Intake Information

Name: _____ Occupation: _____

Age: _____

Date of Birth: _____ Emergency Contact:

Year/Month/Day Name: _____

Address: _____ Phone No. _____

_____ Address: _____

_____ _____

Phone: (H) _____

(W) _____

(C)_____

May we leave messages relating to your visits? Y □ / N □

If so, which phone number ?_____

Email address: _____

Marital/Relationship Status: _____

Who referred you to the clinic and/or where did you hear about the clinic?

_____

Please list the medical professionals you currently see:

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

Please list any serious conditions, illnesses, or surgeries/hospitalizations:

Condition	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies and/or Adverse Reactions:

_____

(chemical/drug)

_____

(food)

_____

(other)

Number and Age of Siblings:

_____

_____

Indicate if a close relative (grandparent, parent, child, or sibling) has had any of the following. Please indicate which family member:

diabetes _____
heart problems _____
thyroid problems _____
cancer _____
psychiatric problems _____
lung problems _____
smokers _____
gallbladder problems _____
others _____

arthritis _____
high blood pressure _____
glaucoma _____
kidney problems _____
tuberculosis _____
strokes _____
alcohol problems _____
liver problems _____

If you are not bringing the bottles to your first visit, please list all current medications (prescriptions, over-the-counter, vitamins, herbs, homeopathics, etc.), including brand, exact product name, and dose taken:

_____

_____

_____

_____

_____

_____

Please list any past prescription medications:

_____

_____

_____

Do you get regular screening tests done by another doctor? (PAP, blood tests, etc.) Y □ / N □

How many times have you been treated with antibiotics?

_____

_____

Please indicate any way in which your immunizations have varied from the standard schedule:

_____

_____

Have you received adult 'boosters' to immunizations? If yes, please provide any details you remember:

_____

_____

Please indicate any adverse reactions to any immunizations:

_____

_____

Do you frequently use any of the following?

- ☐ Painkillers
- ☐ Muscle Relaxers
- ☐ Laxatives
- ☐ Antacids
- ☐ Diet Pills

Please list any traumas (physical and/or emotional):

_____

_____

How many hours of sleep do you get a night? _____ Do you wake up often? Y □ / N □
If so what times? _____
Do you awake well rested? _____
Do you smoke? Y □ / N □ If yes, for how long? _____
Do you exercise? Y □ / N □ If yes, how much and how often?

_____

_____

Are you exposed to significant tobacco smoke? Y □ / N □
Are you frequently exposed to animals (work, pets, etc.) ? Y □ / N □
Are you frequently exposed to toxins or other hazards (home, work, hobbies, etc.)? Please describe.

_____

_____

How would you describe the emotional climate of your home?

_____

_____

How stressful is your work, or other aspects of your life? How do you handle these stresses?

_____

_____

_____

Describe a typical day's diet:
Breakfast:_____
Snack:_____
Lunch:_____
Snack:_____
Dinner:_____
Snack:_____
Beverages (and total quantity):_____
Alcohol:_____
Caffeine:_____

Do you have any dietary restrictions?

_____
_____

Thank you for taking the time to fill out this form. If there is anything else you would like to add please do so, your concerns and information are important to your case.

_____
_____
_____
_____

For the rest of this document, please check:

Y For a condition you have now
P For a condition you have had in the past
N For a condition you have NEVER had

GENERAL				**(Add any details or comments here)**
Weight				
Weight one year ago				
Maximum weight				When?
Minimum weight				When?
Height				
Fatigue/weakness	**Y** □	**P** □	**N** □	
Fever/chills	**Y** □	**P** □	**N** □	
SKIN				
Rashes	**Y** □	**P** □	**N** □	
Eczema, hives	**Y** □	**P** □	**N** □	
Acne, boils	**Y** □	**P** □	**N** □	
Itching	**Y** □	**P** □	**N** □	
Colour change	**Y** □	**P** □	**N** □	
Lumps	**Y** □	**P** □	**N** □	
Night sweats	**Y** □	**P** □	**N** □	
Dryness/moistness	**Y** □	**P** □	**N** □	

Nail changes	**Y** □	**P** □	**N** □	
Change in mole	**Y** □	**P** □	**N** □	
Skin cancer	**Y** □	**P** □	**N** □	
HEAD				
Headache	**Y** □	**P** □	**N** □	
Head injury	**Y** □	**P** □	**N** □	
Dizziness	**Y** □	**P** □	**N** □	
EYES				
Impaired vision	**Y** □	**P** □	**N** □	
Glasses/contacts	**Y** □	**P** □	**N** □	
Eye pain	**Y** □	**P** □	**N** □	
Tearing or dryness	**Y** □	**P** □	**N** □	
Double vision	**Y** □	**P** □	**N** □	
Glaucoma	**Y** □	**P** □	**N** □	
Cataracts	**Y** □	**P** □	**N** □	
Blurring	**Y** □	**P** □	**N** □	
Bothered by sun	**Y** □	**P** □	**N** □	
Itching	**Y** □	**P** □	**N** □	
Redness	**Y** □	**P** □	**N** □	
Discharge	**Y** □	**P** □	**N** □	
Blind spot	**Y** □	**P** □	**N** □	
EARS				
Impaired hearing	**Y** □	**P** □	**N** □	
Earache	**Y** □	**P** □	**N** □	
Dizziness	**Y** □	**P** □	**N** □	
Discharge	**Y** □	**P** □	**N** □	
Infections	**Y** □	**P** □	**N** □	
NOSE AND SINUSES				
Frequent colds	**Y** □	**P** □	**N** □	
Nose bleeds	**Y** □	**P** □	**N** □	
Stuffiness	**Y** □	**P** □	**N** □	
Hay fever	**Y** □	**P** □	**N** □	
Sinus Problems	**Y** □	**P** □	**N** □	
MOUTH AND THROAT				
Frequent sore throat	**Y** □	**P** □	**N** □	

Sore tongue/mouth	**Y** □	**P** □	**N** □	
Gum problems	**Y** □	**P** □	**N** □	
Hoarseness	**Y** □	**P** □	**N** □	
Dental cavities	**Y** □	**P** □	**N** □	
Loss of taste	**Y** □	**P** □	**N** □	
NECK				
Lumps	**Y** □	**P** □	**N** □	
Swollen glands	**Y** □	**P** □	**N** □	
Goiter (enlarged thyroid)	**Y** □	**P** □	**N** □	
Pain or stiffness	**Y** □	**P** □	**N** □	
RESPIRATORY				
Cough	**Y** □	**P** □	**N** □	
Sputum/Phlegm	**Y** □	**P** □	**N** □	
Spitting up blood	**Y** □	**P** □	**N** □	
Wheezing	**Y** □	**P** □	**N** □	
Asthma	**Y** □	**P** □	**N** □	
Bronchitis	**Y** □	**P** □	**N** □	
Pneumonia	**Y** □	**P** □	**N** □	
Pleurisy	**Y** □	**P** □	**N** □	
Emphysema	**Y** □	**P** □	**N** □	
Difficulty breathing	**Y** □	**P** □	**N** □	
Pain on breathing	**Y** □	**P** □	**N** □	
Shortness of breath	**Y** □	**P** □	**N** □	
Shortness of breath at night	**Y** □	**P** □	**N** □	
Shortness of breath lying down	**Y** □	**P** □	**N** □	
Tuberculosis	**Y** □	**P** □	**N** □	
Tuberculin test	**Y** □	**P** □	**N** □	
Last chest x-ray				
CARDIOVASCULAR				
Heart disease	**Y** □	**P** □	**N** □	
Angina	**Y** □	**P** □	**N** □	
High blood pressure	**Y** □	**P** □	**N** □	
Murmurs	**Y** □	**P** □	**N** □	
Rheumatic fever	**Y** □	**P** □	**N** □	
Chest pain	**Y** □	**P** □	**N** □	
Swelling in ankles	**Y** □	**P** □	**N** □	
Palpitations/fluttering	**Y** □	**P** □	**N** □	

Cyanosis (ex. lips or skin turn blue)	**Y** □	**P** □	**N** □	
Past ECG	**Y** □	**P** □	**N** □	
Other heart tests	**Y** □	**P** □	**N** □	
BREASTS				
Do you do self exams?	**Y** □	**P** □	**N** □	
Lumps	**Y** □	**P** □	**N** □	
Pain (or tenderness)	**Y** □	**P** □	**N** □	
Nipple discharge	**Y** □	**P** □	**N** □	
GASTROINTESTINAL				
Trouble swallowing	**Y** □	**P** □	**N** □	
Heartburn	**Y** □	**P** □	**N** □	
Change in thirst	**Y** □	**P** □	**N** □	
Change in appetite	**Y** □	**P** □	**N** □	
Nausea	**Y** □	**P** □	**N** □	
Vomiting	**Y** □	**P** □	**N** □	
Vomiting blood	**Y** □	**P** □	**N** □	
Bowel movements – how often?				
Is this a change?	**Y** □	**P** □	**N** □	
Blood in stool	**Y** □	**P** □	**N** □	
Belching or passing gas	**Y** □	**P** □	**N** □	
Jaundice (yellow skin)	**Y** □	**P** □	**N** □	
Liver disease	**Y** □	**P** □	**N** □	
Gall bladder disease	**Y** □	**P** □	**N** □	
Ulcer	**Y** □	**P** □	**N** □	
Indigestion	**Y** □	**P** □	**N** □	
Constipation	**Y** □	**P** □	**N** □	
Diarrhea	**Y** □	**P** □	**N** □	
Rectal bleeding	**Y** □	**P** □	**N** □	
Hemorrhoids	**Y** □	**P** □	**N** □	
Black/tarry stool	**Y** □	**P** □	**N** □	
Abdominal pain	**Y** □	**P** □	**N** □	
Food allergy	**Y** □	**P** □	**N** □	
Hernias	**Y** □	**P** □	**N** □	
URINARY				
Pain on urination	**Y** □	**P** □	**N** □	
Increased frequency	**Y** □	**P** □	**N** □	
Frequency at night	**Y** □	**P** □	**N** □	

Inability to hold urine	**Y** □	**P** □	**N** □	
Frequent infections	**Y** □	**P** □	**N** □	
Kidney stones	**Y** □	**P** □	**N** □	
Blood in urine	**Y** □	**P** □	**N** □	
Urgency	**Y** □	**P** □	**N** □	
Hesitancy	**Y** □	**P** □	**N** □	
MALE REPRODUCTIVE				
Hernias	**Y** □	**P** □	**N** □	
Testicular masses	**Y** □	**P** □	**N** □	
Testicular pain	**Y** □	**P** □	**N** □	
Are you sexually active?	**Y** □	**P** □	**N** □	
Sexual difficulties	**Y** □	**P** □	**N** □	
Venereal disease	**Y** □	**P** □	**N** □	
Discharge or sores	**Y** □	**P** □	**N** □	
Sexual orientation: Heterosexual	**Y** □	**P** □	**N** □	
Bisexual	**Y** □	**P** □	**N** □	
Homosexual	**Y** □	**P** □	**N** □	
Other	**Y** □	**P** □	**N** □	
FEMALE REPRODUCTIVE				
Age menses began				
Average number of days you menstruate				
Length of cycle (ie 28 days?)				
Bleeding between periods	**Y** □	**P** □	**N** □	
Are cycles regular	**Y** □	**P** □	**N** □	
Pain during intercourse	**Y** □	**P** □	**N** □	
Painful menses	**Y** □	**P** □	**N** □	
Excessive flow	**Y** □	**P** □	**N** □	
PMS	**Y** □	**P** □	**N** □	
Birth control	**Y** □	**P** □	**N** □	
What type?				
Number of pregnancies				
Number of live births				
Number of miscarriages				
Number of abortions				
Difficulty conceiving	**Y** □	**P** □	**N** □	
Are you sexually active?	**Y** □	**P** □	**N** □	
Sexual difficulties	**Y** □	**P** □	**N** □	
Venereal disease	**Y** □	**P** □	**N** □	

Sexual orientation: Heterosexual	**Y** □	**P** □	**N** □	
Bisexual	**Y** □	**P** □	**N** □	
Homosexual	**Y** □	**P** □	**N** □	
Other	**Y** □	**P** □	**N** □	
Last menstrual period				
Vaginal discharge	**Y** □	**P** □	**N** □	
Vaginal itching	**Y** □	**P** □	**N** □	
Last PAP – (date)				
MUSCULOSKELETAL				
Joint pain or stiffness	**Y** □	**P** □	**N** □	
Arthritis	**Y** □	**P** □	**N** □	
Broken bones	**Y** □	**P** □	**N** □	
Muscle spasms or cramps	**Y** □	**P** □	**N** □	
Weakness	**Y** □	**P** □	**N** □	
Joint swelling	**Y** □	**P** □	**N** □	
Backache	**Y** □	**P** □	**N** □	
PERIPHERAL VASCULAR				
Deep leg pain	**Y** □	**P** □	**N** □	
Cold hands/feet	**Y** □	**P** □	**N** □	
Varicose veins	**Y** □	**P** □	**N** □	
Thrombophlebitis (clotting disorder)	**Y** □	**P** □	**N** □	
Leg cramps	**Y** □	**P** □	**N** □	
Extremity numbness	**Y** □	**P** □	**N** □	
Extremity coldness	**Y** □	**P** □	**N** □	
Extremity ulcers	**Y** □	**P** □	**N** □	
Extremity swelling	**Y** □	**P** □	**N** □	
NEUROLOGIC				
Fainting	**Y** □	**P** □	**N** □	
Seizures/convulsions	**Y** □	**P** □	**N** □	
Paralysis	**Y** □	**P** □	**N** □	
Muscle weakness	**Y** □	**P** □	**N** □	
Numbness or tingling	**Y** □	**P** □	**N** □	
Loss of memory	**Y** □	**P** □	**N** □	
Involuntary movement	**Y** □	**P** □	**N** □	
Loss of balance	**Y** □	**P** □	**N** □	
Speech problems	**Y** □	**P** □	**N** □	

ENDOCRINE				
Heat or cold intolerance	**Y** □	**P** □	**N** □	
Thyroid trouble	**Y** □	**P** □	**N** □	
Excessive thirst	**Y** □	**P** □	**N** □	
Excessive hunger	**Y** □	**P** □	**N** □	
Excessive urination	**Y** □	**P** □	**N** □	
Diabetes	**Y** □	**P** □	**N** □	
Hypoglycemia	**Y** □	**P** □	**N** □	
Hormone therapy	**Y** □	**P** □	**N** □	
BLOOD/LYMPHATIC				
Anemia	**Y** □	**P** □	**N** □	
Easy bleeding or bruising	**Y** □	**P** □	**N** □	
Past transfusions	**Y** □	**P** □	**N** □	
Lymph node swelling	**Y** □	**P** □	**N** □	
EMOTIONAL				
Depression	**Y**□	**P**	**N** □	
Mood swings	**Y**□	**P** □	**N** □	
Anxiety or nervousness	**Y**□	**P** □	**N** □	
Tension	**Y**□	**P** □	**N** □	
Phobias	**Y**□	**P** □	**N** □	
Alcohol/drug abuse	**Y**□	**P** □	**N** □	
Insomnia	**Y**□	**P** □	**N** □	
HOBBIES/HABITS				
Do you watch television?	**Y**□	**P** □	**N** □	
How many hours/day?				
How many hours per day do you spend in front of a computer?				
Do you read?	**Y**□	**P** □	**N** □	
Do you take vacations?	**Y**□	**P** □	**N** □	
Do you use recreational drugs?	**Y**□	**P** □	**N** □	
Have you been treated for drug dependence?	**Y**□	**P** □	**N** □	
Have you been treated for alcoholism?	**Y**□	**P** □	**N** □	
What are your main interests and hobbies?				