# Mary Galic, ND
**(416) 708-4836**

Date: __________________

Name: __________________________________________________

Email__________________________________________________

Address: ____________________________________________________________________________________

Phone: (home) _______________ (work) _______________ Occupation: ____________________________

Age:_____________ Date of Birth: __________________________

Weight: _________________ Height: _________________ Blood Type: _________________

Marital Status: _________________________________ Children: (no/yes - how many?) _____________________

Contact in Case of Emergency: ________________________________________ (phone)__________________

Name & Address of MD:

________________________________________________________________________

**WHAT ARE YOUR MAJOR HEALTH CONCERNS?**

1 ____________________________________________________________________________________________

2 ____________________________________________________________________________________________

3 ____________________________________________________________________________________________

4 ____________________________________________________________________________________________

5 ____________________________________________________________________________________________

Describe a typical day's diet

| Breakfast |
|---|
| Lunch |
| Dinner |
| Snacks |
| Beverages |

**HEALTH AND LIFESTYLE ASSESSMENT**

- Rate your average energy level: (lowest) 1 2 3 4 5 6 7 8 9 10 (highest)
- Rate your usual stress level: (lowest) 1 2 3 4 5 6 7 8 9 10 (highest)
- What causes stress in your life? _______________________________________________________________
- What kind of exercise do you get?_______________________________________________________________

- How well do you sleep? ____________________
- How would you describe your emotional life? ____________________
- How would you describe your diet? ____________________
- Do you have food reactions/allergies? ____________________
- How do you feel after eating? ____________________
- How is your appetite? ____________________
- Do you tend to have constipation/diarrhea? ____________________
- Are you or have you been a smoker? ____________________
- How much coffee/tea __________ , alcohol __________ , tobacco products __________ do you consume?
- Do you have frequent infections? ____________________
- Do you feel your health is getting better/worse? ____________________
- Do you use recreational drugs? ____________________
- Are you satisfied with your relationships? ____________________
- Are you satisfied with your career/work? ____________________

**MEDICAL HISTORY**

- What hospitalizations/surgery have you had? ____________________

____________________

____________________

- Circle any of the following health conditions you have now or have had:

| | | | | |
|---|---|---|---|---|
| Abscesses | Alcoholism | Anemia | Arthritis | Allergies |
| Asthma | Cancer | Chicken Pox | Cold Sores | Depression |
| Diabetes | Emphysema | Epilepsy | Gall Stones | Goitre |
| Gonorrhea | Gout | Hay Fever | Heart Disease | Hepatitis |
| Herpes Genitalia | High Cholesterol | High Blood Press. | Influenza | Kidney Disease |
| Leukemia | Malaria | Measles | Migraines | Miscarriage |
| Mononucleosis | Mumps | Parasites | Pleurisy | Pneumonia |
| Prostatitis | Psoriasis | Rheumatic Fever | Rubella | Scarlet Fever |
| Skin Disease | Strep Throat | Sinusitis | Stroke | Syphilis |
| Tonsillitis | Tuberculosis | Typhoid Fever | Venereal Warts | Warts |
| Whooping Cough | Worms | Yellow Fever | | |

- Any other present or past health conditions? ____________________

____________________

____________________

- Are there any of the preceding conditions after which you have never felt totally well again?

_______________________________________________________________________________

_______________________________________________________________________________

- What have been the major traumas in your life? (accidents, injuries, emotional traumas, deaths of loved ones, separations, etc)

_______________________________________________________________________________

_______________________________________________________________________________

**CURRENT MEDICATIONS**

Please list all prescription, over the counter and supplements you are currently taking.

| **Medication** | **Strength** (i.e 400 IU) | **Amount** (i.e one) | **Time** AM/PM | **Date** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**WOMEN'S HEALTH**

| **Symptom** | **Yes** | **Sometimes** | **Never** | **Symptom** | **Often** | **Sometimes** | **Never** |
|---|---|---|---|---|---|---|---|
| Hot Flashes/Flushes | | | | Mood Changes | | | |
| Night Sweats | | | | Irritability | | | |
| Depression | | | | Forgetfulness | | | |
| Fatigue | | | | Difficulty Concentrating | | | |
| Acne | | | | Vaginal Dryness | | | |
| Hair Thinning/ Loss | | | | Painful Intercourse | | | |
| Headaches/Migraines | | | | Decreased Sex Drive | | | |
| Insomnia/Sleep Disorders | | | | Breast Tenderness | | | |
| PMS | | | | Urinary Tract Infections | | | |
| Bloating | | | | Yeast Infections | | | |
| Weight Gain | | | | Joint Tenderness | | | |

Do you perform monthly self breast examinations? _ Yes _ No

Age of first menses:_____________________ Age of last menses (if applicable):___________________

Still Menstruating: Y or N Regular Periods: Y or N Duration of cycle: _______________

Number of pregnancies:_________________ Number of Live Births:________________

Birth Control Pills: Y or N Premarin/Prempro: Y or N Date Discontinued________________

**MEN'S HEALTH**

| Symptom | Yes | Sometimes | Never | Symptom | Often | Sometimes | Never |
|---|---|---|---|---|---|---|---|
| Loss of Libido | | | | Mood Changes | | | |
| Stamina Decrease | | | | Irritability | | | |
| Weight Gain | | | | Forgetfulness | | | |
| Muscle Building Difficulty | | | | Difficulty Concentrating | | | |
| Acne | | | | Joint Tenderness | | | |
| Hair Thinning/ Loss | | | | Frequent Urination | | | |
| Headaches/Migraines | | | | Urinary Tract Infections | | | |
| Insomnia/Sleep Disorders | | | | Other | | | |
| Fatigue | | | | | | | |
| Erectile Dysfunction | | | | | | | |

**FAMILY HISTORY**

| Relation | Age | State of Health | Age of Death and Cause (if applicable) | Check and Designate if Near Relatives Had |
|---|---|---|---|---|
| Mother | | | | _ Tuberculosis<br>_ High Blood Pressure<br>_ Heart Disease<br>_ Migraine<br>_ Strokes<br>_ Cancer<br>_ Allergies/Asthma<br>_ Arthritis<br>_ Kidney Disease<br>_ Nervous Troubles<br>_ Diabetes |
| Father | | | | |
| Grandmother - Maternal | | | | |
| Grandfather - Maternal | | | | |
| Grandmother - Paternal | | | | |
| Grandfather - Paternal | | | | |
| Sibling (M) (F) | | | | |
| Sibling (M) (F) | | | | |
| | | | | |