

Patient Intake Form

Personal Information

Name _____	Date _____
Date of birth _____	Age _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address _____	City _____
Province _____	Postal Code _____
Phone: Home _____	Work _____ Other _____
Email _____	May we leave messages relating to your visits? <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Common-Law	
Number of Children: _____	
Occupation: _____ Employer: _____	
Emergency contact:	
Name _____	Relation _____ Phone _____
How did you hear about our clinic? _____	
Other health care providers (family physician, specialists, complementary and alternative therapy):	
1. _____	2. _____ 3. _____
Ph: _____	Ph: _____ Ph: _____
What are your main health concerns that you would like addressed:	
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	
If you are female, are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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

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

Medication	Dose	Duration	Condition Treating

Please list all natural health products you are taking (vitamins, supplements, herbs, homeopathics).

Natural Health Product	Dose	Duration	Condition Treating

Please list past prescription medications.

How frequently are you treated with antibiotics? _____

Do you regularly use any of the following?

- Aspirin Laxatives Antacids Diet pills Birth control pills Implants Injections

Alcohol—how much/ day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often _____

Please indicate which immunizations you have had:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Tetanus booster; when? _____ | <input type="checkbox"/> "Flu" | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Polio | <input type="checkbox"/> Smallpox |
| Other _____ | | |

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? _____

Diet

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

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

Family 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			

I don't know my family medical history

Environment

Occupation _____

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?

Are there any other services you would like to learn more about?

- Massage Therapy/Shiatsu
 Psychotherapy
 Chiropractic