INITIAL INTAKE FORM

NAME:_____ LAST NAME: _____ DATE:_____

MALE ☐ FEMALE ☐ BIRTHDATE:_____WEIGHT:_____ HEIGHT:_____

OCCUPATION: _____ ADDRESS: _____ APPT: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHONE(MAIN): _____ EMAIL: _____

OTHER METHOD OF CONTACT: _____

PHYSICIAN NAME: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

CURRENT MEDICATIONS, SUPPLEMENTS, VITAMINS, HERBS:

_____
_____
_____

PRIOR SURGERIES, MAJOR TRAUMAS AND/OR INJURIES:

_____
_____
_____

KNOWN ALLERGIES

_____
_____
_____

GENERAL DIET (Eg. Vegetarian, Atkins, Paleo, Vegan, etc. or foods you avoid)

_____
_____
_____

BRIEF, KNOWN FAMILY HISTORY

_____
_____
_____

REASON FOR SEEKING TREATMENT

_____
_____
_____
_____
_____
_____

Of the following conditions, circle it if you have had the symptom in the last *3 months*, star (*) for emphasis

Head and Face
Headaches
Dizziness
Memory loss
Other:-
_____

Eyes
Poor vision
Eye pain
Watering eyes
Inflammation
Other: -
_____

Ears
Poor hearing
Earaches
Discharge
Ringing
Other:_____

Nose
Frequent colds
Sinus trouble
Bleeding
Difficulty breathing
Other:
_____

Mouth
Gum problems
Teeth problems
Jaw problems
Unusual taste
Other:_____

Throat
Sore throat
Hoarse voice
Difficulty swallowing
Other:_____

Heart and Chest
Palpitations
High blood pressure
Tightness in chest

Low blood pressure
Difficulty laying flat
Cardiovascular event
Other:_____

Circulation
Bruise easily
Bleed easily
Slow wound healing
Cold limbs
Other:-
_____

Gastrointestinal
Excess thirst
Never thirsty
Excess appetite
Decreased/no appetite
Digestive pain
Nausea
Vomiting
Diarrhea
Constipation
Blood in stool
Colon problems
Hemorrhoids
Other:_____

Urination
Frequent
Difficulty
Painful
Nighttime
Bleeding
Pain
Other:_____

Skin
Rashes
Dryness
Moles or lumps
Excess sweating
Night sweating
Rarely sweat
Other:_____

Neurological
Nervousness
Tremors
Convulsions
Numb/tingling
Loss of balance
Nerve pain
Other:
_____

Sleep
Insomnia
Drowsiness
Dreams
Other:
_____

Energy
Low
High

Mental Health
Depression
Anxiety
Bipolar
Schizophrenia
Addiction
Sexual abuse
Emotional abuse
Other:
_____

Pain
Arthritis
Surgery
Injury
Fractures
Broken bones
Gout
Joint
Bone
Osteoporosis
Qsteopenia
Neck
Chest pain
Upper extremity
Upper back
Low back
Hip
Lower extremity
Other:_____

Have you ever had…
HIV/AIDS
Hepatitis A
Hepatitis B
Hepatitis C
Cancer type:
Rheumatic fever
Hemorrhoids
Arthritis
Diabetes
Epilepsy/seizures
Diphtheria
Scarlet fever
Mononucleosis
Anemia
Hyperthyroid
Hypothyroid
Asthma
COPD
Jaundice
Autoimmune disorder

MEN ONLY

Male Reproduction
Erectile dysfunction
Sexual difficulties
Testicular pain
Testicular swelling
Prostate problems
Penile discharge
Other:_____

WOMEN ONLY

Menopause: Not Applicable Perimenopausal Menopausal Postmenopausal

Menstrual Cycle
Irregular
Early
Late
Excess blood
Lack of blood
Dark coloured
Light coloured
Clots
PMS symptoms
Cramping
Other:_____

Gynecological
Bleeding between cycles
Menopausal symptoms
Vaginal discharge
Difficulty conceiving
Sexual difficulties
Pelvic pain
Other: _____

Pregnancy
Are you pregnant? yes no
Are you on birth control? yes no

If yes, method: _____

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages:_____

Number of abortions:_____

Period Specifics

Period Length:_____ days

Cycle length: _____ days

ANY OTHER HEALTH RELATED INFORMATION OR CONCERNS

_____
_____
_____
_____
_____
_____
_____
_____