

### ADULT INTAKE FORM

Please complete the following questionnaire to the best of your ability.  
All information is kept confidential. Thank you.

Last name \_\_\_\_\_ First Name \_\_\_\_\_

Male  Female  today's date \_\_\_\_\_ Age \_\_\_\_\_

Who referred you? \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Prov \_\_\_\_\_ Postal code \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Cell. Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Date of birth (DD/MM/YY) \_\_\_/\_\_\_/\_\_\_ Occupation \_\_\_\_\_

Single  Married  Divorced  Separated

Children (names & ages) \_\_\_\_\_

Emergency contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**Health Concerns:** (please list your current concerns/complaints and when they first began)

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

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

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

4. \_\_\_\_\_

**Current medications:** (Please include all prescription medications, on-prescription medications, vitamins, herbs, etc.)

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**Past Medical History:** (Please check and date the conditions that pertain to YOU personally)

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Seizures                             |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever                      |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart Disease                        |
| <input type="checkbox"/> Alcohol Abuse       | <input type="checkbox"/> STI (sexually transmitted infection) |
| <input type="checkbox"/> Drug Addiction      | <input type="checkbox"/> Thyroid Disease                      |
| <input type="checkbox"/> Parkinson's         | <input type="checkbox"/> Hepatitis                            |

Hospitalizations/Surgeries: \_\_\_\_\_

Occupational Exposure to toxins: \_\_\_\_\_

Allergies: (Medications, environmental, food, etc.) \_\_\_\_\_

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**Family Medical History:** (Please check condition & circle F for father's side or M for mother's side)

- |  |     |                                       |     |
|--|-----|---------------------------------------|-----|
| <input type="checkbox"/> Cancer                    | F/M | <input type="checkbox"/> Allergies    | F/M |
| <input type="checkbox"/> Diabetes                  | F/M | <input type="checkbox"/> Arthritis    | F/M |
| <input type="checkbox"/> Stroke                    | F/M | <input type="checkbox"/> Tuberculosis | F/M |
| <input type="checkbox"/> Heart Disease             | F/M | <input type="checkbox"/> Addiction    | F/M |
| <input type="checkbox"/> Seizures/Epilepsy         | F/M | <input type="checkbox"/> Gout         | F/M |
| <input type="checkbox"/> High Blood Pressure       | F/M | <input type="checkbox"/> Obesity      | F/M |
| <input type="checkbox"/> Asthma                    | F/M | <input type="checkbox"/> Hepatitis    | F/M |
| <input type="checkbox"/> Pregnancy/Labour Problems | F/M |                                       |     |

**Women's Health:**

Age of first menses \_\_\_\_\_ Duration of period \_\_\_\_\_ Days between cycles \_\_\_\_\_

Date of last period (first day) \_\_\_\_\_ Date of last PAP test \_\_\_\_\_

Any abnormal PAP result ?  yes  no Monthly self breast exam  yes  no

- |  |  |  |                                     |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Heavy flow |
| <input type="checkbox"/> Pelvic pain       | <input type="checkbox"/> Cramps            | <input type="checkbox"/> Clots             | <input type="checkbox"/> Light flow |

Any premenstrual symptoms? If so describe: \_\_\_\_\_

Birth control use? If so, what type and for how long \_\_\_\_\_

# pregnancies \_\_\_\_\_ # births \_\_\_\_\_ # miscarriages \_\_\_\_\_ # abortions \_\_\_\_\_

Menopause: no menses since \_\_\_\_\_

Experiences/symptoms you are currently feeling/having? \_\_\_\_\_  
\_\_\_\_\_

Experiences/symptoms you had in the past during menopause? \_\_\_\_\_  
\_\_\_\_\_

**Sleep:**

Average # of hours/night \_\_\_\_\_ Time to bed \_\_\_\_\_ Waking time \_\_\_\_\_

- Good  Difficulty falling asleep  Difficulty staying asleep  Nightmares

**Personal:**

Alcohol consumption:  Y  N Type and amount (per week) \_\_\_\_\_

Smoker:  Y  N How long have you smoked for \_\_\_\_\_ How much \_\_\_\_\_

Recreational drugs use:  Y  N Type and how often \_\_\_\_\_

Do you exercise regularly?  Y  N Type and how often \_\_\_\_\_  
\_\_\_\_\_

Hobbies: \_\_\_\_\_  
\_\_\_\_\_

**Personal Stress:**

Please rate your stress on a scale of 0 to 10: (10 being the most) and write in any comments

Stress Level \_\_\_\_\_

- |   |            |
|---|------------|
| 1. I worry a great deal                               | q Yes q No |
| 2. I feel lonely                                      | q Yes q No |
| 3. I am bored with my life                            | q Yes q No |
| 4. I think a lot about dying                          | q Yes q No |
| 5. I have particular concerns relating to my religion | q Yes q No |
| 6. I feel fearful or afraid                           | q Yes q No |
| 7. I feel nervous most of the time                    | q Yes q No |
| 8. I often feel depressed                             | q Yes q No |
| 9. I feel anxious often                               | q Yes q No |
| 10. I am ill frequently                               | q Yes q No |
| 11. I sometimes feel weak or light-headed             | q Yes q No |
| 12. I often have pains in my shoulders, neck or back  | q Yes q No |
| 13. I often feel like crying                          | q Yes q No |
| 14. I lose my temper more than I used to              | q Yes q No |
| 15. Other personal concerns                           | q Yes q No |

Please describe \_\_\_\_\_

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**Eating habits:**

- Poor (mostly processed/fast food)
- Normal (occasional fast food, mostly home made)
- Good (I read labels and watch what I eat carefully)

**24 Hour Diet Recall:** (please list the food & drinks consumed on a typical day)

- Breakfast \_\_\_\_\_
- Lunch \_\_\_\_\_
- Supper \_\_\_\_\_
- Snacks \_\_\_\_\_
- Liquids \_\_\_\_\_
- Other \_\_\_\_\_

Any food cravings? \_\_\_\_\_

Any known food sensitivities? \_\_\_\_\_

Bowel Movements (# per day) \_\_\_\_\_ colour \_\_\_\_\_ Visible undigested food  Y  N

