

Point Grey Wellness Clinic

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Adult Patient Initial Intake Form

Welcome to our clinic. Please complete this confidential intake form so that we may help you achieve your optimal level of health. Thank you!

Date _____

Female
 Male _____ Birth Date (Mo/Day/Year) _____ AGE _____
First Name Middle Name Last Name

HOMEADDRESS _____
Street City / Province Postal Code

HOME PHONE _____ BUSINESS PHONE _____ OCCUPATION _____

NAME OF SPOUSE _____ # OF CHILDREN AND AGES _____

NEAREST RELATIVE OR NEXT OF KIN _____
Name Relationship

REFERRED BY _____ E- MAIL ADDRESS: _____

IF PATIENT IS UNDER 18 YEARS, NAME AND RELATIONSHIP OF PERSON LEGALLY RESPONSIBLE (Parent, Guardian)

CARECARD NUMBER _____ FAMILY M.D. _____

CURRENT HEALTH CONCERN(S): When did your concerns(s) begin (be specific)?

1. _____
2. _____
3. _____
4. _____

Are you under the care of another physician or practitioner (ND, MD, DC?) _____

CURRENT MEDICATIONS:

PLEASE LIST ALL OF YOUR PRESCRIPTION MEDICATIONS (SLEEPING PILLS, BIRTH CONTROL PILLS), NON-PRESCRIPTION MEDICATIONS (ASPIRIN, ANTACIDS), VITAMINS, HERBS, ETC.

- | | |
|--|---|
| 1) _____ Dosage: _____ Since when: _____ | (5) _____ Dosage: _____ Since when: _____ |
| 2) _____ Dosage: _____ Since when: _____ | (6) _____ Dosage: _____ Since when: _____ |
| 3) _____ Dosage: _____ Since when: _____ | (7) _____ Dosage: _____ Since when: _____ |
| 4) _____ Dosage: _____ Since when: _____ | (8) _____ Dosage: _____ Since when: _____ |

PAST MEDICAL HISTORY (include date):

- Asthma Diabetes Hepatitis High Blood Pressure Venereal Disease
 Heart Disease Cancer Seizures Thyroid Disease Other _____

Surgeries/Hospitalization (date): _____

Significant Trauma (auto accidents, falls, etc.) _____

Allergies (drugs, chemicals, environmental, foods, animals, ect.) _____

Blood type? A B AB O

FAMILY MEDICAL HISTORY: Please put a check by the illness that was/is present in your family:

	Mother	Father	Brother/Sister	Grandparents	Other Relative
Cancer					
Heart Disease					
Arthritis					
Kidney Disease					
Depression					
Anemia					
Asthma					
Diabetes					
High Blood Pressure					
Other					

OCCUPATIONAL STRESS (chemical, physical, psychological): _____

Energy level from 1 – 10 _____ (10 being the highest)

DESCRIBE YOUR WEEKLY EXERCISE: _____

Have you traveled outside of Canada in the past 5 years? Where?

DIETARY INFORMATION: Are you or have you ever been on a restricted diet? Please describe your diet:

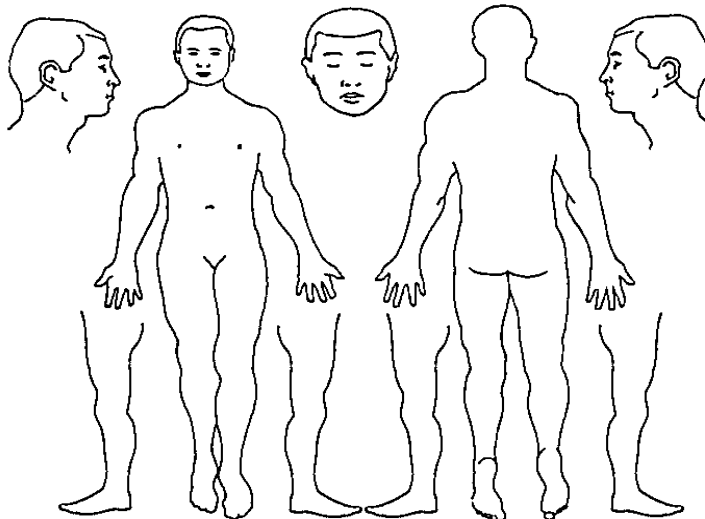
Morning

Afternoon

Evening

Tobacco use? Yes No How often? _____
 Alcohol use? Yes No How often? _____
 Coffee use? Yes No How often? _____

INDICATE PAINFUL OR DISTRESSED AREA:



Check only symptoms that pertain to YOU personally :**GENERAL**

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Strong thirst |
| <input type="checkbox"/> Bleed/bruise easily | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Sudden energy drop (what time of day)? | |

SKIN AND HAIR

- | | | |
|---|---|----------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Moles |
| <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Any other hair or skin problems? | |

HEAD, EYES, EARS, NOSE AND THROAT

- | | | |
|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Silver/mercury fillings |
| <input type="checkbox"/> Poor /blurry vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Colour blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Earaches | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> cold/flu/ sore throats | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Headaches? _____ | |

CARDIOVASCULAR

- | | | |
|--|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Swelling of hands or feet | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Any other heart or blood vessel problems? | |

RESPIRATORY

- | | | |
|--|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with a deep breath |
| <input type="checkbox"/> Difficulty in breathing when lying down | <input type="checkbox"/> Production of phlegm (what colour)? | |
| <input type="checkbox"/> Any other lung problems? | | |

GASTROINTESTINAL

- | | | |
|---|--|---|
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Constipation//Diarrhea | <input type="checkbox"/> Bloating | |

Any other problems with your stomach or intestines? _____

GENITO-URINARY

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Decreased urination |
| <input type="checkbox"/> Impotency | <input type="checkbox"/> Genital sores | |
| <input type="checkbox"/> Do you wake to urinate (how often)? _____ | | |
| <input type="checkbox"/> Any other problems with your genital or urinary system | | |

PREGNANCY AND GYNECOLOGY

ARE YOU CURRENTLY PREGNANT? Yes No Not sure

DATE OF LAST PERIOD: _____ LENGTH OF CYCLE: _____

- | | | |
|---|--|--|
| __ Age at first menses | __ Number of births | __ Premature births |
| __ Abortions | __ Number of pregnancies | __ Miscarriages |
| <input type="checkbox"/> Heavy menses | <input type="checkbox"/> Light menses | <input type="checkbox"/> Clots |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Last PAP exam _____ |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Breast cysts | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Do you practice birth control? | What type and for how long? _____ | |

MUSCULOSKELETAL

- | | | |
|---|--|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Foot/ ankle pain |
| <input type="checkbox"/> Hand/ wrist pain | <input type="checkbox"/> Shoulder pain | |

NEUROPSYCHOLOGICAL

- | | | |
|---|--|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Quick temper / irritable | <input type="checkbox"/> Susceptible to stress | |
| <input type="checkbox"/> Have you ever been treated for emotional problems? | | |
| <input type="checkbox"/> Have you ever considered or attempted suicide? | | |
| <input type="checkbox"/> Any other neurological or psychological problems? | | |

COMMENTS:

Please indicate any other concerns you would like to discuss:
