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INTAKE FORM FOR YOUNG ADULT

NAME ____ **AGE** _______ **BIRTHDATE** ________________

ADDRESS _________________________________**CITY** ________________ **POSTAL CODE** _________

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

HEALTH CARD #____

LEGAL GUARDIAN(S) NAME (S): __________________________ **CONTACT#**________________________

EMERGENCY CONTACT _____________________________ **RELATION** __________________________

CONTACT NUMBER __________________________**E-mail Address**: ______________________________

How did you find out about our office? (check all that apply)
______website: integratedhealthcare.ca _______ google _______yellow pages
______website: stcatharinesbioidentical.ca _______facebook _______word of mouth

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

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

Are there any concerns with the genitor-urinary system (ex: undescended testicle, etc) _____________________________

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? ____
____
____
____