NEW PATIENT INTAKE FORM

Information contained here will be kept in this office, and will not be released to any person except when you have authorized us in writing to do so.

Patient's Full Name:

_____

Date of Birth (month/day/year): _____

Sex: M / F Blood Type if known: _____

Address: _____

City _____ Province _____

Postal Code _____

Home phone:

Cell phone:

E-mail:

Would you prefer to be contacted by phone or by e-mail?

May we leave messages concerning appointment times? Yes No

Who can we thank for referring you to our clinic?

Approximate date that you last felt really well from a health perspective? _____

What are your primary Health Concerns in order of importance to you?

1.

2.

3.

4.

How would you describe your general state of health currently?

Excellent Good Fair Poor

Are you experiencing any current illness or pain?
Y / N Please describe if yes:

Medical Conditions

Have you ever had any serious medical conditions?
Yes No
If yes, please describe and give approximate date(s):

Allergies

Are you aware of any allergies whether from medicine, food, environment? Y / N
If yes, please list known/suspected allergies as well as approximate time of identification.

Stress

How would you rate your stress on a scale of 0 to 10 (10 being the most)? _____
Please describe:

Medications

Please list all medications, including over-the-counter, that you are currently taking (use back of page if more room is needed):

Vitamins & Supplements

Please list all vitamins, supplements, herbs, and homeopathic remedies you are taking (use back of page if more room is needed):