEGRATIVE HEALTH GROUP and thank you for the opportunity to help you with your health. To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly.

PERSONAL INFORMATION

Name _____ Date _____
Address _____
City, Province _____ Postal Code _____
Phone: Home _____ Business _____ Cell _____
E-mail _____ Alberta Health Card Number _____ - _____
Date of Birth (D/M/Y) _____ Age _____ Male [] Female []
Occupation _____ Employer _____
Contact Person _____ Their phone number _____
Do you have extended health care benefits? **Yes** **No** With whom? _____

CURRENT HEALTH CONCERNS

What are the most important health concerns for which you are seeking treatment from us or are receiving elsewhere? List in order of importance to you.

1. _____
2. _____
3. _____

What do you hope to receive from this detoxification? _____

Have you ever participated in a detoxification or cleanse before? **Yes** **No** If yes, what have you done?

HEALTH HISTORY

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking, the dosage and the reason for using them:

1. _____
2. _____
3. _____
4. _____

Please list any prescription and non- prescription medications, vitamins and other supplements, the dosage and reason for using them.

1. _____
2. _____
3. _____
4. _____

Please list all of your known medical conditions (i.e. Irritable Bowel Syndrome, Heart disease, Gallstones, Gout, Liver disorders, Cancer, Diabetes, Hemorrhoids).

1. _____
2. _____
3. _____
4. _____

REVIEW OF SYSTEMS

Please check the box if you are currently experiencing any of these symptoms.

- Mental/Emotional:** Mood swings Anxiety or nervousness Poor concentration
 Memory Problems Depression Anger
- Endocrine:** Thyroid disease Heat or Cold Intolerance Diabetes
 Sugar Sensitivities Fatigue Weight loss/Weight gain
- Immune:** Chronic Infections Chronic swollen glands Slow wound healing
 Frequent colds
- Skin:** Rashes Eczema, Hives Acne, Boils Itching
- Head:** Headaches Migraines Head Injury
- Ears:** Earaches Impaired Hearing Dizziness Ringing in Ears
- Nose and Sinuses:** Nosebleeds Seasonal Hay fever Sinus problems Loss of smell
- Mouth and Throat:** Frequent sore throat Sore tongue/lips Tonsils removed
 Change or loss of taste
- Respiratory:** Cough Wheezing Asthma Bronchitis Emphysema
 Chronic Phlegm Pneumonia
- Cardiovascular:** Heart disease High/Low Blood Pressure Palpitations
 Arrhythmia High Cholesterol Cold extremities
- Gastrointestinal:** Heartburn Belching or Passing Gas Change in thirst Change in Appetite Constipation Diarrhea
- How many bowel movements do you have per day? ____ Per week? ____
- Have you ever had parasites? **Yes** **No** **Don't know**
- Have you ever had a colonoscopy? **Yes** **No**

Genital-urinary: Difficulty with urination and/or frequent urination Frequent night time urination Incontinence Discharge or sores Chronic Infections

FEMAIL: Irregular periods Severe cramping Heavy bleeding Vaginal dryness
 Vaginal discharge Vaginal odor

Nervous System: Numbness/pain in extremities Tingling in hands or feet Paralysis

Musculoskeletal: Joints: pain/swelling/stiffness
Muscles: aches/cramps
Spine: recurrent neck or back pain spreading pain to arms or legs

Do you smoke? **Yes** **No** How many per day? _____ How many years? _____

Chew tobacco? **Yes** **No** How many per day? _____ How many years? _____

Have you ever tried to stop? **Yes** **No**

Do you drink alcohol? **Yes** **No** How often? daily weekly infrequently

Do you use recreational drugs? **Yes** **No** How often? daily weekly infrequently

How often do you eat out per week? less than 3 between 4 and 8 over 9

What would you say about your diet? needs significant improvement ok for now very healthy

Do you drink coffee? **Yes** **No** How many cups/day? _____

Have you any diet preferences or restrictions? vegetarian celiac other: _____

DETOXIFICATION CONSENT FORM

I, the undersigned, acknowledge that I am voluntarily participating in this supervised Wellness Detoxification program. I understand this program is intended to provide the tools necessary to aid my body in its detoxification processes. During the detoxification program I agree to continue taking all my current prescribed medications unless modified by the prescribing physician.

I agree to disclose and/or consent to release all information, including that know by other health providers, where that information might affect my response to the detoxification program.

I understand and acknowledge that Downtown Integrative Health Group (DIHG), its director, clinical and administrative staff are not responsible for possible adverse or side- effects of the detoxification program and release Downtown Integrative Health Group, its director, clinical and administrative staff from any liability for my health that may arise because of my participation in this detoxification program.

Name: _____

Signature: _____ Date: _____

Witness: _____

Signature: _____ Date: _____