PATIENT INTAKE FORM

This information is strictly confidential and is only used in accordance with our privacy policy.

Personal Information

Full Name____ Date ____________________
Date of birth _______________________ Age ______ Sex: Male Female
Address ____ City _______________________
Province __________________________ Postal Code ___________________
Phone: Home _____________________ Work _______________________ Other ____________
Personal email ____________________________
May we leave messages relating to your visits? Yes No
Do you want to receive our newsletter? Yes No

Marital Status: Single Married Widowed Divorced Separated Common-Law
Number of Children: ____________
Occupation: _______________________________ Employer: ___________________________

Emergency contact:
Name _____________________Relation ______________________ Phone _________________
How did you hear about our clinic? ____

Other health care providers (family physician, specialists, complementary and alternative therapy):
1.________________________ 2.________________________ 3.________________________
Tel:_____________________ Tel:______________________ Tel:______________________

What are your main health concerns that you would like addressed:
1. ____
2. ____
3. ____
4. ____
5. ____

If you are female, are you currently pregnant? Yes No

Medical history

How would you describe your general state of health?

Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates. If "yes" indicate current with "C", past with "P"

	Yes	No		Yes	No		Yes	No
Anemia			Diabetes			Kidney Disease		
Arthritis			Epilepsy			Liver Disease		
Asthma			Gallbladder Disorder			Multiple Sclerosis		
Cancer			Heart Disease			Rheumatic fever		
Crohn's or Ulcerative colitis			Hepatitis			STD		
Depression			HIV/AIDS			Thyroid disorder		

Other:

____

____

Do you have any allergies (medicines, environmental, etc.)?

____

____

Please list all current medications, including dosages, duration of use and why you are taking them.

Medication	Dose	Duration	Condition Treating

Please list all natural health products you are taking (vitamins, supplements, herbs, homeopathics)

Natural Health Product	Dose	Duration	Condition Treating

Please list past prescription medications.

____
____

How frequently are you treated with antibiotics? ____________________________________

Do you regularly use any of the following?

Aspirin	Laxatives	Antacids	Diet pills
Birth control pills	Implants	Injections	

Alcohol—how much/ day or week ____
Tobacco—form and amount/day ____
Caffeine—form and amount/day ____
Recreational drugs—what and how often ____

Please indicate which immunizations you have had:

DPT (diphtheria, pertussis, tetanus)	Haemophilus influenza B	Hepatitis A
Tetanus booster; when? ________________	"Flu"	Hepatitis B
MMR (measles, mumps, rubella)	Polio	Smallpox

Other ____
Please indicate if any caused adverse reactions:

____
____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Yes No

When were your most recent tests performed? ______________________________________

Skin and Hair (Please check conditions that affect you presently)

Rashes	Ulcerations	Eczema	Loss of hair
Change in hair or skin texture		Pimples	Recent moles
Itching	Changing moles	Hives	Dandruff

Any other hair or skin problems? ____

Head, Eyes, Ears, Nose and Throat

Dizziness	Concussions	Migraines	Glasses/contact
Eye strain	Eye pain	Poor vision	Night Blindness
Color blindness	Cataracts	Blurry vision	Earaches
Ringing in ears	Poor hearing	Spots in front of eyes	
Sinus problems	Nosebleeds	Recurrent sore throats	
Grinding teeth	Facial pain	Sores on lips or tongue	
Teeth problems	Jaw clicks	Macular degeneration	

Headaches (where and when)?____
Any other head or neck problems? ____

Cardiovascular

High blood pressure	Low blood pressure	Chest pain
Irregular heartbeat	Dizziness	Fainting
Cold hands or feet	Swelling of hands	Swelling of feet
Blood clot	Phlebitis	Difficulty in breathing

Any other heart or blood vessel problems? ____________________________________

Respiratory

Cough   Coughing blood   Bronchitis   Pneumonia
Pain with deep breath   Asthma   Difficulty in breathing when lying down

Production of phlegm (what colour)? ____

Any other lung problems? ____

Gastrointestinal

Nausea	Indigestion	Black stools	Vomiting
Belching	Blood in stools	Constipation	Gas
Rectal pain	Diarrhea	Hemorrhoids	Abdominal pain
Itchy rectum	Chronic laxative use	Bad breath	

Any other problems with your stomach or intestines? _____________________________

Genito-Urinary

Pain on urination	Freq. urination	Blood in urine	Urgency to urinate
Unable to hold urine	Kidney stones	Decrease inflow	Impotency
Recurrent UTIs	Sores on genitals	Yeast infections	

Do you wake to urinate (how often)?____

Any particular colour to your urine?____

Any other problems with your genital or urinary system? ______________________

Pregnancy and Gynecology – Women only

Age at first menses _______Length of cycle ________ Duration of menses __________

Unusual menses	Painful periods	Clots	Heavy ☐ Light
Irregular periods	Last PAP ____________________		Vaginal discharge
Vaginal sores	Breast lumps		

Changes in body / psyche prior to menses __________________________________

Do you practice birth control? Y /N
What type and for how long? ____
Could you be pregnant now? Y/N (circle Yes if it is possible)
1st day of last menses: ______________

Number of pregnancies _____________
These pregnancies resulted in:
Premature births: ______ Abortion: _______ Miscarriage: _______
Full term birth: ______ Postdate birth: _______
Any other obstetrical or gynecological issues? ______________________________
____

Musculoskeletal

Neck pain | Muscle pain | Knee pain | Back pain
Muscle weakness | Foot/ ankle pain | Hand/ wrist pain
Shoulder pain | Any other joint or bone problems? ______________________________

Neuropsychological

Seizures | Dizziness | Loss of balance | Numb regions
Lack of coordination | Poor memory | Concussion | Depression
Anxiety | Quick temper | Irritable
Easily susceptible to stress
Have you ever been treated for emotional problems? Y / N
Have you ever considered or attempted suicide? Y / N
Any other neurological or psychological problems?
____

COMMENTS

Please indicate any other concerns you would like to discuss:
____
____

Diet

Do you have any food allergies or intolerances? Please list.
____
____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?
____
____

Family History

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

I don't know my family medical history

Environment

Occupation ____

Hobbies____

Do you exercise regularly? Yes No

What do you do for exercise, for what duration and how often?

____

____

Are you exposed to significant tobacco smoke (at work, home, etc.)? Yes No

Are you frequently exposed to animals (work, pets, etc.)? Yes No

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

____

____

How would you describe the emotional climate of your home?

____

____

How would you rate your stress levels?

Overwhelming High Moderate Low Minimal

Is there anything that you feel is important that has not been covered?

____

____

____

____

Would like to learn more about:

Homeopathy
EFT
Nutrition Counseling
The Bowen Therapy
VEGA testing
Botanical Medicine