PATIENT INTAKE FORM

General Information
Patient name:_____ Date: _____
Date of birth:_____/_____/_____ (M/D/Y) Age: _____ Sex: M / F
Address:_____
_____
_____

Marital Status: Single / Married / Common Law / Other
Telephone number: Home:_____ Work:_____
E-mail address: _____ Cell: _____
Emergency contact Name: _____
Phone number: _____ Relation: _____

How did you hear about the Clinic?

Brochure	Yellow Pages	Family Doctor	BCNA
Television	Friend	Chiropractor	Directory
Radio	Relative	Specialist	Newspaper
Internet	Coworker	Health Professional	Health Food Store
Other:			

Other health care providers you are seeing:
1. _____
2. _____
3. _____
4. _____
5. _____

Please list your health concerns, in order of importance to you:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

What long-term expectations do you have from working with our clinic?

_____
_____
_____

What expectations do you have of me personally as your physician?

_____
_____
_____

What is your present level of commitment to address any underlying causes of your signs/symptoms that relate to your lifestyle?

_____
_____
_____

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

_____
_____
_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

Medical History

Describe your general state of health: Excellent Good Fair Poor

Please indicate all past or current medical conditions, previous illnesses, injuries and or hospitalizations. Include approximate dates.

Do you have any allergies (medications, environmental, foods etc.)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, Chinese patents etc.)

Have you ever had any adverse reactions to any medication, supplement, herb or Homeopathic?

Please list all past prescription medications, why you were taking them and for how long.

How many times have you been treated with antibiotics? _____

Female Patients
Are you currently pregnant? Yes / No
When was your last pap? _____ Have you ever had an abnormal pap? Y / N
When was your last breast exam? _____
What is your method of birth control? _____

Do you frequently use any of the following?
Alcohol—how much/day or week: _____
Tobacco—form and amount/day: _____
Caffeine—form and amount/day: _____
Recreational drugs—what and how often: _____

Please indicate what immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Haemophilus
- ☐ Hepatitis A
- ☐ Influenza B
- ☐ Tetanus booster; when? _____
- ☐ "Flu"
- ☐ Hepatitis B
- ☐ MMR (measles, mumps, rubella)
- ☐ Polio
- ☐ Smallpox

Please indicate if any caused adverse reactions: _____
_____

Diet

Do you have any food allergies or intolerances? What are your symptoms? Please list.
_____
_____
Do you have any dietary restrictions (religious, vegetarian, vegan, etc.)?
_____
_____

Describe a typical day's diet:
Breakfast _____
Lunch _____
Dinner_____
Snack_____

Family History

Indicate if a relative or family member has had any of the following:

	Who?		Who?
Allergies		Cancer	
Asthma		Diabetes	
Heart disease		Drug abuse /alcoholism	
High blood pressure		Depression	
Stroke		Other mental illness	
Kidney disease		Other	

☐ I don't know my family medical history

Environment

Occupation _____
Hobbies_____
Do you exercise regularly? Y / N
What do you do for exercise, how much, how often? _____
_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N
Are you frequently exposed to animals? Y / N
How old is your house? _____
How is your home heated? _____
Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?
Please describe? _____
_____

How would you describe the emotional climate of your home?
_____
_____

Do you have someone in your life you can talk to about your emotions? Family or friends whom are a support network? Y / N Whom? _____

Please rate your stress level: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

How do you handle these stresses?
_____
_____

Have you ever experienced anything in your life that was traumatic to you? If you are able to comment on it, please write down a few points?

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____