Please complete this form as thoroughly as possible. The information provided is kept strictly confidential. This complete form is required prior to your first appointment.

ADULT INTAKE

(Please print clearly)

Date: ______________________ Height: _______________ Weight: _______________

Name: Mr. Mrs. Ms. Dr. ______________________ ______________________________
(Given Name) (Family Name)

Address: ____

City: _________________________ Prov: _______ Postal Code: _____________________

Telephone: (_______) _____________________ (H) (_______)_____________________ (B)

May the clinic leave voice mail messages relating to appointments? Yes No

Email: ____

Date of Birth (yyyy/mm/dd): ______________________________

Emergency Contact Name: ____

Telephone: (_______) _____________________ Relation: ______________________________

How did you hear about the clinic? ____

If you were referred, please indicate the name of the person who referred you:

____

Other Health Care Providers (HCPs) involved in your care:

Medical/Family Doctor: ____

Telephone: (_______) _____________________ Fax: (_______) _____________________

Permission to contact: Yes No

Other HCP: ____

Telephone: (_______) _____________________ Fax: (_______) _____________________

Permission to contact: Yes No Type of Practitioner: ______________________________

Other HCP: ____

Telephone: (_______) _____________________ Fax: (_______) _____________________

Permission to contact: Yes No Type of Practitioner: ______________________________

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Health History

What are your health concerns, in order of importance to you:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

If you are female, are you pregnant? Yes No or trying to become pregnant? Yes No

Please indicate any serious health conditions, illnesses and hospitalizations you have had:

1. ______________________________ Date: __________
2. ______________________________ Date: __________
3. ______________________________ Date: __________
4. ______________________________ Date: __________
5. ______________________________ Date: __________

Do you have any allergies (environmental, food, pet, medications, etc)?

____

____

List all **current** medications (prescription, over-the-counter, supplements, homeopathics)

____

____

____

____

____

____

List all **past** medications (prescription, over-the-counter, supplements, homeopathics, etc).

____

____

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When was the last time you were treated with antibiotics? ______________________

For what reason(s) were the antibiotics given? ______________________

Do you regularly use any of the following? (☑ all those that apply)

Aspirin/ASA	☐	Tylenol/Acetaminophen	☐
Advil/Ibuprofen	☐	Laxatives	☐
Antacids	☐	Diet Pills	☐
Oral Birth control	☐		

Tobacco ☐ form, amount per day, how long ______________________

Alcohol ☐ form and amount per day ______________________

Recreational Drugs ☐ what and how often ______________________

Caffeine ☐ form and amount per day ______________________

Family History

Briefly describe the health status and concerns of the following family members

Mother: ______________________

Maternal Grandmother: ______________________

Maternal Grandfather: ______________________

Father: ______________________

Paternal Grandmother: ______________________

Paternal Grandfather: ______________________

Sibling (specify): ______________________

Sibling (specify): ______________________

Vaccinations

Please indicate which immunizations you have had (☑ all those that apply)

*Vaccinations in **bold** are considered routine as per the Ontario Childhood Immunization Schedule 2004*

Please refer to your vaccination record

DPT (Diptheria, Pertussis, Tetanus)	☐	**Hemophilus Influenza B (HiB)**	☐
Hepatitis A	☐	**Hepatits B**	☐
Flu Vaccine	☐	**MMR (Measles, Mumps, Rubella)**	☐
Varivax/Varilrix (Chicken Pox)	☐	**Polio**	☐
BCG (Tuberculosis)	☐	Gardasil/Cervarix (HPV Vaccine)	☐
Pneumococcal Conjugate (Meningitis/Pneumonia)	☐	**Meningococcal C Conjugate (Meningitis)**	☐
Other:______________	☐	Other: ______________	☐

Did you experience any reactions to any of the vaccinations? If so, describe.

____

____

Sleeping Habits

Would you say you sleep well? Yes No

If No, please describe:____

____

On average, how many hours do you sleep per night? ______________________________

On average, how many times do you wake up per night? ______________________________

For what reasons to you wake up? ____

Dietary/Lifestyle Habits

On average, how many meals do you eat per day? ______________________

Do you have any food allergies or intolerances? Please specify

____

____

Do you have any dietary restrictions (religious, vegetarian/vegan, celiac, etc)? Please specify.

____

Do you exercise regularly? Yes No

If Yes, what form(s) and how often? ____

Are you currently on a "diet?" Yes No If Yes, please specify __________________________

Do you enjoy your work? 1 2 3 4 5 6 7 8 9 10
Not at all Very much

Rate your average daily stress level? 1 2 3 4 5 6 7 8 9 10
No stress Very stressful

How do you cope with stressful situations in your life? ______________________________

____

____

Are you regularly exposed to any toxins or other hazards? Please specify.

____

____