Patient Intake Form

Name: ____

Address: ____

City: ____________ Province: __________ Postal Code: ____________

Phone (home): __________ (work): __________ (cell): ____________

Male ☐ Female ☐ Date of Birth: ________________ Age: __________

Occupation: ____________________ Employed by: ________________

Marital status: ______________________ Number of children: __________

Best contact # to reach you at? __________ May we leave a message? YES / NO

Emergency contact: ____________ Phone: ________ Relation to you: ______

Name of Medical Doctor: ____________________ Phone: ____________

How did you hear about us? Friends Family Presentation Website Newspaper Other:

> This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless authorized by you in writing.

Health Concerns

What are your main health concerns, in order of importance to you?

Vitamins and Supplements

Please list all vitamins/ mineral/ herbal supplements you are currently taking:
*** Please bring all supplements to initial visit***

Supplement (Including brand)	Dosage	When did you begin taking this supplement?

Medications

Please list all prescription and non-prescription medications you are currently taking:
Please bring in all medications to initial visit

Medication	Dosage	When did you begin taking this medication?

Please list all prescription medications you have taken in the past for longer than six months. How long did you take each medication?

Family History

Next to each family member listed below, please indicate if the person is living (L) or deceased (D). Include present age or age at time of death. Please note if the family member suffered from any disease such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, asthma, allergies, arthritis, etc.

Relationship	L/D	Age	Disease suffered/ Cause of death
Mother			
Father			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Sister(s)			
Brother(s)			
Maternal Aunts			
Maternal Uncles			
Paternal Aunts			
Paternal Uncles			

Medical History

Please list any injuries and/or major surgery you had in the past, and when they occurred:

Please list any major illnesses or diseases you have or had in the past:

Vaccinations (please check):

☐ DPT (Diphtheria, Pertussis, Tetanus)
☐ MMR (Measles, Mumps, Rubella)
☐ Chicken Pox
☐ Polio
☐ Flu Shot
☐ Hepatitis A
☐ Hepatitis B
Other: ____________________

Did you experience any adverse effects from any of these vaccinations? If yes, please explain:

Please check "✔" any of the following that you have experienced in the past or are suffering from now:

General
- Fatigue
- Change in appetite
- Change in thirst
- Cravings
- Weight gain
- Weight loss
- Poor sleep
- Chills or fever
- Night sweats
- Sweat easily
- Allergies
- Cancer
- Diabetes

Skin and Hair
- Dryness
- Rash
- Itching
- Eczema
- Psoriasis
- Acne
- Recent moles
- Hives or allergic reactions
- Loss of hair
- Thinning hair
- Dandruff
- Other skin problem(s)

Eyes Ears Nose & Throat
- Eye pain
- Eye strain
- Blurry vision
- Impaired vision
- Cataracts
- Earaches
- Ear infections
- Ringing in ears
- Vertigo or dizziness
- Sinus infections
- Nasal obstruction
- Post nasal drip
- Nosebleeds
- Loss of smell/ taste
- Sores in mouth
- Mercury fillings
- Jaw pain or clicks
- Recurrent sore throat
- Tonsillitis
- Enlarged glands
- Enlarged thyroid
- Facial pain/ tics
- Headaches

Cardiovascular
- Chest pain
- Palpitations
- High blood pressure
- Low blood pressure
- Heart attack
- Congestive heart failure
- Irregular heartbeat
- Pacemaker
- Artificial heart valve
- Stroke
- Fainting
- Varicose veins
- Deep leg pain
- Cold hands or feet
- Swelling of limbs
- Anemia
- Easy Bruising

Respiratory
- Difficulty breathing
- Shortness of breath
- Chronic cough
- Bronchitis
- Emphysema
- Asthma
- Wheezing
- Coughing blood
- Phlegm in throat

Muscle Bone & Joints
- Neck pain
- Back pain
- Arthritis
- Bursitis
- Joint pain or stiffness
- Artificial joint
- Muscle pain
- Muscle weakness

Gastrointestinal
- Nausea
- Vomiting
- Vomiting blood
- Reflux or heartburn
- Constant hunger
- Ulcer
- Indigestion
- Abdominal pain or cramping
- Bloating
- Gallstones
- Liver disease
- Jaundice
- Intestinal parasites
- Gas
- Constipation
- Diarrhea
- Chronic laxative use
- Rectal burning/ pain
- Hemorrhoids
- Blood in stool

Neurological
- Anxiety
- Depression
- Irritability
- Emotional problems
- Loss of balance
- Poor memory
- Dizziness
- Seizures/ Epilepsy
- Concussion
- Lack of Coordination
- Extremity numbness
- Extremity tingling
- Paralysis

Infections
- Strep throat
- Mononucleosis
- Tuberculosis
- Hepatitis
- HIV/ AIDS

Urinary
- Frequent urination
- Urgency to urinate
- Incontinence
- Pain on urination
- Waking at night to urinate
- Urinary tract infection
- Blood in urine
- Kidney stones
- Sexually transmitted disease

Male Reproductive
- Prostate problem
- Impotence
- Sores on genitals
- Discharge
- Testicular Mass
- Testicular pain
- Infertility/ low sperm count
- Hernia

Female Reproductive
- Irregular periods
  - Heavy
  - Light
  - Clots
- Painful periods
- PMS
- Sore breasts with menses
- Infertility
- Vaginal sores
- Vaginal discharge

Date of last Pap: ____________

Date of last menses: _________

Cycle lengths? ______________

Age of first menses? _________

Menopause onset? __________

Age of last menses: __________

Currently pregnant? YES / NO

Currently breastfeeding? Y / N

Do you use birth control? Y / N

Type: ____________________

Number of:
Pregnancies: _______________

Abortions: _________________

Miscarriages: _______________

Births: ____________________

Breasts
- Lumps
- Tenderness
- Nipple discharge

Do you do breast self-exams?
YES / NO

Personal Habits and Lifestyle

How would you rate your current stress level? Mild Moderate High Severe

What would you describe as your main cause(s) of stress?______________________________

Do you smoke? YES / NO If yes, how many per day?
If no, did yo smoke before? YES / NO If yes, how long ago?

Do you use any recreational drugs? YES / NO

How frequently do you move your bowels? ________ Per day or week?

How many hours of sleep do you get on average?
Do you feel refreshed in the morning? YES / NO

How many hours do you work each day?

Do you exercise? YES / NO If yes, how often? ____________________________________
What do you do for exercise? (list activities, frequency, intensity and duration)

Do you have pets in the house? YES / NO If yes, what type?
Do they sleep with you on the bed? YES / NO In the bedroom? YES / NO

Have you travelled outside of North America recently? YES / NO

Where did you travel? ____

Did you feel sick during or after the trip? YES / NO

What symptoms did you experience? ____

Diet

What diet do you follow? (circle) Non Vegetarian Vegetarian Vegan For how long?

Known Food Allergies/ Intolerance:

Known Environmental Allergies/ Sensitivities:

How many cups/ bottles/ glasses do you drink on average, each day?

Coffee	Milk 2%	Fruit Juice
Tea	Skim Milk	Soft Drinks (diet)
Water	Beer	Soft Drinks (regular)
Herbal tea	Wine	Vegetable Juice
Milk 1%	Liquor	Other

Circle the source of your drinking water:

Tap (city)	Well	Bottled (spring)	Filtered	Distilled

Diet Diary

In the space provided below, please list every food item that you consumed for at least a 7 day period. Take note of any physical symptoms or sensitivities that you may experience in the course of any given day. Take special note of gas, bloating, bowel movements, heartburn, and/ or any other irregularity.

Diet Diary

Breakfast							
Lunch							
Dinner							
Snacks							
Notes:							