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):

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				

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 : _____

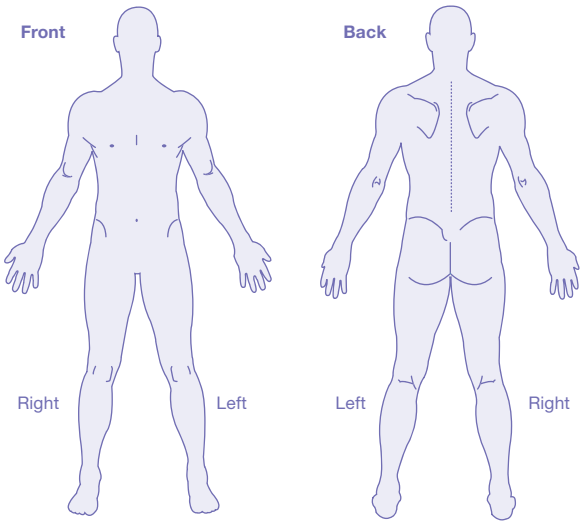
_____

SECTION 4 :

1 2 3 4 5 6 **7** 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: _____

_____

_____

_____

_____

_____

_____

_____

_____