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Adult Patient Intake Form

Patient Name:____________________________Date:______________ Date of Birth:________________

Street Address:____

City:________________________ Province:___________________ Postal Code:____________________

Home phone: ____________________Work Phone:________________Cell Phone:_________________

Email Address:____

Highest level of education:__________________________________

Occupation:______________________Employer____________________ Hours worked/week:_______

Marital Status (Select): Single Married Separated Divorced With Partner Widow(er)

Person to call in case of Emergency:___________________________Relationship to you:___________

Phone number contact for them:___________________________

Regular Physician: ______________________________________

How did you hear of the clinic:____________________________

Would you like to receive our email newsletter? Yes No

Would you like to receive appointment confirmation via email? Yes No

List in Order of Importance what your problems are:

1. ____
2. ____
3. ____
4. ____
5. ____

Last time you had blood work done and with what doctor:________________________________

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Family history

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living						
Age when died						
Reason for death						
	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Cancer (Type)						
High Blood Pressure						
Heart Attack/Stroke						
Heart Disease						
Asthma/Allergies						
Mental illness						
TB						
Auto-immune disease						
Diabetes Mellitus						
Osteoporosis						

List All Surgeries and Hospitalizations—including date occurred:

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________
6. ____________________________________

Please Note When and Why You Had Each of The Following:

X-rays: ____________________________________

MRI/Cat Scans:____________________________________

Ultrasounds:____________________________________

Accidents:____________________________________

Last time you had a:

Dental Exam:______________________

Eye Exam:______________________

Please List All Sensitivities/Allergies/Reactions

Drugs: ____________________________________

Foods: ____________________________________

Environment: ______________________________

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Select Yes, No, or Past, regarding use of the following:
Antacids: __________
Laxatives: __________

Steroids: __________
Analgesics: __________
Smoking: __________ Packs per day if Yes/Past:_________
Coffee: __________ Cups per day if Yes/Past:__________
Soda Pop: __________ Ounces per day if Yes/Past:__________
Alcohol: __________ How often and how much if Yes/Past:__________

Any alcohol addiction: __________
Any alcohol treatment: __________

Recreational drugs: __________

Any drug addiction: __________

Any drug treatment: __________

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:
____
____

Present Weight:_____________ Weight one year ago:_______________
Height: _______________ Maximum weight and when:___________
Minimum Weight as adult and when: _____________
Ideal Weight:___________

Exercise:
How often:______________________________
What type(s):____________________________
For How long:___________________________

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Hobbies:

____

____

Sleep:

How many hours per night: ____________________

Any troubles falling asleep: __________________

Any troubles staying asleep:_____________________

If you wake up frequently, what is the reason: ________________________

Food:

Appetite Good?: _________

Foods crave: _________________________________

Foods that don't sit well:_________________________

Toxin Exposure:

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?:____

Are you particularly sensitive to perfumes, gasoline, or other vapors?:__________

Do you use pesticides, herbicides, other chemicals around your home?_______________________

____

Social Life:

Enjoy job?: _________

Active Spiritual practice: _________

Quality of most significant relationship?_______________

What is your greatest health concern?____

How does it limit you the most? ____

How committed are you towards making valuable changes: Little Moderately Very