

# NEW PATIENT INTAKE FORM

Appointment Date: \_\_\_\_\_

Please complete the following pages so we can best meet your healthcare needs. If you have any questions, please do not hesitate to ask.

## Personal Information

Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: (DD/MM/YYYY) \_\_\_\_\_

What are your pronouns? (Optional):  
\_\_\_\_\_

**How do you identify? (Check all that apply):**

Male  Female  Transgender  Non-Binary

MTF  FTM  Intersex  Genderqueer

Other: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City, Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Phone numbers: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Ext: \_\_\_\_\_

(Cell) \_\_\_\_\_ (Other) \_\_\_\_\_

Main Email: \_\_\_\_\_ (for appointment reminders and other information, if any).

Emergency contact details: Name - \_\_\_\_\_ Phone number - \_\_\_\_\_

Relationship - \_\_\_\_\_

**Reason(s) for visit (Please rank by priority):**

*E.g. Headaches*

**Onset**

*E.g. June 2002*

**Frequency**

*E.g. 4x/week*

**Severity**

*E.g. Scale: 5 out of 10,  
or mild/mod/severe*

1. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How were you referred to our centre?  
\_\_\_\_\_  
\_\_\_\_\_

What are your goals for this visit?  
\_\_\_\_\_  
\_\_\_\_\_

**Your past medical history (please include date/year of diagnosis. You may also attach a separate list).**

*E.g. Reflux/heartburn – started 2003, had scope procedure 8/05 w/ normal result; please be succinct*

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Family medical history (please indicate type of disease)**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

\_\_\_\_\_

**Surgery (major/minor procedures), when, where**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Injuries**

*E.g. Car accident in 1995 – head injury*

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Lifestyle habits**

Tobacco  None  Smoked cigarettes from age \_\_\_\_ to \_\_\_\_ . \_\_\_\_ packs per day.

Check if you have used the following:  Cigars  Chewing tobacco

Alcohol  None  Estimated drinks per week \_\_\_\_ Preferred drink(s) \_\_\_\_\_

Other drugs  None  Type(s) and frequency \_\_\_\_\_

**Medical history (please check)**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV         | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> MS              | <input type="checkbox"/> Ischemic stroke    | <input type="checkbox"/> Gastritis            |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Hemorrhagic stroke | <input type="checkbox"/> IBS                  |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Goiter         | <input type="checkbox"/> Pacemaker       | <input type="checkbox"/> Hyperthyroid       | <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gout           | <input type="checkbox"/> Pleurisy        | <input type="checkbox"/> Hypothyroid        | <input type="checkbox"/> Mononucleosis        |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Bronchitis           |
| <input type="checkbox"/> Birth trauma     | <input type="checkbox"/> Hepatitis ____ | <input type="checkbox"/> Polio           | <input type="checkbox"/> Typhoid fever      | <input type="checkbox"/> Osteo-arthritis      |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Ulcers             | <input type="checkbox"/> Enteritis            |
| <input type="checkbox"/> Chicken pox      | <input type="checkbox"/> Hypotension    | <input type="checkbox"/> Scarlet fever   | <input type="checkbox"/> Whooping cough     | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Measles        | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Colitis            |   |

**Allergic reactions/ intolerances to medications**

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**Allergic reactions/ intolerances to foods, environment**

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<b>Medications (prescription &amp; OTC)</b> <i>or attach your own list</i>	<b>Dosage &amp; Frequency</b>	<b>Reason</b>	<b>Duration of consumption</b>	<b>Cost per month</b>

<b>Herbal Remedies and Supplements</b> <b>Please include brand name</b> <i>or attach your own list</i>	<b>Dosage &amp; Frequency</b>	<b>Reason</b>	<b>Duration of consumption</b>	<b>Cost per month</b>

**What physical activities do you participate in and how often do you do so?**

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**What do you do to relax?**

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**Describe your sleep patterns (please include number of hours per night).**

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**What are the major stressors in your life?**

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**How many servings of fruit do you usually eat/drink each day?** \_\_\_\_\_

*Serving = 1 small piece of fruit, 1/2 cup fruit juice, 1/2 cup canned or chopped fruit, 1/4 cup dried fruit*

**How many servings of vegetables do you consume each day?** \_\_\_\_\_

*Serving = 1/2 cup raw or cooked vegetables, 1 cup fresh green leafy vegetables, 1/4 cup dried vegetables or 1 small piece*

**How much water do you drink on a typical day?** \_\_\_\_\_

**How much caffeinated beverages (coffee/tea, etc.) and/or pop do you drink a day?**

Coffee/tea \_\_\_\_\_ per day

Soda/pop \_\_\_\_\_ per day

**Please check boxes that are relevant to you pertaining to your dietary conditions:**

Poor appetite     Normal appetite     Excessive appetite     Crave sweet     Crave salt

Bitter taste in mouth     Metallic taste in mouth     Sweet taste in mouth     Sour taste in mouth

Other cravings (please indicate) \_\_\_\_\_     Other taste(s) in mouth (please indicate) \_\_\_\_\_

No thirst     Very thirsty     Normal thirst

**Please check boxes that are relevant to you pertaining to your cardiovascular conditions:**

High blood pressure     Lightheaded     Fast heartbeat     Orthostatic hypotension

Low blood pressure     Chest pain     Palpitations     Phlebitis

Fainting     Slow heartbeat     Irregular heartbeat     Heart attack

**Please check boxes that are relevant to you pertaining to your gastrointestinal conditions:**

- |   |  |  |                                      |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Nausea               | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Undigested food in stools | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Constipation        | <input type="checkbox"/> IBS                       | <input type="checkbox"/> Gastritis   |
| <input type="checkbox"/> Acid regurgitation   | <input type="checkbox"/> Laxative use        | <input type="checkbox"/> Stomach cramps            | <input type="checkbox"/> Enteritis   |
| <input type="checkbox"/> Gas                  | <input type="checkbox"/> Black stools        | <input type="checkbox"/> Itchy anus                | <input type="checkbox"/> Hard stools |
| <input type="checkbox"/> Hiccup               | <input type="checkbox"/> Blood in stools     | <input type="checkbox"/> Burning anus              |                                      |
| <input type="checkbox"/> Bloating after meals | <input type="checkbox"/> Mucus in stools     | <input type="checkbox"/> Rectal pain               |                                      |
| <input type="checkbox"/> Bad breath           | <input type="checkbox"/> Intestinal cramping | <input type="checkbox"/> Ulcerative colitis        |                                      |
| <input type="checkbox"/> Gurgling sounds      | <input type="checkbox"/> Loose stools        | # of bowel movements/day: ____                     |                                      |

**Please check boxes that are relevant to you pertaining to the head, eyes, ears, nose, and throat:**

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> Glasses              | <input type="checkbox"/> Blurred vision    | <input type="checkbox"/> TMJ             | <input type="checkbox"/> Excessive saliva      | <input type="checkbox"/> Nose bleeds     |
| <input type="checkbox"/> Eye strain           | <input type="checkbox"/> Night blindness   | <input type="checkbox"/> Gum disease     | <input type="checkbox"/> Sinus problems        | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Red eyes             | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Sore gums       | <input type="checkbox"/> Clear throat often    | <input type="checkbox"/> Poor hearing    |
| <input type="checkbox"/> Itchy eyes           | <input type="checkbox"/> Cataracts         | <input type="checkbox"/> Bleeding gums   | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Earaches        |
| <input type="checkbox"/> Spots in eyes        | <input type="checkbox"/> Grinding teeth    | <input type="checkbox"/> Sores on lips   | <input type="checkbox"/> Swollen glands        | <input type="checkbox"/> Headaches       |
| <input type="checkbox"/> "Floaters" in vision | <input type="checkbox"/> Soft teeth        | <input type="checkbox"/> Sores on tongue | <input type="checkbox"/> Lumps in throat       | <input type="checkbox"/> Migraines       |
| <input type="checkbox"/> Poor vision          | <input type="checkbox"/> Multiple cavities | <input type="checkbox"/> Dry mouth       | <input type="checkbox"/> Enlarged thyroid      | <input type="checkbox"/> Concussions     |

**Please check boxes that are relevant to you pertaining to your respiratory condition:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Feeling short of breath         | <input type="checkbox"/> Tightness in chest | <input type="checkbox"/> Chest oppression | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Difficulty breathing lying down | <input type="checkbox"/> Asthma/wheezing    | <input type="checkbox"/> Dry cough        |  |
| <input type="checkbox"/> Productive cough with:          | <input type="checkbox"/> A lot of sputum    | <input type="checkbox"/> Sticky sputum    |  |
|  | <input type="checkbox"/> Very little sputum | <input type="checkbox"/> Green sputum     |  |
|  | <input type="checkbox"/> Clear sputum       | <input type="checkbox"/> Blood in sputum  |  |

**Please check boxes that are relevant to you pertaining to your sleep patterns:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Insomnia  | <input type="checkbox"/> Problems staying asleep | <input type="checkbox"/> Dream disturbed sleep |
| <input type="checkbox"/> Troubles falling asleep                                 | <input type="checkbox"/> Wake up tired           | <input type="checkbox"/> Nightmares            |
| <input type="checkbox"/> Waking up in the night: time(s) that you wake at: _____ |  |  |

**Please check boxes that are relevant to you pertaining to the condition(s) of your skin and hair:**

- |                                      |                                    |  |  |
|--------------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> Rashes      | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Dandruff          | <input type="checkbox"/> Premature grey hair |
| <input type="checkbox"/> Hives       | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itchy skin        | <input type="checkbox"/> Alopecia/hair loss  |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Shingles  | <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Brittle hair        |
| <input type="checkbox"/> Dry skin    | <input type="checkbox"/> Oily skin | <input type="checkbox"/> Acne              |  |

**Please check boxes that are relevant to you pertaining to your genito-urinary conditions:**

- |   |   |   |  |   |
|---|---|---|--|---|
| <input type="checkbox"/> Painful urination  | <input type="checkbox"/> Cloudy urination   | <input type="checkbox"/> Dark yellow urine  | <input type="checkbox"/> Burning urination           | <input type="checkbox"/> Frequent kidney infections |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Scanty urination   | <input type="checkbox"/> Light yellow urine | <input type="checkbox"/> Retention of urine          | <input type="checkbox"/> Urinary incontinence       |
| <input type="checkbox"/> Copious urination  | <input type="checkbox"/> Urination at night | <input type="checkbox"/> Clear urine        | <input type="checkbox"/> Frequent bladder infections |   |

**Please check boxes that are relevant to you pertaining to your neuropsychological conditions:**

- |                                   |                                      |  |   |   |
|-----------------------------------|--------------------------------------|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Tics        | <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Trigeminal neuralgia |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability    | <input type="checkbox"/> ADHD           | <input type="checkbox"/> Bell's palsy         |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Depression  | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Parkinson's    | <input type="checkbox"/> Fainting             |

*(Please see body diagram on next page to mark down areas of symptoms.)*

**Please check boxes that are relevant to you pertaining to your musculoskeletal conditions:**

- |  |                                      |  |                                     |
|--|--------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Neck pain     | <input type="checkbox"/> Hand pain   | <input type="checkbox"/> Abdominal pain  | <input type="checkbox"/> Leg pain   |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Finger pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Knee pain  |
| <input type="checkbox"/> Arm pain      | <input type="checkbox"/> Chest pain  | <input type="checkbox"/> Mid back pain   | <input type="checkbox"/> Ankle pain |
| <input type="checkbox"/> Elbow pain    | <input type="checkbox"/> Rib pain    | <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Toe pain   |

*(Please see body diagram on next page to mark down areas of symptoms.)*

