



INTAKE FORM

Date: _____

Patient Information	Emergency Contact
Name: _____	Name _____
Address: _____	
City _____ Postal Code _____	Relationship _____
Age: _____ DOB: _____	
Phone: Preferred _____	Phone _____
Secondary _____	
Email _____	
May we contact you by email? Yes No	
Would you like to receive appointment reminders through email?	
Yes No	

Health History

Primary Health Concerns or Treatment goals. Please list in order of importance	
1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____
Any medications/supplements you are taking: _____ _____ _____	List any hospitalizations, surgeries, or significant illnesses: _____ _____ _____
Are you currently pregnant: Yes No	Date of last physical exam: _____
Are you vegan or vegetarian ? Yes No	How would you currently rate your energy levels: Low 0 1 2 3 4 5 6 7 8 9 10 High
Please check any conditions that have occurred in family members: <input type="radio"/> Diabetes <input type="radio"/> High blood pressure <input type="radio"/> Cardiovascular disease	<input type="radio"/> Cancer <input type="radio"/> Mental Health Conditions : _____ <input type="radio"/> Thyroid conditions Other _____
Please circle any of the following symptoms you have experienced <u>in the past year</u> :	
<input type="radio"/> Notable weight loss or weight gain	<input type="radio"/> Excessive joy
<input type="radio"/> Excessive fear	<input type="radio"/> Feelings of sadness or depression
<input type="radio"/> Excessive anger	<input type="radio"/> Feeling overwhelmed
<input type="radio"/> Excessive worry	<input type="radio"/> Easily startled
	<input type="radio"/> Night sweats
	<input type="radio"/> Headache/migraines
	<input type="radio"/> Notable hair loss
	<input type="radio"/> Fatigue
	<input type="radio"/> Difficulty focusing
	<input type="radio"/> Poor memory or concentration



REVIEW OF SYSTEMS: please check any that apply to you

Musculoskeletal

- Tremors
- Cramps
- Swollen/Painful joints
- Pain or weakness of muscles

Cardiovascular

- Chest pain
- Poor circulation
- Swelling of hands, ankles, feet
- Irregular heart beats
- Dizziness or shortness of breath

Eyes, Ears, Nose, Throat, Respiratory

- Asthma or wheezing
- Allergies
- Blurred vision or visual changes
- Eye pain
- Loss of hearing
- Earaches
- Ringing in the ears
- Sore throat

Immune

- Frequent colds, flus or infection
- Swollen glands
- Long recovery following infections

Skin

- Poor wound healing
- Easy or unexplained bruising
- Rashes
- Eczema
- Psoriasis
- Itching dryness
- Frequent or recurring skin infections

Digestion

- Gas or bloating
- Abdominal pain or cramping
- Heartburn/acid reflux
- Nausea or vomiting
- Poor appetite
- Excessive appetite
- Loose stools or diarrhea
- Undigested food in stool
- Blood or mucus in the stool
- Constipation or difficulty passing stool
- Irregular bowel movements
- Pain or itching of the anus

Sleep

- Difficulties falling asleep
- Difficulties staying asleep
- Waking unrefreshed
- Excessive dreaming or nightmares

Genitourinary

- Blood or mucus in urine
- Frequent urination
- Difficulty controlling urine
- Urgency
- Kidney stones
- Bladder infections
- Lowered sex drive
- History of sexually transmitted infection

Mens Health

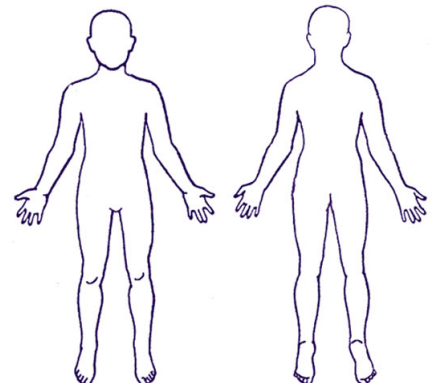
- Erectile difficulties
- Prostate difficulties
- Discharge from the penis

Womens Health

- Average length of cycle (days) _____
- Bleeding between periods
- Clots in menstrual blood
- Heavy or excessive menstrual flow
- Scanty or light menstrual flow
- Excessive menstrual pain or cramping
- Irregular cycles
- Difficulties becoming pregnant
- Difficulty maintaining a pregnancy or history of miscarriages
- Menopausal symptoms

Please list any health concerns not otherwise mentioned: _____

Please mark any areas that you experience pain/discomfort





CONSENT FORM

I attest that that the information provided on this form is correct to the best of my knowledge. I consent to the treatment as I understand it. I understand that I am free to ask questions and that I can withdraw my consent at any time

Name & Signature of patient OR power of attorney:

Name (please print)

Signature

Signature of guardian if patient under 18 years old

Date (D/M/Y)