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ADULT INTAKE FORM

Please Complete and Return to Reception

Name _____ Date _____

Address:_____

City/Postal Code:_____

Telephone number: Home:_____ Work:_____

E-mailAddress:_____

May we leave messages relating to your visits? Y / N

Age:_____ Date of Birth:_____ Gender: Female / Male

Education:_____

Married:___ Separated:____ Divorced:____ Widowed:____ Single:____ Partnership:____

Occupation:_____

Emergency contact name: _____

Phone number:_____ Relation:_____

How did you hear about this Clinic?:_____

If internet: Google:___ OAND website:____ CAND Website:____ Other: _____

Has any other family member already been a patient at this clinic?_____

Context of Care Review

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know or what would you like to learn about the approach?
What *three* expectations do you have from *this* visit to the clinic?

What *long term* expectations do you have from working with this clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

How would you describe your general state of health? Excellent Good Fair Poor

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

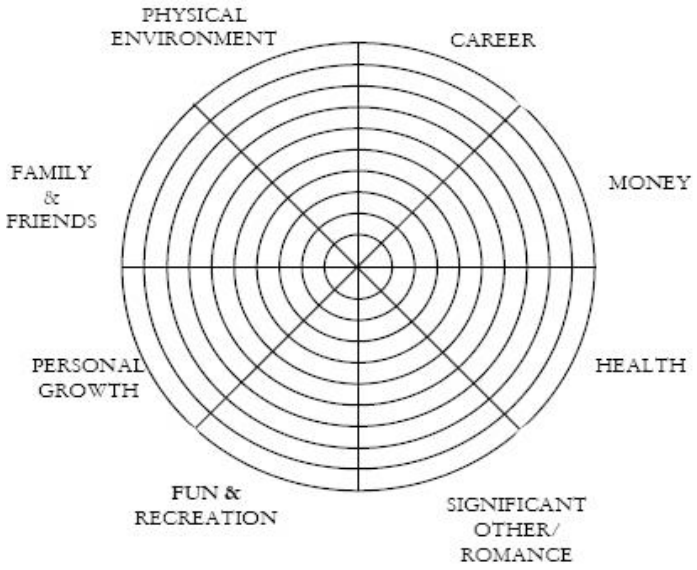
What do you love to do?

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of Satisfaction in each area as it relates to you.

For example if you are 60% Satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, Starting from the center point radiating outward.



STRESS

How stressful is your work? 0 = No stress 10 = Highest level of stress: _____

How stressful are other aspects of your life? _____

How do you handle these stresses?

_____

_____

_____

_____

CURRENT HEALTHCARE

Are you currently receiving healthcare? Yes / No

If yes, where are from whom? This includes MD's (please include phone and fax number), Physiotherapist, Chiropractor etc.)

1. _____ **2.** _____ **3.** _____

_____ _____ _____

Phone:_____ _____ _____

Fax:_____ (_____)_____ (_____)_____

Do you get regular screening tests done? Y / N If so, which ones? _____

_____

If no, when and where did you last receive medical or health care?_____

_____

What are your most important health concerns? List as many as you can in order of importance.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Do you have any known contagious disease at this time? Yes / No

If yes, what?_____

If you are female are you currently pregnant? Yes No (Please circle one)

GENERAL

Height:_____ Weight:_____ Weight one year ago:_____

Maximum Weight:_____ When:_____

When during the day is your energy the best:_____ Worst?_____

Main interests and hobbies:_____

Exercise: Y / N If so, what kind and how often: _____

Watch TV: Y / N If so, how many hours? _____

Read: Y / N If so, how many hours? _____

Do you have a religious or spiritual practice? Y / N If so, what kind? _____

TYPICAL FOOD INTAKE

Briefly describe a typical day's diet:

Breakfast_____

Lunch_____

Dinner_____

Snacks _____

Beverages (and total quantity) _____

FAMILY MEDICAL HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay fever	Hives	

Any other relevant family history?_____

What is your family heritage?_____

CHILDHOOD ILLNESSES

Weight at Birth?:_____

Please circle whether you had any of the following as a child:

Rheumatic fever	Diptheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, ECGs have you had?

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs?_____

Any foods?_____

Any environmentals or chemicals?_____

CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping pills	Thyroid medications
Birth Control Pills	Hormone Replacement		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

Do you think that there is anything else important that has not been covered so far?

_____
_____
_____
_____

Thank-you for taking the time to fill out this intake form, I look forward to working with you in your journey towards better health.