Intake Form

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Contact Information:

Name: _____ Age: _____ Date of Birth: _____ Gender: ☐ M ☐ F

Address: _____ City/Town _____

Email: _____ Postal Code: _____

Phone (H): _____ (W):_____ (C): _____

Emergency contact: _____ Relationship: _____ Phone: _____

Medical doctor: _____ Phone: _____

Where did you hear about this service? _____

Health Goals/Concerns:
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What main health goal/concern brought you to the clinic today?

_____

_____

How long have you had it?

_____

Describe any factors you suspect may have played a role in the onset and perpetuation of your condition:

_____

_____

Previous practitioners consulted for this condition: ☐ MD ☐ ND ☐ Other

_____

Please explain their diagnosis, therapy and results, where applicable:

_____

_____

_____

What types of therapy have you tried for this problem? ☐ Diet modification ☐ Vitamin/mineral supplements ☐ Herbs

☐ Homeopathy ☐ Chiropractor ☐ Acupuncture ☐ Conventional drugs ☐ Osteopathy ☐ Other

_____

What makes it better? _____ What makes it worse? _____

Please list any other health concerns or goals in order of importance:

_____

_____

_____

Personal Information/ Lifestyle:

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ With partner ☐ Number of dependants _____

Occupation: _____ Shift work? ☐ Y ☐ N Do you enjoy your work? ☐Y ☐N ☐Sometimes

Is your job associated with potentially harmful chemicals (e.g. pesticides, solvents, radioactivity) or health and/or life threatening activities (e.g. firefighting, mining, etc.)? Please specify:

_____

Hours/day you spend: Working: _____ Driving: _____ Watching TV: _____ In front of computer/screen: _____

Stress Levels

Circle the level of stress you are presently experiencing in your life (10=highest): 1 2 3 4 5 6 7 8 9 10

Please list the major causes of stress for you (work, finances, relationship, health, etc.)

_____

_____

Do you feel your stress levels are affecting your quality of life?

_____

_____

Do you consider yourself to be a happy person?

_____

_____

Have you experienced any major trauma, loss, or life changing significant events?

_____

Medical History:

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

Do you wear a medical alert bracelet/tag? ☐ Y ☐ N For what condition? _____ What is your blood type? ____

Do you wear: ☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical devices/prosthetics/implants

For the following tables, please use the back of this page if more room is required:

Medical Conditions: Please indicate any hospitalizations, surgeries and injuries you have experienced:

Hospitalization /Surgery/Injury	Date	Symptoms/Condition	Resolved?

X-rays, CT Scans, EKGs, ECGs, MRIs, or other imaging scans you've had in the past:

Scan/Screen/Test	Date	Reason	Result

Allergies and/or food sensitivities:

Allergy/Sensitivity	Symptoms	Treatment/Avoidance

Current medications/supplements: Please list ALL medications or supplements you take on a regular basis:

Medication/Supplement	Dose (if known)	Length of Use	Prescribing Practitioner

Screening Tests: Please indicate when you had the following screening tests (if known):

Screen/Test*	Year	Screen/Test*	Year
PAP (Females)		DEXA Scan (Bone density)	
Digital Rectal Exam (Males)		Complete Blood Count (CBC)	
PSA Test (Males)		Cholesterol	
Breast Exam		Mammogram	

Date of last complete physical exam: _____

Have you taken antibiotics within the last 5 years? ☐ Y ☐ N If yes, how many times? _____

Were you frequently given antibiotics as a child? ☐ Y ☐ N How often? _____

Diet and Health Habits:

General energy level - out of 10 (1=lowest, 10=highest): _____ What time of day is it highest? _____Lowest? _____

What time of day do you eat the following: Breakfast _____ Lunch: _____ Dinner: _____

Do you consume: Canned foods ☐ Pop ☐ Aspartame (e.g. diet pop, gum) ☐ Deli meats ☐ Margarine ☐ Juice ☐

Are you on a special diet? ☐ Y ☐ N Explain:
_____

Do you crave: Sugar ☐ Chocolate ☐ Salt ☐ Protein ☐ Fats ☐ Other:_____

How many glasses of water do you drink on an average day? _____Do you drink purified water/filtered water? ☐ Y ☐ N

Do you eat meals: With family ☐ Home alone ☐ On the run ☐ In restaurants ☐ Fast food ☐

Please provide examples of things you typically consume at the following meals:

Breakfast:
_____

Lunch:
_____

Dinner:
_____

Snacks:
_____

Do you consider yourself to be an emotional eater?

_____
_____

Do you feel there are restrictions to your diet due to preferences of others (family, roommates, etc.) Y ☐ N ☐

If yes, please explain:

_____

Are you a: Vegetarian ☐ Vegan ☐

How often do you eat meat? Daily ☐ 3-5 times/week ☐ 1 time/week or less ☐

How often do you consume dairy? (Milk, cheese, yogurt) Daily ☐ 3-5 times/week ☐ 1 time/week or less ☐

What are your favourite foods?

_____

How often do you eat them?

_____

Do you avoid certain foods? Please explain:

_____

Do you experience any symptoms if meals are missed? Please explain:

_____

_____

Do you experience any symptoms after meals? Please explain:

_____

Lifestyle Habits

Do you smoke? Y☐ N ☐ How long ago did you start? _____ Number of cigarettes per day: _____

Did you smoke in the past? Y☐ N☐ For how long? _____ Number of cigarettes per day: _____

Do you drink alcohol? Y☐ N ☐ What type? _____ How frequently?_____

Do you take recreational drugs? Y☐ N☐ What type? _____ How frequently? _____

Do you drink coffee? Y☐ N☐ How many cups per day? _____

How often do you exercise? 5-7 days/week ☐ 3-4 days/week ☐ 1-2 days/week ☐ How long do you spend? _____

What do you do for exercise/movement?

_____

Sleep Patterns

How many hours of sleep do you get each night? _____ Do you wake feeling rested? Y ☐ N ☐

Do you nap? Y☐ N ☐ Do you wake in the night? Y ☐ N ☐ For any particular reason? _____

At any particular time? _____

Have you ever been diagnosed with any of the following?

☐ Alcoholism	☐ Colitis	☐ Genetic Disorder	☐ Mono
☐ Alzheimer's Disease	☐ Crohn's Disease	☐ Glaucoma	☐ Osteoarthritis
☐ Anaemia	☐ Depression	☐ Gastric/Duodenal Ulcer	☐ Osteoporosis
☐ Asthma	☐ Diabetes	☐ Head Injury	☐ Pancreatitis
☐ Autoimmune Disease	☐ Drug Addiction	☐ Hepatitis	☐ Pneumonia
☐ Benign Prostatic Hypertrophy	☐ Eating Disorder	☐ High Blood Pressure	☐ Psoriasis
☐ Cancer	☐ Emphysema	☐ HIV	☐ Skin Condition

☐Cardiovascular Disease	☐Endometriosis	☐Intestinal Parasites	☐STD
☐Chronic Fatigue Syndrome	☐Fibromyalgia	☐Migraine Headaches	☐Thyroid Condition

Other: _____

Childhood History:

Were you breastfed? Y ☐ N ☐ If yes, for how long? _____

Were you immunized? Y ☐ N ☐ If yes, any reactions? _____

Which "childhood" illnesses did you have?

☐ ADD/ADHD	☐ Eczema	☐ German Measles	☐ Mumps
☐ Frequent Ear Infections	☐ Meningitis	☐ Red Measles	☐ Rheumatic Fever
☐ Chicken Pox	☐ Whooping Cough	☐ Thrush/Candida	☐ Autism/Asperger's

Family History:

Has anyone in your family been diagnosed with any of the following conditions?

☐ Alcoholism	☐ Diabetes	☐ Heart Disease	☐ Multiple Sclerosis
☐ Alzheimer's Disease	☐ Drug Abuse	☐ High Blood Pressure	☐ Cholesterol
☐ Osteoporosis	☐ Cancer	☐ Epilepsy	☐ Kidney Disease
☐ Psoriasis	☐ Depression	☐ Fibromyalgia	☐ Mental Illness
☐ Thyroid Disorder	☐ Asthma	☐ Eczema	☐ Osteoarthritis

Please list any other illnesses of your relatives, such as: parents, siblings, grandparents,

The Digestive System:

PLEASE CHECK BOX IF SYMPTOMS APPLY. **Leave blank if system or activity does not apply.**

Underactive Stomach	Overactive Stomach
☐ Excessive gas, belching or burping after meals	☐ Stomach pain 1 hour after eating or at night
☐ Stomach bloated after eating	☐ Burning sensation in stomach
☐ Sleepy after eating	☐ Pain aggravated by worry/tension
☐ Longitudinal striations on fingernails	☐ Hiatal hernia
☐ Eat when rushed/in a hurry	☐ Gastritis, gastric ulcer
☐ Bad breath	☐ Nausea, vomiting
☐ Full feeling after heavy meat meal	☐ Sensation of acidity in abdominal area
☐ Heavy, tired feeling after eating	☐ Heartburn, indigestion
☐ Nausea after taking supplements	☐ Blood in stool
☐ Acne	☐ Lower back pain
☐ Undigested food in stool	☐ Long term aspirin use

Liver	Pancreas
☐ Yellow or pale fingernails	☐ Severe abdominal pain
☐ Skin oily on nose and forehead	☐ Nausea and vomiting
☐ Fats/greasy foods cause nausea, headaches	☐ Slow digestion; feel full for hours after eating
☐ Vertical white streaks on fingernails	☐ Fever
☐ Bad breath; bad taste in mouth	☐ Alcohol addiction
☐ Excess body odor	☐ Jaundice
☐ Onions, cabbage, radishes, cucumbers cause bloating or gas	**Hypoglycemia**
☐ Stiff, aching muscles	☐ Hungry up to 3 hours after eating
☐ Migraine headaches	☐ Strong, sudden cravings for sweets, starches, coffee or alcohol
☐ Discomfort underneath right ribcage	☐ Nervous/anxious feeling relieved by eating
☐ Food allergies	☐ Irritable if late for or skip a meal
☐ Irritable, easily angered	☐ Overweight
☐ Weight gain around abdomen	☐ Addicted to coffee with sugar and/or colas
☐ Yellow Palms	☐ Frequent “midnight snacks”
☐ Jaundice	☐ Family history of diabetes
☐ Poor concentration	☐ Fatigue
☐ Difficulty losing weight	☐ Frequent headaches
☐ Acne, boils, rashes, psoriasis or eczema	☐ Fainting spells
☐ Constipation	☐ Depression
☐ High cholesterol/high cholesterol diet (sugar)	☐ Lose temper easily

Gallbladder
☐ Gall stones; history of gall stones
☐ Stool appears clay-coloured, foul odour
☐ Constipation
☐ High cholesterol diet; high blood cholesterol levels
☐ Severe pain in right upper abdomen

The Intestinal System:

Parasites/Candida	
☐ Depression or anger for no reason	☐ Forgetfulness
☐ Anxiety/panic attacks	☐ Slow reflexes
☐ Inability to concentrate	☐ Gas and bloating
☐ Phobic/compulsive	☐ Unclear thinking
☐ Lethargy	☐ Loss of appetite
☐ Mood swings	☐ Yellowish or pale face
☐ Itchy ears, nose, anus	☐ Fast heartbeat
☐ Memory loss	☐ Heart pain
☐ Mental confusion	☐ Pain in navel
☐ Abnormal muscle aches from exercise	☐ Eating more than normal but still feeling hungry
☐ Excessive wax in ears	☐ Blurry or unclear vision
☐ Unexpected/unexplained weight gain	☐ Pain in the back, thighs, shoulders
☐ Impotence	☐ Numb hands
☐ Canker sores	☐ Drooling while sleeping
☐ Athlete's foot, finger/toenail fungus, ringworm	☐ Damp lips at night
☐ Jock itch	☐ Dry lips at night
☐ "Brain fog"	☐ Bedwetting
☐ Irritability	☐ Lethargy; chronic fatigue
☐ Extreme fatigue	☐ Dark circles under eyes
☐ Recurrent vaginal infections	☐ Cancer
☐ Frequent use of antibiotics	
☐ White coated tongue, oral thrush	
☐ Crave sugars, bread, alcohol	
☐ Headaches	
☐ Tonsillitis, recurrent strep throat	
☐ Itchy, watery or dry eyes	
☐ Skin flushes	
☐ Chronic indigestion, frequently use of antacids	
☐ Always cold, especially in extremities	
☐ Female: PMS	
☐ Pain in pelvic area	
☐ Loss of sex drive	
☐ Cystitis, repeated bladder infection	
☐ Female: endometriosis/ovary problems	
☐ Chronic diarrhea	
☐ Hives, psoriasis, acne, skin rashes	
☐ Rectal itching	

The Structural-Muscular/Skeletal System:

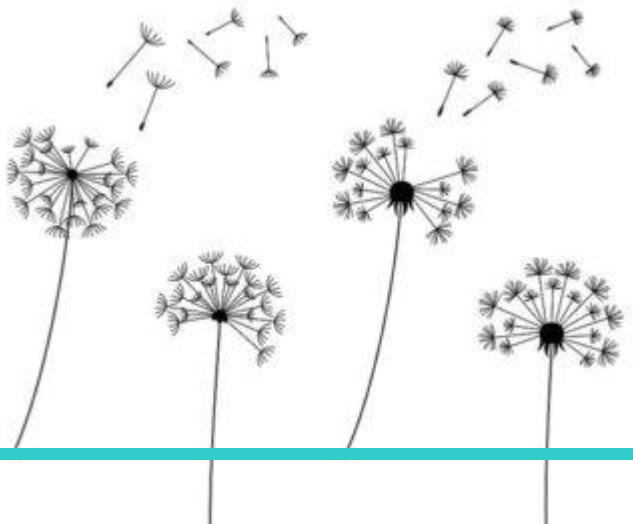
Skeletal	Neuromuscular
☐ Pain, swelling, stiffness in joints	☐ Muscles wasting in some part of the body
☐ Joint inflammation (rheumatoid arthritis)	☐ Numbness or loss of sensation
☐ Pain, stiffness, inflammation of spine	☐ Mood swings and/or depression
☐ Facial pain	☐ Blurred or double vision
☐ Joints make sounds like crinkling cellophane	☐ Loss of balance and/or coordination
☐ Joints make popping sounds	☐ Tingling and/or numbness, especially in extremities
☐ Gout	☐ Muscular stiffness
☐ Bones fracture easily	☐ Difficulty breathing
☐ Gradual loss of height	☐ Male: Impotence
☐ Tooth loss; teeth “falling out”, gum disease	☐ Tremors
☐ Lack of exercise	☐ Loss of peripheral vision
☐ Rounding of shoulders; stooping	☐ Slurred speech
☐ Female: Menopause	☐ Objects fall from hands; reach in wrong place
☐ Pain in forearm or biceps	☐ Hands tremble
☐ Painful cramping of feet or toes	☐ Impaired speech
☐ Cramps in calf muscle during sleep or exercise	
☐ Painful cramping of feet or toes	
☐ Teeth prone to decay, frequent toothaches	
☐ Malformation of bones	**Muscular**
☐ Insomnia	☐ Muscle Pain
☐ Muscles weak, weak grip, light objects feel heavy	☐ Muscle weakness
☐ Heart palpitations	☐ Sprains; muscle strains
☐ Diet high in animal protein (meat, dairy, eggs)	☐ Muscle(s) spasm

The Lymphatic/Immune System:

Thymus (Immunity)	Allergies (Cont.)
☐ Excessive Sleep	☐ Muscle cramps or spasms
☐ Very susceptible to infections	☐ Abnormal body odor
☐ Swollen glands; tonsils, throat, armpits	☐ Excessive sweating, night sweats
☐ History of cancer, MS, Parkinson’s arthritis	☐ Bowel disease: IBS, IBD, Crohn’s, Colitis etc.
☐ Loss of appetite	☐ Joint pains or stiffness
☐ Headaches	☐ Frequent night urination
☐ Soreness on both sides of neck at shoulder	☐ Wheezing
☐ Feel puffiness in throat	☐ Pale face
☐ Look older than chronological age	☐ Hives
☐ Flu-like symptoms often occur	☐ Nose runs constantly
☐ Lupus	☐ Nosebleeds
	☐ Noticeable changes in writing throughout day
Allergies	☐ Bloating or gas after eating certain foods
☐ Frequent cravings for certain foods	☐ Canker sores
☐ Periods of blurred vision	☐ Dark circles under eyes
☐ Repeated ear problems	☐ Stuffy nose
☐ Hyperactivity	☐ Acne, psoriasis, dermatitis, eczema
☐ Dizzy spells	☐ Rapid pulse, heart irregularities
☐ Periods of confusion	☐ Frequent headaches
☐ Poor concentration	☐ Hay fever
☐ Epilepsy	

The Glandular/Endocrine System:

Underactive Thyroid/Hypothyroid	Overactive Thyroid /Parathyroid
☐ Lethargic, tiredness or sluggishness	☐ Losing weight without trying
☐ Cold hands or feet	☐ Heart races while at rest
☐ Mercury amalgams (fillings)	☐ Feel warm/flushed at room temperature
☐ Gain weight easily, fail to lose on diets	☐ Hands shake or tremble
☐ Constipation, less than one bowel movement/day	☐ Protruding tongue
☐ Low energy in the morning	☐ Heart palpitations
☐ Low pulse rate	☐ Nervous behaviour, hyperactivity
☐ Low body temperature, especially at bed rest	☐ Insomnia
☐ Hair dry, brittle, dull, lifeless, losing hair	☐ Increased appetite
☐ Flaky, dry, rough skin	☐ Frequent bowel movements, diarrhea
☐ Feel stiff after sitting still for some time	☐ Excessive sweating without exercising
☐ Mood swings	
☐ Square and wide fingernails/vertical ridges	
☐ High cholesterol	
☐ Diminished sex drive	
Pituitary	**Adrenals**
	☐ Stress or emotional upsets cause exhaustion
☐ Infertility or impotence	☐ Blood pressure decreases when going from lying position to standing position
☐ Headaches	☐ Perspire excessively
☐ Female: Loss of menstrual function	☐ Neck and/or shoulder tension
☐ Moody	☐ Frequent headaches
☐ Overweight from waist down	☐ Beau's lines (depressed furrows) on fingernails
☐ Overweight from waist up	☐ Occasional cold sweats
☐ Excessive urination	☐ Tightness or lump in throat, especially when emotionally disturbed
☐ Pain in little finger of left hand	☐ High or low blood pressure
☐ Swelling in ankles, fingers and feet	☐ Rapid pulse
☐ Cold hands or feet	☐ Short temper
☐ Pain in left side of upper neck	☐ Puffy face



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