

DATE _____

CONFIDENTIAL ADULT PATIENT INTAKE FORM

_____ SEX _____ BIRTHDATE ____/____/____
First Name Middle Name Last Name D M Y

HOME ADDRESS _____
Street City/Province Postal Code

HOME PHONE _____ WORK _____ CELL _____

EMAIL _____ OK to receive clinic notices Email for private use only

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____
Name Relationship Phone

REFERRED BY: _____ GUARDIAN (if child) _____

CARECARD NUMBER: _____ FAMILY M.D. _____

WHEN WAS YOUR LAST VISIT TO YOUR MD? _____

ARE YOU SEEING ANY MEDICAL SPECIALISTS? Y N IF YES, FOR WHAT PURPOSE? _____

PRACTITIONER(S) I'VE SEEN RELATED TO MY MAJOR CONCERN:

Name	Type of Practitioner	Treatment(s)
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DO YOU HAVE ANY KNOWN CONTAGIOUS ILLNESSES AT THIS TIME? Y N IF YES, WHAT? _____

DO YOU HAVE ANY KNOWN ALLERGIES/SENSITIVITIES? Y N IF YES, PLEASE LIST:

FOODS _____ DRUGS (e.g. Penicillin) _____

ENVIRONMENTAL OR CHEMICALS (pollen, perfume, sulphites, latex) _____

EXPOSURE TO TOXINS (glues, pesticides, dye, ink) _____

CURRENTLY ON A DIET OR AVOIDING CERTAIN FOODS? _____

HEALTH HISTORY QUESTIONNAIRE

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? _____

WHAT ARE YOUR MOST IMPORTANT HEALTH CONCERNS? PLEASE LIST IN ORDER OF IMPORTANCE TO YOU:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PAST & PRESENT ILLNESSES (asthma, bronchitis, hepatitis, eczema, cancer, etc., including hospitalizations):

PAST ACCIDENTS/INJURIES/TRAUMAS (MVA, head injury, fractures, recurrent sprains, whiplash, sciatica, etc.):

IMAGING (X-rays, CT scans, MRIs; please note dates if possible): _____

SCARS, SURGERIES (include small scars, tonsils, wisdom teeth, tattoos, stitches, mole removals): _____

CHRONIC OR CURRENT PAIN (low back, headache, TMJ) _____

MOTHER'S FAMILY HISTORY: _____

FATHER'S FAMILY HISTORY: _____

CURRENT PRESCRIPTIONS OR OVER THE COUNTER MEDICATIONS (include dose & brand name if known):

CURRENT REMEDIES (nutritional, herbal, vitamins, minerals, homoeopathic; dose & brand name if known):

PAST PRESCRIPTION MEDICATIONS AND/OR NATURAL HEALTH PRODUCTS:

HEIGHT _____ WEIGHT _____ WEIGHT 1year ago _____

WHEN DURING THE DAY IS YOUR ENERGY BEST? _____ WORST? _____

DO YOU SMOKE CIGARETTES? Y N In the past # pack(s)/day _____ # years? _____

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ALCOHOL USE ? Y N type _____ frequency _____

COFFEE Y N cups/day _____ TEA Y N cups/day _____ WATER Y N cups/day _____

RECREATIONAL DRUG/MARIJUANA USE? Y N No answer type _____ frequency _____

OF DENTAL: EXTRACTIONS _____ ROOT CANALS _____ SILVER FILLINGS _____

PLEASE INDICATE WHICH VACCINATIONS YOU HAVE HAD:

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza b (Hib) | <input type="checkbox"/> Polio |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Influenza (seasonal flu shot) | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> HPV |

Date of last Tetanus booster _____

Other, please list _____

Please indicate if any caused adverse reactions: _____

HOW MANY HOURS SLEEP DO YOU GET ON AVERAGE? _____ HOW MANY TIMES DO YOU WAKE UP? _____

IS YOUR SLEEP PATTERN MOSTLY CONSISTENT? Y N DO YOU WAKE UP RESTED? Y N SOMETIMES

DO YOU HAVE DIFFICULTY FALLING ASLEEP? Y N STAYING ASLEEP? Y N

WHAT DO YOU DO FOR EXERCISE (activity, intensity, frequency)? _____

DO YOU HAVE ANY MAJOR STRESS FACTORS? On a scale of 1-10 (10 = highest) _____

DO YOU HAVE SUPPORTIVE RELATIONSHIPS? On a scale of 1-10 (10 = highest quality of support) _____

INTERESTS, HOBBIES, SPIRITUAL PRACTICE OR RELIGION _____

WHAT HOPES OR EXPECTATIONS DO YOU HAVE OF BEING A PATIENT AT OUR CLINIC?

DO YOU HAVE ANY CONCERNS ABOUT NATUROPATHIC TREATMENT? (diet change, supplements, needles, appointments, homework, cost, etc.)

REVIEW OF SYSTEMS

NOW PAST ENDOCRINE

		Thyroid Problems
		Dysglycemia/hypoglycemia
		Diabetes
		Excess thirst or hunger

IMMUNE

		Recurrent infections
		Recurrent or chronic swollen glands, sore throat
		Poor wound healing

CARDIOVASCULAR

		Murmurs
		Blood clots
		Ankle swelling
		Palpitations or rapid heart beat
		Cold hands/feet
		Varicose or spider veins
		Anemia
		Easy bruising and bleeding
		Other blood disorder
		Chest pains
		Pain over heart
		Blood clots
		Blood pressure problems

RESPIRATORY

		Difficulty breathing, short of breath
		Persistent cough
		Coughing phelgm
		Dry cough
		Wheezing
		Nasal discharge, post nasal drip

MENTAL/EMOTIONAL

		Depression or seasonal affective disorder
		Anxiety/panic attacks
		Inability to concentrate, focus, multi-task
		Mood swings
		Irritability
		Forgetful, confusion, memory loss

NOW PAST MUSCULO SKELETAL

		Low back pain
		Pain between shoulders
		Neck problems
		Arm problems
		Leg problems
		Swollen joints
		Painful joints
		Stiff joints
		Sore muscles
		Weak muscles
		Walking problems
		Ruptures, hernia
		Broken bones
		TMJ

GASTRO INTESTINAL

		Excessive burping
		Excessive bloating, gas, flatulence
		Reflux, heartburn, hiatal hernia
		Abdominal pain or cramping
		Ulcers
		Constipation
		Diarrhea
		Stools with blood or mucous
		Undigested food in stools
		Nausea, vomitting
		Liver problems
		Gall bladder problems
		Difficulty chewing or swallowing
		Cravings
		Poor appetite
		Weight trouble

GENITO URINARY

		Bladder trouble
		Painful urination
		Scanty urination, dribbling
		Excessive urination
		Discoloured or smelly urine

NOW PAST EYES, EARS, NOSE AND THROAT

- Eye strain
- Eye inflammation, bloodshot
- Eye pain, light sensitivity
- Vision loss, change
- Ear pain
- Ear ringing, noise
- Ear discharge, excessive wax
- Hearing loss
- Recurrent nose bleeds
- Nose discharge, sniffing
- Sinus pressure, pain
- Loss of smell or taste
- Snoring or sleep apnea
- Hayfever
- Dental problems
- Gums sore, bleeding, excessive receding
- Sore mouth, cancrs
- Recurrent sore throat, swollen glands

NOW PAST NERVOUS SYSTEM

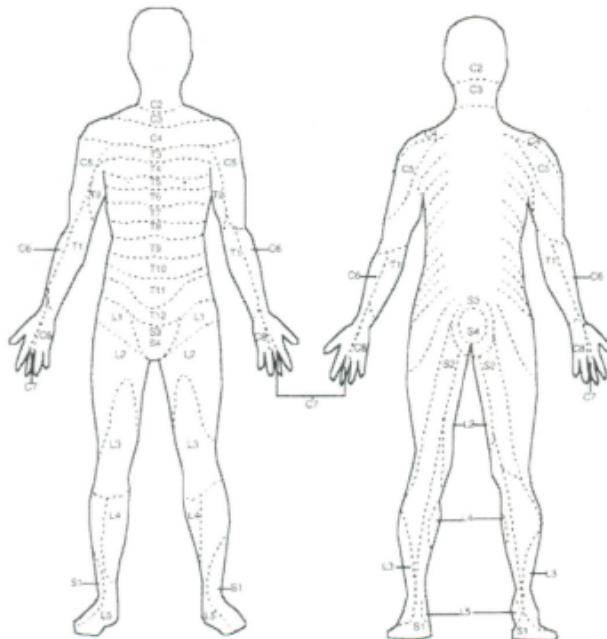
- Poor balance, accident prone
- Muscles always tight
- Muscle twitching, jerking
- Numbess, tingling
- Complete loss of feeling
- Head injury, concussion
- Major chronic pain
- Headaches, migraine
- Dizziness, vertigo, fainting
- Convulsion, epilepsy
- Pinched nerve, sciatica
- Neuropathy

FEMALE SYSTEM

- Menstrual problems
- Menopausal symptoms
- Vaginal pain, discharge, bleeding
- Sore breasts, lumps

OTHER _____

Please mark areas of symptoms on the figures



XXX pain ///// tingling \\\\ num vvv stiffness

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