PATIENT INTAKE FORM

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (H): _____ (Bus.): _____ (Cell)_____

E-mail: _____

Male: ❒ Female: ❒ Date of Birth: _____

Occupation: _____ Employed By: _____

Marital Status: _____ Number of children: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Name of Medical Doctor: _____ Phone: _____

How did you hear about us? ❒ Radio ❒ T.V. ❒ Newspaper ❒ Website ❒ Friends ❒ Family

❒ Other: _____

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.

Health Concerns

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

_____

_____

_____

_____

Prescription Drugs

List all prescription drugs that you are currently taking. Indicate present dose and how long you have been on each medication.

_____

_____

_____

_____

List all prescription drugs you have taken in the past for longer than six months. Indicate how long you were on each medication.

_____

_____

Medical History

List any major surgery or injury and when it happened?

_____

_____

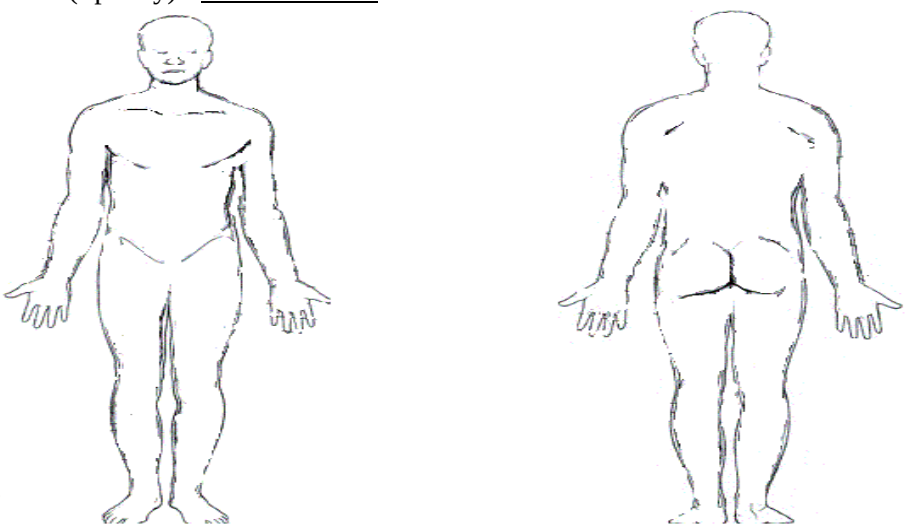
Visual Pain Rating Scale

Make a mark (/) along the line which you think represents your current level of pain

No pain at all _____ As bad as it could be

Pain Diagram

On the following diagrams, indicate all areas of:
Pain – xxxx Stiffness - //// Numbness - 0000
Other (Specify) - _____



Medical History

In the lists below, check all major illnesses that you have experienced.

Measles		Stomach/Duodenum Ulcers		Genital Herpes		Heart Problems	
German Measles		Hiatal Hernia		Genital Warts		Heart attack, angina	
Chicken Pox		Constipation		Gonorrhea		Palpitation	
Mononucleosis		Crohn's Disease		Spleen Disease		Circulation Problems	
Mumps		Appendicitis		Hypoglycemia		Varicose Veins	
Whooping Cough		Rheumatoid Arthritis		Jaundice		Anemia	
Scarlet Fever		Osteoarthritis		Hepatitis		Raynaud's Disease	
Polio		Rheumatism		Liver Disease		Platelet Disorders	
Reye's Syndrome		Back pain/Sciatica		Pancreatic Disease		Miscarriage	
Worms/Parasites		Fibromylagia		Bladder Problems		Abortion	
Cholera		Gout		Prostate Problems		Gestational Diabetes	
Malaria		Strep Throat		Diabetes		Uterine Prolapse	
Food Poisoning		Sinusitis		Gall Bladder Disease		Pre-eclampsia	
Typhoid		Allergies (Environmental)		Eye Problems		Other Pregnancy Related Illness	
Diarrhea		Hay Fever		Kidney Problems		Fibrocystic Breast Disease	
Acne, Boils, Impetigo		Bronchitis		Cushing's Disease		PMS	
Shingles		Pneumonia, Pleurisy		Addison's Disease		Uterine Fibroids	
Eczema		Asthma		Hypothyroid		Endometriosis	

Keloids		Tuberculosis		Hyperthyroid		Ovarian Cysts	
Psoriasis		Malnutrition		Eating Disorder		Vaginitis (recurrent)	
Warts		Rickets		Schizophrenia		Painful Periods	
Herpes (cold sores)		Osteoporosis		Bipolar Disease		Infertility	
Urticara		Wilson's Disease		Clinical Depression		Migraine Headaches	
Ulcers		Chronic Fatigue Syndrome		Suicidal Tendencies		Dizziness	
Skin Cancer		Environmental Illness		Multiple Sclerosis		Numbness	
Candida (yeast syndrome)		Human Papillovirus (HPV)		Lupus		Cramps	
Irritable Bowel Syndrome		Chlamydia		Myasthenia Gravis		Epilepsy	
Colitis		Syphilis		High Blood Pressure		Meningitis	
Diverticulitis		HIV		Low Blood Pressure		Other:	
Cancer, specify type:		Cancer, specify type:		Fainting		Other:	

Please check "√" if you are experiencing the following symptoms or write 'P' beside the box if you have experienced these symptoms in the past.

General

- ❑ Poor/Change in appetite
- ❑ Nervousness
- ❑ Weight gain
- ❑ Weight loss
- ❑ Cancer
- ❑ Diabetes
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Allergies
- ❑ Chills and fevers
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Cravings
- ❑ Strong thirst

Skin and Hair

- ❑ Rash
- ❑ Itching
- ❑ Eczema
- ❑ Acne
- ❑ Loss of hair
- ❑ Thinning hair
- ❑ Dandruff
- ❑ Recent moles
- ❑ Dryness
- ❑ Hives or allergy reaction
- ❑ Boils
- ❑ Other skin problem(s)

Eyes Ears Nose Throat

- ❑ Ear aches
- ❑ Ear infections
- ❑ Ringing in ears
- ❑ Sinus infections
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Recurrent sore throat
- ❑ Tonsillitis
- ❑ Nasal obstruction
- ❑ Post nasal drip
- ❑ Nosebleeds
- ❑ Headaches
- ❑ Loss of taste/smell
- ❑ Eye pain
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Vertigo
- ❑ Impaired vision
- ❑ Cataracts
- ❑ Facial pain/tics
- ❑ Jaw pain or clicks
- ❑ Mercury fillings
- ❑ Sores in mouth

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Congestive heart failure
- ❑ Heart attack
- ❑ Phlebitis
- ❑ Stroke/cardiovascular accident
- ❑ Pacemaker or similar device
- ❑ Artificial valve
- ❑ Irregular heartbeat
- ❑ Dizziness
- ❑ Fainting
- ❑ Chest pain
- ❑ Varicose veins
- ❑ Cold hands or feet
- ❑ Swelling of limbs

Respiratory

- ❑ Difficulty breathing
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema
- ❑ Shortness of breath
- ❑ Coughing blood
- ❑ Throat phlegm
- ❑ Wheezing

Muscle, Bone & Jointsl

- ❑ Neck pain
- ❑ Back pain
- ❑ Muscle pain
- ❑ Muscle weakness
- ❑ Arthritis
- ❑ Bursitis
- ❑ Other pain
- ❑ Artificial joint

Gastrointestinal

- ❑ Indigestion
- ❑ Gas or burping
- ❑ Bad breath
- ❑ Constipation
- ❑ Diarrhea
- ❑ Incomplete bowel movements
- ❑ Abdominal pain or cramps
- ❑ Nausea
- ❑ Vomiting
- ❑ Chronic laxative use
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Blood in stool
- ❑ Constant hunger
- ❑ Colon trouble
- ❑ Bloating
- ❑ Gall bladder trouble
- ❑ Intestinal worms

- ❑ Jaundice

Neurological

- ❑ Loss of balance
- ❑ Irritable
- ❑ Poor memory
- ❑ Anxiety
- ❑ Depression
- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Seizures/Epilepsy
- ❑ Concussion
- ❑ Loss of sensation
- ❑ Emotional problems
- ❑ Other psychological problem

Infections

- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ HIV/AIDS

Genito-Urinary

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Pain on urination
- ❑ Wake up at night to urinate
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Kidney infection
- ❑ Blood in urine

Male

- ❑ Prostate problem
- ❑ Impotence
- ❑ Sores on genitals
- ❑ Pain
- ❑ Infertility/low sperm count
- ❑ STD
- ❑ Hernia

Female

- ❑ Irregular periods
  - ❑ Heavy
  - ❑ Light
  - ❑ Clots
- ❑ Painful periods
- ❑ Vaginal discharge
- ❑ Pregnant
- ❑ Infertility
- ❑ Vaginal sores
- ❑ Sore breasts
- ❑ STD

Date of last Pap _____
Age of first menses __
Menopausal Y□ N□
Age of last menses ___
Pregnant Y □ N□
Do you practice birth control?
Y□ N□ Type _____
Number of:

- pregnancies _____
- abortions _____
- miscarriages _____
- births _____

SIGNATURE

I attest that the information provided is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Thank you for taking the time to fill out this questionnaire.
It will help greatly in our study of your present health concerns
and in our understanding of your health goals.
Your responses will assist us in choosing the appropriate treatment that will
bring about your return to optimal health.