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INTAKE FORM FOR ADULT

NAME _____ AGE _____ BIRTHDATE _____

ADDRESS _____ CITY _____ POSTAL CODE _____

PHONE (Home) _____ (Work) _____ Is it okay to leave a message? Yes/No

OCCUPATION _____ EMPLOYER _____

EMERGENCY CONTACT _____ RELATION _____

CONTACT NUMBER _____ E-mail Address: _____

HEALTH CARD # _____

How did you find out about our office? _____

Name of family physician and phone number _____ fax: _____ Last seen _____

YOUR CURRENT HEALTH CONCERNS

Please list in order of importance any other health concerns that you may have:

1. _____ and length of time _____
2. _____ and length of time _____
3. _____ and length of time _____
4. _____ and length of time _____

YOUR HEALTH HISTORY

What is your current level of energy from 1 to 10 (where 10 is the best you have ever felt)? _____

Please list the five most significant, stressful events in your life:

1. _____ date _____
2. _____ date _____
3. _____ date _____
4. _____ date _____
5. _____ date _____

Are any of these situations continuing to have an impact on your life? **Yes/No** (Please indicate which by number)

Are you currently working with a professional counselor, psychologist, social worker, or other therapist? **Yes/No**

Have you in the past? _____ When? _____

Which of the following conditions apply to you? Please indicate if **NOW (N)** or in the **PAST (P)**.

	N	P		N	P		N	P		N	P
Allergies			Weight problems			Stroke			Venereal disease		
Asthma			Gallstones			Cancer			Syphilis		
Eczema			Gout			Epilepsy			Gonorrhea		
Psoriasis			Arthritis			Migraine			Miscarriage		
Ear infections			Thyroid problems			Pneumonia			Varicose veins		
Strep throat			Anemia			Diabetes			Broken bones		
Hay fever			High blood press.			Malaria			Numbness/tingling		
Measles			Rheumatic fever			Tuberculosis			Cold hands/feet		
Mumps			Fainting			Small pox			Warts		
Chicken pox			Poor memory			Polio			Mono		
Whooping cough			Balance problems			Gas/bloating			Depression		
Diphtheria			Speech problems			Hemorrhoids			Yeast infection		
Scarlet fever			Ringing in ears			Parasites			Mental illness		
Sinusitis			Jaundice			Rectal bleeding			Child abuse		
Canker sores			Hepatitis			Herpes			Physical abuse		
Acne			Heart disease			Headaches			Sexual abuse		
Tonsillitis			Alcoholism			Visual problems			Emotional abuse		

Other: _____

Are there any of these from which you feel you have never been well since?

Do you have any allergies to drugs, herbs, foods, or other? If so, please specify: _____

Have you had any major injuries, previous surgeries and hospitalizations? If so, what happened and when?

Which of the following do you currently use? Please indicate how much, how often and for how long.

Alcohol		Tobacco	
Hormones		Coffee	
Cortisone		Laxatives	
Sedatives		Antacids	
Recreational drugs		Aspirin or Tylenol	

Other medications (please give the name, dose and length of time on the medication):

Vitamins/Herbs

FAMILY HEALTH HISTORY

	Mother	Father	Sibling	Grandparents	Any other blood relative
Cancer (type)					
Eczema					
Heart disease					
Arthritis					
Diabetes					
High blood pressure					
Asthma					
Kidney disease					
Depression					
Anemia					
Other					

REPRODUCTIVE

Are you sexually active? **Yes/No** Is this more or less than one year ago? _____

Sexual preference: **Heterosexual** ____ **Bisexual** ____ **Homosexual** ____

Do you use birth control? **Yes/No** If yes, what type of birth control? _____

FEMALE

Are you still menstruating? **Yes/No** Age of first menses _____ Are your cycles regular? **Yes/No**

Periods begin every ____ days, and last ____ days. Do you experience any spotting or bleeding between your periods? **Y/N**

Is the flow of your periods: **Heavy** **Medium** **Light** What colour is the blood? _____ Are there any clots? **Y/N**

Do you experience any premenstrual symptoms? **Water retention** **Breast tenderness** **Irritability** **Acne**
 Depression **Headaches** **Anger** **Mood swings** **Crying** **Bloating** **Food cravings**

If you are in menopause, are you experiencing any symptoms? **Hot flashes** **Insomnia** **Anxiety** **Other**

Number of pregnancies _____ Number of abortions _____ Number of miscarriages _____

Number of live births _____ Do you have any problems getting pregnant? _____

How many children do you have? (names and ages) _____

Do you receive regular PAP smears? **Yes/No** Have you had any abnormal PAP's? _____

Do you do regular self breast exams? **Yes/No** Have you noticed any breast lumps? _____

MALE

Do you experience any problems with impotency (getting or maintaining an erection)? **Yes/No**

Do you have any prostate problems? **Yes/No** Have you had your prostate examined? **Yes/No** When? _____

Do you have any difficulty starting or stopping when urinating? **Yes/No** _____

DIGESTION AND ELIMINATION

Do you experience any symptoms after you finish eating (e.g. gas, bloating, heartburn, etc.) _____

How often do you have a bowel movement? _____

Are your stools: **Formed** or **Loose**

Have you ever had alternating constipation and diarrhea? **Yes/No**

How often may this occur? _____

In the stool, do you notice any: **Blood** **Mucus**

Undigested food **Black colour**

Do you pass gas (flatus) frequently? **Yes/No**

Do you burp frequently? **Yes/No**

Do your stools have a strong disagreeable odour? **Yes/No**

PERSONAL HABITS

Do you exercise? **Yes/No** If yes, what and how often? _____

Do you have a religious or spiritual practice? **Yes/No** If yes, please specify _____

If you answered yes to the above, does your religion have certain practices (nutritional, etc) that I should be aware of : _____

On a scale of 1-10, how would you rate the quality of your sleep (10 being great?) _____

Do you have any problems falling asleep? _____ staying asleep? _____ How much do you sleep? _____ hrs Is it enough? ____

Do you work in an office building? **Yes/No**

Do the windows in your office open? **Yes/No**

Do you work in a factory, or in the presence of toxic fumes/chemicals?

Do any of your hobbies involve the use of toxic materials? **Yes/No** If yes, please explain.

Are you currently exposed to second hand smoke? **Yes/No**

Is there anything else you feel that I should know about you? _____
