



ADULT INTAKE

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone (home): _____ (work): _____ (cell): _____

Email address: _____

Age: _____ Date of Birth: _____ Gender: Female / Male

Married: _____ Separated: _____ Divorced: _____ Widowed: _____ Single: _____ Partnership: _____

Live with: Spouse: _____ Partner: _____ Parents: _____ Children: _____ Friends: _____ Alone: _____

Occupation: _____ Hours per week: _____

Employer: _____

How did you hear about this clinic? _____

If internet: Google: _____ OAND Website: _____ CAND Website: _____ Other: _____

Emergency contact: _____ Relationship: _____

Phone: _____ Address: _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What *three* expectations do you have from *this* visit to our clinic?



What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? What good things do you do for yourself?

What behaviours or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What are some obstacles that you foresee in addressing the lifestyle factors which are undermining your health and that may prevent you from following the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?



Wheel of Balance

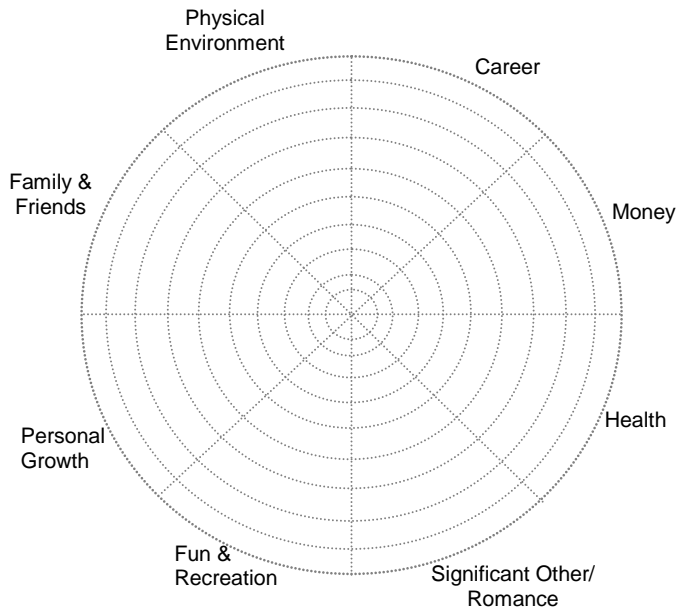
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.

100
%

80%



Are you currently receiving healthcare? Yes ___ No ___

If yes, please list your healthcare providers below:

1. _____ 2. _____ 3. _____

() _____ () _____ () _____

Reason: _____ Reason: _____ Reason: _____



What are your most important health problems? List as many as you can in order of importance.

- 1) _____ 4) _____
 2) _____ 5) _____
 3) _____ 6) _____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? Please List Below:

Cancer		Diabetes		Heart Disease	
High Blood Pressure		Stroke		Epilepsy	
Arthritis		Glaucoma		Bowel Conditions	
Tuberculosis		Kidney Disease		Anemia	
Mental Illness		Asthma		Hay Fever	
Osteoporosis		Other:		Other:	

Any other relevant family history? _____
 What is your family heritage? _____

CHILDHOOD ILLNESSES

Please circle whether you had any of the following as a child:

Rheumatic Fever	Diphtheria	Scarlet Fever
German Measles	Measles	Mumps
Frequently Ill	Recurring Ear Infections	Chicken Pox

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____ year _____ year _____
 _____ year _____ year _____
 _____ year _____ year _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____
 Any foods? _____
 Any environmental or chemicals? _____



CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

- | | | | |
|---------------------|---------------------|----------------|--------------------|
| Laxatives | Pain relievers | Antacids | Cortisone |
| Antibiotics | Tranquilizers | Sleeping Pills | Thyroid Medication |
| Birth Control Pills | Hormone Replacement | | |

Please note any other medications, over the counter medications not listed above, vitamins or other supplements you are taking with the doses and for how long.

Medication	Amount	How Long
<i>Example:</i> Vitamin C	1200mg/day	About a year

GENERAL

Height: _____ Weight: _____ Weight one year ago: _____
 Maximum Weight: _____ When: _____
 When during the day is your energy the best? _____ Worst? _____
 Main interests and hobbies: _____
 Exercise: Y / N If so, what kind and how often: _____
 Watch TV: Y / N If so, how many hours? _____ Read: Y / N If so, how many hours? _____
 Do you have a religious or spiritual practice? Y / N If so, what kind? _____

DIET

Please indicate the number of times per week you eat or drink the following:

Food	#/ Week	Food	#/ Week	Food	#/ Week
Fruits/ Fruit Juices		Soy Products		Fast Food	
Vegetables/ Veg Juices		Soft Drinks		Coffee	
Luncheon Meats		Soft Drinks (Diet)		Regular Tea	
White Flour/ Rice		Salty Snacks		Herbal Tea	
Margarine		Sweets/ Candies		Wine	
Milk/ Cheese Products		Artificial Sweeteners		Other Alcoholic Drinks	
Microwaved Foods		Meal Replacement Bars/ Drinks		Glasses of water (per day)	



FOR THE FOLLOWING, PLEASE CIRCLE:

Y = Yes N = No P = In the Past

GENERAL

Do you sleep well? Y N P
 Average 6-8 hours? Y N
 Wake rested? Y N
 Have a supportive relationship? Y N
 Have a history of abuse? Y N
 Experienced a major trauma Y N
 Do you enjoy your work? Y N
 Take vacations? Y N
 Spend time outside? Y N
 Eat three meals a day? Y N
 Do you go on diets often? Y N
 Do you eat out often? Y N
 Do you drink coffee? Y N
 Drink black/green tea? Y N
 Drink soda? Y N
 Do you eat refined sugar? Y N
 Spend time with TV/computer each day? _____ hours
 Use recreational drugs? Y N P
 Treated for drug dependence? Y N P
 Use alcoholic beverages? Y N P
 Use tobacco? Y N P
 If in the past, how many years? _____
 How many packs per day? _____

NEUROLOGIC

Seizures? Y N P
 Muscle weakness? Y N P
 Loss of memory? Y N P
 Vertigo or dizziness? Y N P
 Paralysis? Y N P
 Numbness or tingling? Y N P
 Easily stressed? Y N P
 Loss of balance? Y N P

HEAD

Headaches? Y N P
 Migraines? Y N P
 Head injury? Y N P
 Jaw or TMJ problems? Y N P

NOSE AND SINUS

Frequent colds? Y N P
 Stuffiness? Y N P
 Sinus problems? Y N P
 Nose bleeds? Y N P
 Hayfever? Y N P

ENDOCRINE

Hypothyroid? Y N P
 Hypoglycemia? (low blood sugar) Y N P
 Excessive thirst? Y N P
 Fatigue? Y N P
 Heat or cold intolerance? Y N P
 Diabetes? Y N P
 Excessive hunger? Y N P
 Seasonal depression? Y N P
 Difficulty exercising? Y N P

IMMUNE

Reactions to immunizations? Y N P
 Chronically swollen glands? Y N P
 Slow wound healing? Y N P
 Chronic fatigue syndrome? Y N P
 Chronic infections? Y N P
 Night sweats? Y N P

EARS

Impaired hearing? Y N P
 Ringing in ears? Y N P
 Dizziness? Y N P
 Ear aches? Y N P

EYES

Impaired vision? Y N P
 Cataracts? Y N P
 Glaucoma? Y N P
 Spots in vision? Y N P
 Color blindness? Y N P
 Tearing or dryness? Y N P
 Eye pain or strain? Y N P
 Double vision? Y N P

NECK

Lumps in neck? Y N P
 Goiter? Y N P
 Difficulty swallowing? Y N P
 Pain or stiffness in neck? Y N P

MOUTH AND THROAT

Frequent sore throat? Y N P
 Sore tongue or lips? Y N P
 Hoarseness? Y N P
 Jaw clicks? Y N P
 Teeth Grinding? Y N P



Nose and Sinus Continued...

Loss of smell? Y N P
 Difficulty breathing? Y N P
 Shortness of breath? Y N P
 “ “ when lying? Y N P
 Pain on breathing? Y N P
 Emphysema? Y N P
 Tuberculosis? Y N P

GASTROINTESTINAL

Ulcer? Y N P
 Trouble swallowing? Y N P
 Change in thirst? Y N P
 Change in appetite? Y N P
 Nausea/vomiting? Y N P
 Jaundice? Y N P
 Gall bladder disease? Y N P
 Liver disease? Y N P
 Blood in stools? Y N P
 Hemorrhoids? Y N P
 Pancreatitis? Y N P
 Heartburn? Y N P
 Abdominal pain or cramps? Y N P
 Belching or passing gas? Y N P
 Constipation? Y N P
 Bowel movements: how often? _____
 Is this a change? Y N
 Black stools? Y N P

URINARY

Increased freq. of urination? Y N P
 Inability to hold urine? Y N P
 Pain on urination? Y N P
 Frequency at night? Y N P
 Frequent UTIs? Y N P
 Kidney stones? Y N P

MUSCULOSKELETAL

Joint pain or stiffness? Y N P
 Arthritis? Y N P
 Broken bones? Y N P
 Weakness? Y N P
 Muscle spasms or cramps? Y N P
 Endometriosis? Y N P

Mouth and Throat Continued...

Dental Cavities? Y N P
 Gum Disease? Y N P

CARDIOVASCULAR

Blood clots? Y N P
 Fainting? Y N P
 Phlebitis? Y N P
 Palpitations/fluttering heart? Y N P
 Chest pain? Y N P
 Rheumatic fever? Y N P
 Swelling in ankles? Y N P
 Anemia? Y N P
 Easy bleeding or bruising? Y N P
 Cold hands/feet? Y N P
 Varicose veins? Y N P

SKIN

Rashes? Y N P
 Acne/boils? Y N P
 Change in skin color? Y N P
 Lumps or bumps on skin? Y N P
 Eczema or hives? Y N P
 Itching? Y N P
 Perpetual hair loss? Y N P

MENTAL/EMOTIONAL

Depression? Y N P
 Anxiety or nervousness? Y N P
 Poor concentration? Y N P
 Do you have mood swings? Y N P
 Considered suicide? Y N P
 Memory problems? Y N P
 Tension? Y N P



FEMALE REPRODUCTIVE

Age of first menses: _____
 Age of last menses (if menopausal): _____
 Menopausal symptoms? _____

 Length of cycle: _____ days
 Duration of menses: _____ days
 Are your cycles regular? Y N P
 Painful menses? Y N P
 Heavy or excessive flow? Y N P
 PMS? Y N P
 Symptoms: _____

 Bleeding between cycles? Y N P
 Clotting? Y N P
 Sciatica? Y N P
 Ovarian cysts? Y N P
 Vaginal odor? Y N P
 Vaginal discharge? Y N P
 Date of last pap smear: _____
 Abnormal PAP? Y N P
 Are you sexually active? Y N P
 Sexual orientation: _____
 Birth control? Type: _____
 Pain during intercourse? Y N P
 Gonorrhea? Y N P
 Herpes? Y N P
 Chlamydia? Y N P
 Genital warts? Y N P
 Syphilis? Y N P
 Difficulty conceiving? Y N P
 Number of pregnancies: _____
 Number of live births: _____
 Number of miscarriages: _____
 Number of abortions: _____
 Do you do self breast exams? Y N P
 Breast pain/tenderness? Y N P
 Breast lumps? Y N P

MALE REPRODUCTIVE

Hernias? Y N P
 Testicular masses? Y N P
 Testicular pain? Y N P
 Prostate disease? Y N P
 Nipple discharge? Y N P
 Impotence? Y N P
 Premature ejaculation? Y N P
 Are you sexually active? Y N P
 Sexual orientation: _____
 Birth control? Type: _____
 Discharge or sores? Y N P
 Chlamydia? Y N P
 Gonorrhea? Y N P
 Genital warts? Y N P
 Herpes? Y N P
 Syphilis? Y N P

Thank you for your time and effort. We look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so on the back of this page.