

## New Patient Intake Form for Adalen Holistic

### Personal Information

Full Name \_\_\_\_\_ Date \_\_\_\_\_  
Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: ☐ Male ☐ Female  
Birthplace \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Work \_\_\_\_\_  
Other \_\_\_\_\_  
Personal email \_\_\_\_\_  
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?

\_\_\_\_\_

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.

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

[illegible]

Please list all natural health products you are taking:

| Natural Health Product | Dose | Duration | Condition Treating |
|------------------------|------|----------|--------------------|
|                        |      |          |                    |
|                        |      |          |                    |
|                        |      |          |                    |
|                        |      |          |                    |
|                        |      |          |                    |
|                        |      |          |                    |

Please list past prescription medications.

How frequently are you treated with antibiotics?

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Do you regularly use any of the following?

☐ Aspirin ☐ Laxatives ☐ Antacids ☐ Diet pills

☐ Birth control pills ☐ Implants ☐ Injections

Please list any surgeries, dates of surgery and any complications (please include all cosmetic and elective surgeries as well as dental surgery)

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

Average daily water consumption \_\_\_\_\_ Type \_\_\_\_\_

Sleep posture: side \_\_\_\_\_ back \_\_\_\_\_ stomach \_\_\_\_\_

Number of hours sleep per night \_\_\_\_\_

Quality of sleep (Refreshing, unbroken)

\_\_\_\_\_  
Sleep environment (Quiet, peaceful, 100% darkness):

\_\_\_\_\_  
Did/do you wear braces on your teeth? No \_\_\_\_\_ Yes \_\_\_\_\_ # months/years

\_\_\_\_\_  
Did/do you wear a dental appliance? No \_\_\_\_\_ Yes \_\_\_\_\_

Did/do you have mercury dental amalgam? No \_\_\_\_\_ Yes \_\_\_\_\_ Explain:

\_\_\_\_\_  
Do you drink alcohol? (Daily average) \_\_\_\_\_

Do you smoke? (Daily average) \_\_\_\_\_

Weekly consumption of beverages? Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Soft Drinks \_\_\_\_\_

Other \_\_\_\_\_

Do you use 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

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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?

| MUSCLES/JOINTS/NERVES<br>C P           | HEART/CIRCULATION<br>C P                | GENERAL/SYSTEMIC<br>C P                |
|----------------------------------------|-----------------------------------------|----------------------------------------|
| Head and Neck                          | ___ ___ high/low blood pressure         | ___ ___ anxiety/stress                 |
| ___ ___ headaches/migraines            | ___ ___ chest pain/angina               | ___ ___ fatigue/insomnia               |
| ___ ___ neck pain/whiplash             | ___ ___ heart attack/stroke             | ___ ___ eating disorder                |
| ___ ___ tingling/numbness              | ___ ___ heart disease                   | ___ ___ drug/alcohol issues            |
| ___ ___ tooth/jaw/ear pain/TMJ         | ___ ___ pacemaker                       | ___ ___ fibromyalgia/chronic fatigue   |
| ___ ___ vision condition (s)           | ___ ___ bruise easy                     | ___ ___ osteoarthritis/osteoporosis    |
| ___ ___ hearing condition/dizziness    | ___ ___ arrhythmia                      | ___ ___ inflammatory arthritis         |
| ___ ___ head trauma/concussion         | ___ ___ phlebitis/thrombosis            | ___ ___ diabetes                       |
| ___ ___ loss of coordination           | LUNGS RESPIRATION                       | ___ ___ undiagnosed lump               |
| Trunk                                  | ___ ___ shortness of breath             | ___ ___ cancer                         |
| ___ ___ back pain/injury/scoliosis     | ___ ___ chronic cough                   | ___ ___ epilepsy                       |
| ___ ___ degenerative/herniated disc    | ___ ___ asthma bronchitis               | ___ ___ TB/hepatitis/HIV               |
| ___ ___ hip pain/sciatica              | ___ ___ emphysema                       | ___ ___ internal pins/plates/wires     |
| Arms / Hands / Legs / Feet             | DIGESTION                               | ___ ___ artificial joints              |
| ___ ___ pain/tingling                  | ___ ___ IBS/Crohn's/colitis             | WOMEN                                  |
| ___ ___ weakness/numbness              | ___ ___ Celiac disease                  | ___ ___ menstrual changes/problems     |
| ___ ___ fractures/strains/sprains      | ___ ___ constipation/diarrhea (chronic) | ___ ___ endometriosis                  |
| ___ ___ tendonitis/fibrositis/bursitis | ___ ___ nausea/bloating/gas (chronic)   | ___ ___ PMS/menopausal complications   |
|                                        |                                         | ___ ___ other gynecological conditions |
|                                        |                                         | ___ ___ pregnant –due date?            |
|                                        |                                         | _____                                  |
|                                        |                                         | ___ ___ other _____                    |
|                                        |                                         | _____                                  |

|                                                                                                                                                                                                        |                                                                                                                                           |                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| ___ ___ osteo/rheumatoid arthritis<br>___ ___ muscle/nerve disease<br>Skin<br>___ ___ lack of sensation/numbness<br>___ ___ irritated condition/frostbite<br>___<br>___eczema/psoriasis/skin infection | ___ ___ ulcer/hernia<br>UROGENITAL<br>___ ___ liver/gall bladder<br>___ ___ urinary infection/disease<br>___ ___ kidney infection/disease | MEN<br>___ ___ prostate problem<br>___ ___ other |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|

All Current (C) and Past Conditions (P). Check box if applicable; Circle specific conditions.

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 / mental health 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? \_\_\_\_\_

## Diet

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

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

Family History (☐ I don't know my family medical 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            |      |                       |      |

Environment

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?

### **Statement of Acknowledgement**

Each patient seeking care from Adalen Holistic should understand that the Heilkunst Practitioner is certified and specialized in Heilkunst Treatment and is not a Medical Doctor. If standard medical diagnosis or treatment is required, it must be obtained from a licensed Medical Doctor.

### **Patient Consent Form**

Privacy of your personal information is an important part of providing you with quality care. This document is confidential information and will not be released to any persons without your consent.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Adalen Holistic respects your rights to privacy. This information will remain on your file and will be accessed solely as a resource for your personal treatment and for the purpose of confirming your appointments. If any other situation arises, your consent will be sought