Adult Intake Date:___________________________

Name:____Gender: F M

Age:______________Date of Birth:____________________________________(Year/Month/Date)

Address:____

City:____Postal Code:____________________

Telephone:________________(home)______________(work)_______________________(mobile)

E-mail:____

How would you like to be addressed at the Clinic?_____________________________________

May we give you reminder calls? y (number__________________) n
May we leave you telephone messages? y (number__________________) n

How did you hear about us?____

Emergency contact:___________________________________relationship:____________________

Telephone:________________(home)______________(work)_______________________(mobile)

Are you presently under the care of a medical doctor(s)? y n Other practitioners? y n

Name:____ Telephone:____________________________

Name:____ Telephone: ___________________________

Name:____ Telephone: ___________________________

What are your health concerns today in order of most importance to you?

1. ____
2. ____
3. ____
4. ____
5. ____

Has anything recently changed or become worse?______________________________________

____

Medication and Supplements

Current Prescription Medications and Supplements: please include dosage, length of use and any adverse reactions

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____

Past Prescription Medications: please include dosage, length of use and any adverse reactions

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List any allergies (e.g. prescription medications, environmental, food, etc.)

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