LisaBoyd
INTEGRATIVE CARE

Intake Form - Adult

Please complete this form as thoroughly as possible. This information will be kept in strict confidentiality.

SECTION 1 - GENERAL INFORMATION:

Name: ______________________ Date: ______________________

Age: __________ Date of Birth: __________________

Address: ____

City: __________________ Province: ______________ Postal Code: ______________

Telephone (home): ______________________ Telephone (cell): ______________________

Email address: ______________________ Telephone (work): ______________________

Occupation: ______________________ Referred by: ______________________

SECTION 2 - CURRENT MEDICAL INFORMATION:

Please list the health concerns that you wish to address:

	Health Concern:	How long have you had this condition?
1		
2		
3		
4		

If you have any severe allergies or medical conditions (eg. Anaphylaxis, Medications, Epilepsy) please list here:

____

____

Emergency Contact: ____

Relationship: ______________________ Telephone: ______________________

Please list all prescribed medications that you are currently taking:

Name/Brand:	Dose:	For what condition?	Since when?

Please list all supplements, botanicals, homeopathics, etc. that you are currently taking:

____

____

Please list any other allergies or hypersensitivities you may have: ____________________

____

____

What are your goals from treatment? ____________________________

____

____

SECTION 3 - PAST MEDICAL INFORMATION:

Please describe any major illnesses, hospitalizations, surgeries, accidents, injuries, etc.
(including the date of occurrence and any problems experienced since then):

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Please indicate any vaccinations you have had:

- ☐ MMR (measles, mumps, rubella)
- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ IPV (inactivated polio virus)
- ☐ Varicella (chicken pox)
- ☐ Hepatitis A or B or both (ie. – Twinrix)
- ☐ Influenza (flu shot)
- ☐ Meningitis
- ☐ HPV (human papilloma virus)
- ☐ Other (rabies, typhoid, cholera, etc.)

Did you experience any adverse reactions after receiving any of these vaccines? ☐ NO ☐ YES

If yes, please describe: ____

____

Describe any major ailments that have affected your relatives: ____

____

Medical History: Please CIRCLE CURRENT conditions and UNDERLINE PAST conditions:

DIGESTION			
	Loose stool or Diarrhea	Nausea / vomiting	Poor appetite
	Constipation	Gas or belching	Irritable bowels
	Poor digestion	Stomach or intestinal pain	Hemorrohoids
	Parasites	Heartburn	High cholesterol
	Acid reflux	Excessive appetite	Gall stones

RESPIRATORY			
	Cough	Nasal problems	Catches colds easily
	Chest tightness	Poor sense of smell	Pneumonia
	Shortness of breath	Sinus problems	Asthma
	Congestion	Allergies	Bronchitis
	Wheezing	Hay fever	Do you smoke? Number per day: __________

CARDIOVASCULAR			
	Hypertension	Slow heart rate	Heart disease
	Chest pain	Poor circulation	Heart attack How many times? ________
	Cold hands / feet	Blood clots	Stroke How many times? ________
	Restlessness	Sweaty hands / feet	
	Heart palpitation	Anemia	

URINARY			
	Painful urination	Hearing impairment	Bladder infections
	Incontinence	Kidney stones	Low back pain
	Difficulty with urination	Kidney infections	

OTHER			
	Insomnia	Arthritis	Weight gain
	Depression	Broken bones, fractures? ____________	Weight loss
	Sleep too much	Fatigue	Tuberculosis
	Shaky	Learning Disorder	Thyroid problems
	Poor memory	Epilepsy	Fibromyalgia
	Difficulty paying attention	Dry mouth	Poor sense of smell
	Anxiety	Loss of Balance	Poor sense of taste
	Easily angered	Headaches	Cancer, where? ____________
	Obsessive tendencies	Migraines	
	Difficulty making plans or decisions	Eye pain	Allergies? List: ____________
	Dizziness	Dry eyes	
	Soft or brittle nails	Watery eyes	Herpes
	Intolerance to temperature / weather changes	Other eye problems? ____________	Candida
	Numbness, where? ____________	Dental problems	Shingles
	Tingling, where? ____________	Poor hearing	Chemical dependency ____________
	Nose bleeds	Difficulty swallowing	
	TMJ Pain	Diabetes	Skin condition: ____________

MEN ONLY			
	Prostate problems	Impotence	Infertility
	Pain associated with genitals	Problems urinating	Prostate cancer

WOMEN ONLY			
	Breast lumps	Menopause	Endometriosis
	Are your cycles regular? Yes No Length of cycle: ____________	Menopausal symptoms: ____________	PMS
	Ovarian cysts	Painful menses with heavy or excessive flow	Infertility

Please CIRCLE any of the following feelings you have experienced in the last few months.

WELL BEING					
	Abused	Paranoid	Unable to grieve	Panic	Criticized
	Overwhelmed	Apprehensive	Intolerant	Overworked	Muddled
	Agitated	Uncertainty	Paralyzed	Persecuted	Uneasy
	Aggravated	Depressed	Guilty	Distress	Annoyed
	Rejected	Easily irritated	Fearful	Angry	Despair
	Anxious	Impatient	Outraged	Helpless	Sad
	Intimidated	Nervous	Hopeless	Grieving	Restless
	Worried				

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Please mark the circle that best describes the level of stress for the below listings.

WELL BEING

My family stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My relationship stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My work stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My financial stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My health stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
Other stress is ________________ :	◯ None	◯ Minimal	◯ Moderate	◯ Severe

How many hours a night do you sleep? _________ Is your sleep restful? __________ . If not, please explain : ________________

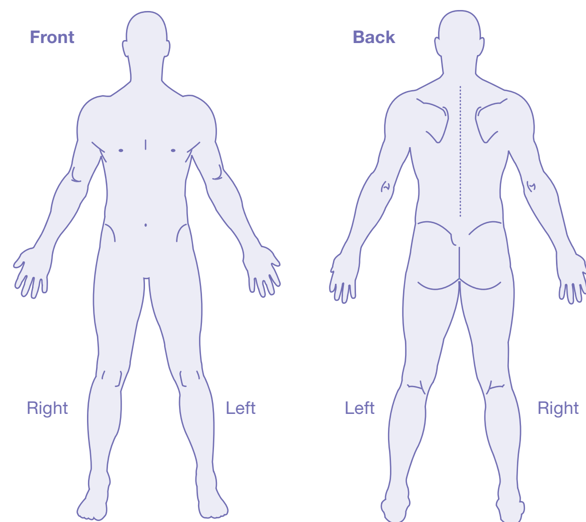
____

SECTION 4 :

1 2 3 4 5 6 ● 8 9 10	neck
1 2 3 4 5 6 7 8 9 10	________________
1 2 3 4 5 6 7 8 9 10	________________
1 2 3 4 5 6 7 8 9 10	________________
1 2 3 4 5 6 7 8 9 10	________________

1	Slight awareness of discomfort.
2-3	Awareness of discomfort as an aggravation.
4-6	Pain is strong but you are still functional.
7-9	Pain is so strong you are unable to function normally.
10	You feel like you need to go to the emergency room.

Please shade areas of pain or discomfort on the body diagrams and make comments if necessary.



Comments: ____

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