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

____

____

____

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

____

____

____

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

____

____

Medical History

Do you currently have regular medical screenings: y n

Please list any serious conditions, illnesses or injuries, and any hospitalizations along with approximate dates:

____

____

____

How many times have you been treated with antibiotics? ___________________________

For what conditon?____

Childhood illnesses: (please circle) Chicken pox Measles

Mumps Reubella Rheumatic fever Scarlet fever

Polio Tuberculosis Whooping cough

Immunization: (please circle)

DPT (diptheria, pertussis, tetanus) Haemophilus influenza

MMR (measles, mumps, rubella) Flu shot

Polio smallpox Hepatitis A / B

Adverse reactions or other:____

Family Medical History

Please circle if any close relative had or has the following (grandparent, parent, sibling):

allergies/hay fever	eating disorders	mental disorders
asthma	epilepsy	obesity
arthritis	gout	stroke
bleeding problems	heart problems	substance abuse
cancer	high blood pressure	thyroid problems
diabetes	kidney problems	tuberculosis

Other____

☐ I don't know my family medical history

Current Health Profile

Height:__________Weight:___________Max weight:_______max wt when: __________

Have you recently gained or lost weight? y n If so how much_______________

Regular exercise y n Type:_______Duration:__________Frequency:_______

How much time do you spend outdoors on an average day?__________________________

On a scale of 1 to 10 (10 highest) How would you rate your stress level?______________

How would you rate your energy level?______________

How many hours do you sleep nightly?_______ Do you wake feeling rested? y n

If you are female, are you presently pregnant? y n don't know

Last known Menstrual Period: ____________

Do you use a birth control method:_________ For how long:__________

Do you use the following:

Tobacco: y n smoked______years Pack(s)/day:________Year stopped:___________

Alcohol: y n type: ______________servings/day:________

Recreational Drugs: y n type:_______________ how often:______________

Aspirin: y n how often:________ Tylenol: y n how often:_______

Laxatives: y n how often:________ Antacids: y n how often:_______

Coffee: y n cups/day:________ Soft Drinks: y n cups/day:________

Artificial Sweeteners: y n packets/day:_______ Type:___________

Diet

Do you have any food allergies or sensitivities? Please list.

____

____

Do you have any dietary restrictions (religious, vegetarian, vegan, etc…)? _______________

Describe a typical days diet

Breakfast: ____

Lunch: ____

Supper: ____

Snack: ____

Water intake: ____

Environment

Marital status: Single / Married / Common law / same sex / Widow /Divorced / Separated

Number of children:_______

Hobbies: ____

Are you frequently exposed to environmental pollutants at work, home or other? y n

Are you exposed to tobacco smoke? y n

Are you frequently exposed to animals? y n

Is there anything else that we should be made aware of or that you feel is important that has not been covered?

____

____

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