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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? _____

_____

_____

_____