Patient Intake

General Information

Name:____ **Today's Date:** _____________________

Date of birth:______/________/________ (D/M/Y) **Gender:** _________ **Occupation**__________________________

Address:____

Unit/Street number Street City Postal Code

Telephone number: Home:____________________ **Work**:____________________ **Cell:** ______________________

Cell Phone Provider:_________________________ This is for text reminders.

E-mail address: ____________________________

Would you like a reminder call for your appointments? Y / N by phone, text, or email (circle one)

Consent

By my signature below, I authorize consent to treatment and the collection, use and disclosure of personal information as defined in the personal information and protection act (PIPA), required for treatment and/or any related administrative purposes. I understand that all of my personal information is confidential and must be kept in accordance with PIPA..

______________________________ ___________________________

Signature **Date**

How did you hear about the Clinic?: Internet/Family/GP Referral/ Other:______________________ (Please circle one)

Emergency contact

Name: ____

Phone number:_________________________ Relation:____________________________

Other health care providers you are seeing:

( )	( )	( )	( )

Lifestyle

Habits (please check all that apply and frequency):

Alcohol______________________ Tobacco _________________________ Caffeine________________________________
Sugar _______________________ Recreational Drugs ________________ Other________________________________

Diet (without going into great detail, please describe your diet, indicating which foods you consume most often):

____

____

____

Do you have any dietary restrictions? (intolerance, allergy, religious, or ethical):________________________

____

Hobbies ____

____

Exercise (Please indicate your frequency of exercise):

☐ Daily ☐ 3-4 times weekly ☐1-2 times weekly ☐ not at all

Please describe your typical routine and/or list your favourite activities:

____

____

Medical Information

Allergies (medications, environmental, foods etc.):____

____

Medications and Supplements – Including dose (prescription, over-the-counter, vitamins, herbs, homeopathic, Chinese patents etc.):

____

____

____

Hospitalizations (Please note circumstances):____

____

____

Health Concerns (please briefly describe the reason for today's visit)**:**

____

____

____

Health Conditions (please check all that apply, past and present):

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Candida
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gallbladder problems
- ☐ German Measles
- ☐ Goiter
- ☐ Heart Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hernia
- ☐ Herpes Simplex 1
- ☐ Herpes Simplex 2
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Kidney Disorders
- ☐ Liver Disorders
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Measles
- ☐ Menstrual Disorders
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ OC Disorder
- ☐ Osteoarthritis
- ☐ Osteomalacia
- ☐ Osteoporosis
- ☐ Parkinson’s
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Disorders
- ☐ Psoriasis
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Urinary Tract Infections
- ☐ Venereal Disease
- ☐ Other_______________

Symptoms (please check any that apply; circle for emphasis):

GENERAL
- ☐ Fatigue
- ☐ Dizziness
- ☐ Numbness
- ☐ Frequent Chills
- ☐ Fever
- ☐ Premature Hair Loss
- ☐ Premature Greying
- ☐ Hot Flashes

RESPIRATORY
- ☐ Cough
- ☐ Dry Cough
- ☐ Cough with Phlegm
- ☐ Cough with Blood
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Common Cold
- ☐ Excessive Phlegm

CIRCULATORY
- ☐ Cold Hands and Feet
- ☐ Hot Hands and Feet
- ☐ Excessive Bleeding
- ☐ Easy Bruising
- ☐ Edema/Swelling

CARDIOVASCULAR/CHEST
- ☐ Chest Pains/Tightness
- ☐ Palpitations
- ☐ Cloudy Thinking
- ☐ Obsessive Behaviour
- ☐ Lack of Motivation
- ☐ Irregular Heartbeat
- ☐ Rapid Heartbeat
- ☐ Blood Clotting Disorder
- ☐ Right-Sided Rib Pain

DIGESTIVE/EXCRETORY
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Loose Stools
- ☐ Constipation
- ☐ No Daily Bowel Movement
- ☐ Dry Stools
- ☐ Foul Smelling Stools
- ☐ Hemorrhoids
- ☐ Rectal Pain
- ☐ Excessive Hunger
- ☐ Loss of Appetite
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Abdominal Bloating/Gas
- ☐ Belching
- ☐ Acid Reflux
- ☐ Hiccups
- ☐ Stomach Pain
- ☐ Abdominal Pain
- ☐ Food Allergies/Sensitivities

MOUTH AND THROAT
- ☐ Sore Throat
- ☐ Hoarse Voice
- ☐ Dry Throat/Mouth

NERVOUS SYSTEM
- ☐ Tremors
- ☐ Poor Balance
- ☐ Seizures

MUSCULOSKELETAL
- ☐ Muscle Cramps
- ☐ Body Aches
- ☐ Joint Pain
- ☐ Swollen Joints
- ☐ Paralysis
- ☐ Neck and Shoulder Tension
- ☐ Hand and Arm Pain
- ☐ Hip and Leg Pain
- ☐ Foot and Ankle Pain
- ☐ Low Back Pain
- ☐ Upper Back Pain

MENTAL/EMOTIONAL
- ☐ Depression
- ☐ Easily Stressed
- ☐ Anger
- ☐ Irritability
- ☐ Frequent Sighing
- ☐ Fever
- ☐ Grief
- ☐ Worrying
- ☐ Anxiety
- ☐ Forgetfulness
- ☐ Light Sweating
- ☐ Numbness
- ☐ Dry Nails

Continued from MENTAL/EMOTIONAL:

☐ Nervous Tics
☐ Abuse Survivor

HEAD AND FACE

☐ Headache
☐ Migraines
☐ Jaw Pain
☐ Facial Tics
☐ Facial Paralysis
☐ Dizziness

EYES

☐ Degenerating Vision
☐ Blurry Vision
☐ Light Blindness
☐ Visual Spots
☐ Red Eyes
☐ Dry Eyes
☐ Eye Pain

NOSE

☐ Sinus Congestion
☐ Nasal Polyps
☐ Post-nasal Drip
☐ Nose Bleeds
☐ Nasal Discharge
☐ Poor Sense of Smell
☐ Difficulty Swallowing
☐ Mouth Ulcers
☐ Dry Mouth/Throat
☐ Excessive Thirst
☐ Lack of Thirst
☐ Teeth or Jaw Pain
☐ Gum Problems

EARS

☐ Ringing in the Ears
☐ Poor Hearing
☐ Ear Aches
☐ Ear Infection

SKIN

☐ Eczema
☐ Psoriasis
☐ Hives
☐ Acne
☐ Fungal Infections
☐ Itchy Skin
☐ Shingles
☐ Dry Skin
☐ Dandruff
☐ Excessive Sweating
☐ No Sweating

SLEEP

☐ Difficulty Falling Asleep
☐ Waking During the Night
☐ Waking to Urinate
☐ Vivid Dreams
☐ Restless Sleep
☐ Hot Upon Waking
☐ Excessive Sleep

URINARY/GENITAL

☐ Urinary Tract Infection
☐ Kidney Stones
☐ Urinary Incontinence
☐ Frequent Daytime Urination
☐ Frequent Night Urination
☐ Painful Urination
☐ Dribbling Urination
☐ Foamy Urine
☐ Bloody Urine
☐ Genital Pain
☐ Genital Itching
☐ Venereal Diseases

OTHER

☐ Other_______________
☐ Other_______________

Men's Health

☐ Impotence ☐ Seminal Emissions ☐ Premature Ejaculation
☐ Infertility ☐ Decreased Libido ☐ Prostate Issues

Women's Health

☐ Painful Intercourse ☐ Decreased Libido ☐ Vaginal Dryness
☐ Endometriosis ☐ Infertility ☐ Other_______________

Pregnancy:

Are you currently pregnant? Y / N (please inform practitioner if at any time you may be pregnant)

How many pregnancies have you had?____________

Have you had any miscarriages? Y / N

What is your method of birth control? ____

Age of first period _________

Indicate any pregnancy or conception related difficulties:____

____

Are you sexually active? YES NO If you use birth control, what kind?____

Menstruation:

How many days is your cycle _________?

Please indicate if you experience any of the following between periods:

☐ Vaginal Dryness ☐ Bleeding ☐ Cramps/Pain

Please indicate the quality of your menstrual blood:

☐ Light Red ☐ Clotted ☐ Normal Flow
☐ Bright Red ☐ Heavy Flow ☐ Light Flow
☐ Dark Red

Do you experience any of the following?

☐ Cramping Before Menstruation ☐ Breast Tenderness ☐ Bloating
☐ Cramping During Menstruation ☐ Low Back Pain ☐ Headaches
☐ Cramping After Menstruation

Menopause:

Please indicate your current status:

☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal

If applicable, at what age did menopause begin?______

Please indicate any menopause-related symptoms:

☐ Hot Flashes ☐ Mood Swings ☐ Insomnia
☐ Vaginal Dryness ☐ Night Sweats ☐ Depression

Family History:

☐ Arthritis	☐ Drug Dependencies	☐ Obesity
☐ Asthma	☐ Heart Disease	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Other_______________
☐ Depression	☐ Kidney Disease	☐ Other_______________
☐ Diabetes	☐ Liver Disease	☐ Other_______________

NOTES: