

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
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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
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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 you 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
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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.

Notes: