New Patient Intake Form

Date: ___________________________

Note: this is a confidential record of your medical history and will be kept in this office. Information contained here or recorded during the consultation will not be released to any person except when you have authorized in writing to do so. Please complete the questionnaire as thoroughly as possible.

Name: ____ Gender: ____________________

Date of Birth: ____ Occupation: ______________________________

Address: ____

City: ____ Postal Code: ____________________________

Email: ____

Home Phone: ____ Cell Phone: ______________________________

Employer: ____

Marital Status: __________________________ How did you hear about our clinic? ________________________

Health Priorities/Chief Concerns:

List your main health concerns in order of importance

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Medical History:

How would you describe your general state of health? (choose one)

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please indicate any serious illnesses, surgeries or past hospitalizations:

Surgery/Hospitalization	Date of Diagnosis	Is condition still present?	Symptoms

Please list any car accidents or other accidents:

Type of Accident	Date of Accident	Injury Sustained	Chronic Issues

Please list all current medications:

Medications	Dose	Prescribing Physician	Length of Use

Please list all current supplements:

Supplements	Dose	Brand	Length of Use

Please indicate any allergies:

Allergy	Symptoms

How many times have you taken antibiotics within the last 5 years? ______________________________

Were you frequently given antibiotics as a child? ____

Have you had any adverse reactions from any vaccinations? _____________________________________

Do you get a yearly flu vaccination? ______________________________

Do you use any of the following?

Type	*Check one*	*How much/How often*
Alcohol	☐ Yes ☐ No	______________________________
Tobacco	☐ Yes ☐ No	______________________________
Caffeine	☐ Yes ☐ No	______________________________
Recreational Drugs	☐ Yes ☐ No	______________________________
Laxatives	☐ Yes ☐ No	______________________________
Antacids	☐ Yes ☐ No	______________________________

Please indicate any other medical providers:

Type of Medical Provider & Name(s): ____

____

____

____

Family History:

Indicate if any family member has had any of the following:

Illness	*Check one*	*Family Member/Type*
Allergies	☐ Yes ☐ No	______________
Asthma	☐ Yes ☐ No	______________
Diabetes	☐ Yes ☐ No	______________
Heart Disease	☐ Yes ☐ No	______________
High Blood Pressure	☐ Yes ☐ No	______________
Kidney Disease	☐ Yes ☐ No	______________
Cancer	☐ Yes ☐ No	______________
Depression	☐ Yes ☐ No	______________
Other mental illness	☐ Yes ☐ No	______________
Thyroid Conditions	☐ Yes ☐ No	______________
Obesity	☐ Yes ☐ No	______________

Other____

Lifestyle:

Do you exercise? __________ If so, how often? ______________________

What type of exercise do you do? ______________________

Have you recently gained or lost weight? ☐ YES ☐ NO How many pounds? __________

Current Weight __________ Ideal Weight __________

Do you eat 3 meals per day? __________ Do you skip meals? __________

How many meals do you eat out per week? __________

Which of the following foods do you consume regularly?

- ☐ Pop
- ☐ Diet pop
- ☐ Refined sugar
- ☐ Fast food
- ☐ Gluten (wheat, rye, barley) ______________________
- ☐ Dairy (milk, cheese, yogurt) ______________________

Typical Food Intake:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Drinks: ____

What are your biggest challenges with nutrition?

____

____

____

____

Sleep Patterns:

Are you satisfied with your sleep? ______________

Average hours of sleep per night? ______________

Do you fall asleep within 30 minutes? ___________

Do you nap? __________________________

Do you wake up in the night? ____________

Do you feel well rested? ________________

Mental Health:

In general, how are your moods? Do you experience more anxiety, depression or anger than you would like?

____

____

____

On a scale of 1-10, one being the worst and ten being the best, describe your usual level of energy. ___________

Do you experience energy crashes in the day? ____

On a scale of 1-10, one being the worst and ten being the best, describe your current level of stress? __________

What are the main sources of stress in your life? ____

Digestion:

Do you have regular daily bowel movements? __________

Bowel Movement Consistency

☐ Soft & well formed
☐ Often float
☐ Difficult to pass
☐ Diarrhea
☐ Thin, long or narrow
☐ Small and hard
☐ Loose but not watery
☐ Alternating between hard and loose

Do you experience intestinal gas and/or bloating? ____________________

Check any of the conditions that you are currently experiencing:

General

☐ Numbness/tingling
☐ Fainting
☐ Dizziness
☐ Fatigue
☐ Chronic pain
☐ Difficulty losing weight
☐ Other ______________________

Head/Neck

☐ Headaches
☐ Migraines
☐ Vision problems
☐ Earaches
☐ Decreased hearing
☐ Sinus problems
☐ Difficulty swallowing
☐ Other _______________________

Dermatological

- ☐ Eczema/Psoriasis
- ☐ Itching
- ☐ Bruise easily
- ☐ Dryness
- ☐ Boils
- ☐ Hives
- ☐ Acne
- ☐ Cold sores
- ☐ Hair loss
- ☐ Weak fingernails
- ☐ Other ________________________

Respiratory

- ☐ Frequent colds/flus
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Smoking
- ☐ Breathing problems
- ☐ Asthma/Bronchitis
- ☐ Pneumonia
- ☐ Seasonal Allergies
- ☐ Other ________________________

Cardiovascular

- ☐ Blood pressure issues
- ☐ Chest pain
- ☐ Stroke
- ☐ Varicose veins
- ☐ Swelling of the ankles
- ☐ Poor circulation
- ☐ Heart disease
- ☐ Palpitations
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Other ________________________

Gastrointestinal

- ☐ Poor digestion
- ☐ Indigestion
- ☐ Stomach ulcer
- ☐ Belching
- ☐ Gas/Bloating
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Liver concerns
- ☐ Gall bladder issues or stones
- ☐ Other ________________________

Musculoskeletal

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Painful joints
- ☐ Back pain
- ☐ Neck pain
- ☐ Injury
- ☐ Other ________________________

Genitourinary

- ☐ Difficulty urinating
- ☐ Bladder infections
- ☐ Kidney stones
- ☐ Prostate issues
- ☐ Other ________________________

Mental/Emotional

- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Mood swings
- ☐ Panic attacks
- ☐ Irritability
- ☐ Chronic stress
- ☐ Easily overwhelmed
- ☐ Memory issues
- ☐ Brain fog
- ☐ Other ________________________

Women's Health

- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Clots
- ☐ Irregular cycles
- ☐ PMS
- ☐ Cramps or backache
- ☐ Vaginal discharge
- ☐ Painful breasts
- ☐ Lumps in the breast
- ☐ Fertility issues
- ☐ Chronic yeast infections
- ☐ Other _________________________

Number of pregnancies ________

Number of children ________

Menopause

- ☐ Hot flashes
- ☐ Night sweats
- ☐ Vaginal dryness
- ☐ Loss of libido
- ☐ Fatigue
- ☐ Weight gain
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Other _________________________

What are your desired health goals?

- ____
- ____
- ____
- ____

Please use this space to add any other information about yourself that you think will be of help to us.

____

____

____

1. Fill in and email back to cshealth@telus.net *(click directly on email address and it will open)*
   or
2. Fill in and print out (or print out and fill in by hand)

If form does not send or print, it may be required to be downloaded to your computer before sending in or printing.
(Go to File - Save as)