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Adult Intake Form

Name		Date (dd/mm/yr) / /
Birth Date (dd/mm/yr) / /	Age	Gender
Address		
City	Province	Postal Code
Home phone number ()	Work phone number ()	
Family Doctor:		
Phone number: ()		
Emergency Contact:		Relation to Emergency Contact
Phone number: ()		
Would you like to receive our seasonal e-newsletter? Yes or No		
Email:		

Other Health Care Providers:

1. _____ () _____
2. _____ () _____
3. _____ () _____

Please list your primary reason(s) for attending this clinic?

Medical History

Please check the conditions you have had or currently have:

Alcoholism		Diabetes		Kidney Disease	
Allergies		Drug use		Liver Disease/Jaundice	
Anemia		Eczema		Overweight	
Asthma		Emphysema		Pneumonia	
Arthritis		Headaches/Migraine		Rheumatism	
Bleeding		Heart Murmur		Tuberculosis	
Cancer		High Blood Pressure		Ulcers	
Candida		Hyperthyroid		Other	
Colitis		Hypothyroid			

Please list any major traumas, injuries, surgeries or accidents you have sustained. (ex. Car accidents, fractures, sprains, emotional traumas) with corresponding dates:

_____ Long term effects:

_____ Long term effects:

_____ Long term effects:

_____ Long term effects:

Do you have any allergies or intolerances (medications, environment, foods, etc)? Please list:

Please list all current and past medications, including all supplements:

Have you ever been treated with antibiotics? Y or N

Please indicated how many times: _____

Nutrition

Do you have any dietary restrictions (religious, vegetarian, vegan, etc.)? Y or N

Are there any foods you exclude from your diet? Why? _____

Are there any foods that you crave specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy)

Do you prefer your beverages hot, cold, or neutral:

Environment

Have you ever been exposed to any toxic chemicals including pesticides, herbicides, solvents, or sprays? If yes, please explain:

Do you live close to any of the following? Circle all that apply:

Airport / Dump / Highway / Industry / Power lines

How would you describe your home environment? Circle what applies:

Very stable / Stable / Stressful / Very stressful

How would you describe your work environment? Circle what applies:

Very enjoyable / Enjoyable / Stressful / Very stressful

Are there any pets in your household? Y or N

Do you exercise? Y or N

If yes, please describe what activities and how often: _____

How much television do you watch? _____ hrs a day/ week

How much time do you spend on a computer? _____ hrs a day/week

Vaccinations

Please indicate what immunizations you have had (please attach updated vaccination record if possible):

<input type="checkbox"/> DPT (diphtheria, pertussis, tetanus)	<input type="checkbox"/> Haemophilus influenza	<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Tetanus booster: when?	<input type="checkbox"/> Flu	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> MMR	<input type="checkbox"/> Polio	<input type="checkbox"/> Rubella
<input type="checkbox"/> HPV	<input type="checkbox"/> Other _____	

Family History

Please indicate if any close relatives have had any of the following (mother, father, siblings, aunts, uncles, etc):

	Father	Mother	Brothers	Sisters	Maternal		Paternal	
					G.mother	G.father	G.mother	G.father
Age (if living)								
Health G=good P=poor								
Allergies								
Asthma								
Heart Disease								
High blood pressure								
Cancer								
Diabetes								
Depression								
Other mental illness								
Drug abuse/alcoholism								
Osteoarthritis								
Rheumatoid arthritis								
Anemia								
Kidney Disease								
Other								

Is there anything you feel is important that has not been covered?
