newleaf
total wellness centre

DR. PHIMISTER

Confidential Patient History

Please complete the following mandatory questionnaire. Your answers will help us determine the best approach for your pain management care. Thank you!

Full Name: ____ DOB: ______________________

PAIN HISTORY

Describe when and how your chronic pain started: ____

____

Briefly describe your pain story: ____

____

____

Past pain treatments included: ____

Current pain treatments include: ____

TRAUMA HISTORY

Describe any motor vehicle accident injuries with year(s) and recovery: ___________________________

____

Describe any head injuries with year and recovery: ____

____

Describe any other significant injuries with year and recovery: __________________________________

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MEDICAL HISTORY

Current medical conditions include: ____

____

Other past medical conditions include: ____

____

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Past surgical procedures include: ____

____

Medications taken: ____

____

Supplements taken: ____

____

Allergies to medications include: _______________________________________

Family pain history includes: ____

Other ongoing symptoms include: _______________________________________

____

CHILDHOOD HISTORY

Birth: ☐ Vaginal ☐ C-Section Breastfed: ☐ Yes ☐ No Antibiotics as child: ☐ Yes ☐ No

Describe your experience in general: ____________________________________

____

Any neglect/abuse ☐ Yes ☐ No If yes: ☐ Physical ☐ Emotional ☐ Verbal ☐ Sexual
Any comments: ____

____

Describe your personality: ____

Parents' personalities were: ____

Siblings' personalities are now: ____

SOCIAL HISTORY

Employed: ☐ Yes ☐ No If yes, what is your occupation? _________________________

On Disability: ☐ Yes ☐ No If yes, for how long? ______________________________

Martial Status: ________________________ Number of children: _________________________

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Diet: Describe in a few words: ____

Foods/Drinks: Circle what you eat/drink: bread-gluten / rice/ oats / potatoes / sweet potatoes - yams / legumes-beans /tomatoes/ cucumbers / peppers / eggplant / zucchini / green salad / vinegar/ olive oil / lemon / meat / poultry/ fish / eggs / cow milk/ cheese / peanuts / cashews / other nuts / fruits / avocado / flax seed / hemp seed / red wine / coffee - cream / dark chocolate>70% / tea

Water: How many glasses (250ml) drank per day: ______________ Other drinks: _________________

Exercise: ☐Yes ☐ No If yes, describe: ____

Cigarette smokes / Vape per day: ___________________ Alcohol drinks per week: ______________

Marijuana: ☐Yes ☐No If yes: Joints/Edibles per Day/Week/Month (circle one with #)________

Other street drugs: ☐Yes ☐No If yes: Which ones and how often? __________________________

PHYSCIOLOGICAL – SPIRITUAL HISTORY

How are you feeling today? ____

Circle if you have had any of the following: anxiety depression bipolar addictions eating disorder other: ___________________

Circle if you have these stressors: Ill health work money relationships future family other: ___________________

Circle if you have these spiritual practices: being in nature meditation mindfulness faith prayer reading holy book other: ___________________
If appropriate, what religion are you associated with? ____

OTHER

If you want to share any other information you feel relevant to your health, please do: (use other side of paper if needed)

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