NEW PATIENT INTAKE FORM

Appointment Date: _____

Please complete the following pages so we can best meet your healthcare needs. If you have any questions, please do not hesitate to ask.

Personal Information

Name: (First) _____ (Middle)_____ (Last)_____ **Preferred Name: _____**
Date of Birth: (DD/MM/YYYY) _____
What are your pronouns? *(Optional)*:

_____

How do you identify? (*Check all that apply***):**
☐ Male ☐ Female ☐ Transgender ☐ Non-Binary

☐ MTF ☐ FTM ☐ Intersex ☐ Genderqueer
Other: _____

Occupation: _____

Address: _____ **City, Prov**: _____**Postal Code**: _____ **Country**: _____

Phone numbers: (Home) _____ (Work) _____ Ext:_____

(Cell) _____ (Other) _____

Main Email: _____(for appointment reminders and other information, if any).

Emergency contact details: Name - _____ Phone number - _____

Relationship - _____

Reason(s) for visit (Please rank by priority): *E.g. Headaches*	**Onset** *E.g. June 2002*	**Frequency** *E.g. 4x/week*	**Severity** *E.g. Scale: 5 out of 10, or mild/mod/severe*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

How were you referred to our centre?

_____

What are your goals for this visit?

_____

Your past medical history (please include date/year of diagnosis. You may also attach a separate list).
E.g. Reflux/heartburn – started 2003, had scope procedure 8/05 w/ normal result; ***please be succinct***

1. _____
2. _____
3. _____

Family medical history (please indicate type of disease)

Mother: _____ _____

Father: _____ _____

_____ _____

Surgery (major/minor procedures), when, where

1. _____

2. _____

3. _____

Injuries
E.g. Car accident in 1995 – head injury

1. _____

2. _____

3. _____

Lifestyle habits

Tobacco ☐ None ☐ Smoked cigarettes from age ____ to ____. _____ packs per day.

Check if you have used the following: ☐ Cigars ☐ Chewing tobacco

Alcohol ☐ None ☐ Estimated drinks per week _____ Preferred drink(s) _____

Other drugs ☐ None ☐ Type(s) and frequency _____

Medical history (please check)

☐ AIDS/HIV	☐ Emphysema	☐ MS	☐ Ischemic stroke	☐ Gastritis
☐ Alcoholism	☐ Epilepsy	☐ Mumps	☐ Hemorrhagic stroke	☐ IBS
☐ Appendicitis	☐ Goiter	☐ Pacemaker	☐ Hyperthyroid	☐ Anemia
☐ Arteriosclerosis	☐ Gout	☐ Pleurisy	☐ Hypothyroid	☐ Mononucleosis
☐ Asthma	☐ Heart disease	☐ Pneumonia	Tuberculosis	☐ Bronchitis
☐ Birth trauma	☐ Hepatitis ___	☐ Polio	☐ Typhoid fever	☐ Osteo-arthritis
☐ Cancer	☐ Hypertension	☐ Rheumatic fever	☐ Ulcers	☐ Enteritis
☐ Chicken pox	☐ Hypotension	☐ Scarlet fever	☐ Whooping cough	☐ Rheumatoid Arthritis
☐ Diabetes	☐ Measles	☐ Seizures	☐ Colitis	

Allergic reactions/ intolerances to medications

_____

_____

_____

Allergic reactions/ intolerances to foods, environment

_____

_____

_____

Medications (prescription & OTC) *or attach your own list*	**Dosage & Frequency**	**Reason**	**Duration of consumption**	**Cost per month**

Herbal Remedies and Supplements Please include brand name *or attach your own list*	**Dosage & Frequency**	**Reason**	**Duration of consumption**	**Cost per month**

What physical activities do you participate in and how often do you do so?

_____

_____

What do you do to relax?

_____

_____

Describe your sleep patterns (please include number of hours per night).

_____

_____

What are the major stressors in your life?

_____

_____

How many servings of fruit do you usually eat/drink each day? _____
Serving = 1 small piece of fruit, 1/2 cup fruit juice, 1/2 cup canned or chopped fruit, 1/4 cup dried fruit

How many servings of vegetables do you consume each day? _____
Serving = 1/2 cup raw or cooked vegetables, 1 cup fresh green leafy vegetables, 1/4 cup dried vegetables or 1 small piece

How much water do you drink on a typical day? _____

How much caffeinated beverages (coffee/tea, etc.) and/or pop do you drink a day?

Coffee/tea _____ per day Soda/pop _____ per day

Please check boxes that are relevant to you pertaining to your dietary conditions:

☐ Poor appetite ☐ Normal appetite ☐ Excessive appetite ☐ Crave sweet ☐ Crave salt

☐ Bitter taste in mouth ☐ Metallic taste in mouth ☐ Sweet taste in mouth ☐ Sour taste in mouth

☐ Other cravings (please indicate) _____ ☐ Other taste(s) in mouth (please indicate) _____

☐ No thirst ☐ Very thirsty ☐ Normal thirst

Please check boxes that are relevant to you pertaining to your cardiovascular conditions:

☐ High blood pressure ☐ Lightheaded ☐ Fast heartbeat ☐ Orthostatic hypotension

☐ Low blood pressure ☐ Chest pain ☐ Palpitations ☐ Phlebitis

☐ Fainting ☐ Slow heartbeat ☐ Irregular heartbeat ☐ Heart attack

Please check boxes that are relevant to you pertaining to your gastrointestinal conditions:

☐ Nausea	☐ Diarrhea	☐ Undigested food in stools	☐ Hemorrhoids
☐ Vomiting	☐ Constipation	☐ IBS	☐ Gastritis
☐ Acid regurgitation	☐ Laxative use	☐ Stomach cramps	☐ Enteritis
☐ Gas	☐ Black stools	☐ Itchy anus	☐ Hard stools
☐ Hiccup	☐ Blood in stools	☐ Burning anus	
☐ Bloating after meals	☐ Mucus in stools	☐ Rectal pain	
☐ Bad breath	☐ Intestinal cramping	☐ Ulcerative colitis	
☐ Gurgling sounds	☐ Loose stools	# of bowel movements/day: ___	

Please check boxes that are relevant to you pertaining to the head, eyes, ears, nose, and throat:

☐ Glasses	☐ Blurred vision	☐ TMJ	☐ Excessive saliva	☐ Nose bleeds
☐ Eye strain	☐ Night blindness	☐ Gum disease	☐ Sinus problems	☐ Ringing in ears
☐ Red eyes	☐ Glaucoma	☐ Sore gums	☐ Clear throat often	☐ Poor hearing
☐ Itchy eyes	☐ Cataracts	☐ Bleeding gums	☐ Recurrent sore throat	☐ Earaches
☐ Spots in eyes	☐ Grinding teeth	☐ Sores on lips	☐ Swollen glands	☐ Headaches
☐ "Floaters" in vision	☐ Soft teeth	☐ Sores on tongue	☐ Lumps in throat	☐ Migraines
☐ Poor vision	☐ Multiple cavities	☐ Dry mouth	☐ Enlarged thyroid	☐ Concussions

Please check boxes that are relevant to you pertaining to your respiratory condition:

☐ Feeling short of breath ☐ Tightness in chest ☐ Chest oppression ☐ Chronic cough

☐ Difficulty breathing lying down ☐ Asthma/wheezing ☐ Dry cough

☐ Productive cough with: ☐ A lot of sputum ☐ Very little sputum ☐ Clear sputum ☐ Sticky sputum ☐ Green sputum ☐ Blood in sputum

Please check boxes that are relevant to you pertaining to your sleep patterns:

☐ Insomnia ☐ Problems staying asleep ☐ Dream disturbed sleep

☐ Troubles falling asleep ☐ Wake up tired ☐ Nightmares

☐ Waking up in the night: time(s) that you wake at: _____

Please check boxes that are relevant to you pertaining to the condition(s) of your skin and hair:

☐ Rashes ☐ Eczema ☐ Dandruff ☐ Premature grey hair

☐ Hives ☐ Psoriasis ☐ Itchy skin ☐ Alopecia/hair loss

☐ Ulcerations ☐ Shingles ☐ Fungal infections ☐ Brittle hair

☐ Dry skin ☐ Oily skin ☐ Acne

Please check boxes that are relevant to you pertaining to your genito-urinary conditions:

☐ Painful urination ☐ Cloudy urination ☐ Dark yellow urine ☐ Burning urination ☐ Frequent kidney infections

☐ Frequent urination ☐ Scanty urination ☐ Light yellow urine ☐ Retention of urine ☐ Urinary incontinence

☐ Copious urination ☐ Urination at night ☐ Clear urine ☐ Frequent bladder infections

Please check boxes that are relevant to you pertaining to your neuropsychological conditions:

☐ Seizures ☐ Tics ☐ Anxiety ☐ Abuse survivor ☐ Trigeminal neuralgia

☐ Numbness ☐ Poor memory ☐ Irritability ☐ ADHD ☐ Bell's palsy

☐ Tingling ☐ Depression ☐ Easily stressed ☐ Parkinson's ☐ Fainting

(Please see body diagram on next page to mark down areas of symptoms.)

Please check boxes that are relevant to you pertaining to your musculoskeletal conditions:

☐ Neck pain ☐ Hand pain ☐ Abdominal pain ☐ Leg pain

☐ Shoulder pain ☐ Finger pain ☐ Upper back pain ☐ Knee pain

☐ Arm pain ☐ Chest pain ☐ Mid back pain ☐ Ankle pain

☐ Elbow pain ☐ Rib pain ☐ Lower back pain ☐ Toe pain

(Please see body diagram on next page to mark down areas of symptoms.)