RougeHealthSolutions

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Adult Intake Form

Name:_____Date:_____
Date of Birth: (M/D/Y): _____/_____/_____ Current Age:_____
Address: _____
Prov:_____ Postal Code:_____ E-Mail:_____
Cell Phone:_____ Home phone:_____ Work phone:_____
Messages: Cell/Home/Work E-Mail: may we e-mail you? Y/N
How did you find out about our clinic? If referred, by whom? _____
Name of family doctor:_____Phone:_____
Emergency contact person:_____ Phone:_____
Occupation:_____ Marital Status:_____ Dependants:_____

CURRENT HEALTH CONCERNS

What are your health concerns, in order of importance to you: For how long?

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

MEDICAL HISTORY

Please indicate any serious conditions, illnesses, injuries, and any hospitalizations along with approximate dates:_____
_____
_____

Do you have any **allergies** or **sensitivities**? (food, drug, herbs, environmental, etc.)?
_____
_____

List any medications or supplements (vitamins, herbs, etc.) you are currently taking:
_____
_____
_____
_____

If you are female --Are you pregnant? **Y or N** Breastfeeding? **Y or N** Trying to conceive? **Y or N**

DIET *Please list a typical day's diet with quantities (including beverages):*
Breakfast_____
Lunch_____
Dinner_____
Snacks_____
Dietary restrictions (religious, vegetarian, vegan, etc.)_____

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FAMILY HISTORY

Indicate if a close family relative (grandparent, parent, child, sibling) has any of the following: (who?)

Allergies_____ Depression and/or mental illness_____
Asthma_____ Heart disease_____
High blood pressure_____ Alcoholism or drug abuse_____
Cancer_____ Kidney disease_____
Liver disease/Hepatitis_____ Diabetes_____
Auto-immune disease_____ Other_____

REVIEW OF SYSTEMS

Current Weight:_____ Ideal weight:_____ Height_____

*Please indicate by a **circle** any condition you **currently** have, and **underline** if in the past:*

Skin: rashes, eczema, psoriasis, acne, itching, lumps, colour change, dry, moist, easy bruising
Nails: colour change, fungal infections, brittle/shear, vertical/horizontal lines, slow growth
Head: migraines, headaches, dizziness
Eyes: tearing, pain, dryness, blurring, redness, discharge, itching, cataracts, glaucoma
Ears: impaired hearing, earache, dizziness, discharge, infections, ringing, buzzing, stuffed sensation
Nose & Sinus: frequent colds, nose bleeds, stuffiness, hay fever, sinus problems
Mouth &Throat: frequent sore throat, gum problems, hoarseness, dental cavities, loss of taste
Neck: lumps, swollen glands, pain or stiffness, enlarged thyroid
Lungs: cough, phlegm, spitting up blood, wheezing, pain or difficulty breathing, shortness of breath
Cardiovascular: heart disease, high blood pressure, murmurs, palpitations, chest pain
Peripheral Vascular : deep leg pain, cold extremities, varicose veins, extremity swelling/ulcers
Gastrointestinal: heartburn, indigestion, nausea, vomiting, belching, passing gas, stomach pain
Gastrointestinal: constipation, diarrhea, blood in stool, mucous in stool, hemorrhoids, black stools
Urinary : pain, frequent, frequent at night, inability to hold urine, blood in urine, urgency, infections
Musculoskeletal: joint pain/stiffness, muscle pain/stiffness, weakness, back pain, broken bones
Neurologic: fainting, seizures, paralysis, numbness/tingling
Neurologic: loss of balance, muscle weakness, involuntary movement, speech problems, memory loss
Endocrine: fatigue, heat/cold intolerance, thyroid problems, excess thirst/hunger/sweating
Women's Health: fibrocystic breasts, breast lumps, breast tenderness, nipple discharge
Women's Health: painful periods, PMS, excessive menstrual flow, irregular periods
Women's Health: vaginal discharge, painful/difficult intercourse, vaginal itching
Men's Health: hernias, testicular masses/pain, discharge from penis, difficult intercourse
Exposure to pets, tobacco smoke, toxins/chemicals at work or home
Sleep - difficulty falling asleep, frequent waking. Hours asleep: ___ Do you feel well-rested? Y/N
Elimination: ___bowel movements/___d/wk
Stress (10 high): 0 1 2 3 4 5 6 7 8 9 10 **Energy level:** (10 best) 0 1 2 3 4 5 6 7 8 9 10
Adverse reaction to immunizations - childhood vaccinations, flu vaccination, travel vaccinations, other
Exercises/interests/hobbies_____ _
Date of last physical exam _____

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep my practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners' part should I fail to do so.

Signature: _____ Date:_____

285 Lawson Road, Suite 110, Scarborough, Ontario, M1C 2J6 T.416-724-6532 F.416-724-9531

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1. Why did you choose to come to this clinic?

_____
_____

2. What 3 expectations do you have from this visit?

_____
_____
_____
_____

3. What are your short-term goals? What are your long-term goals?

_____
_____
_____
_____

4. What do you do that is health-promoting? What do you do that is health-destructive?

_____
_____
_____
_____

5. What potential obstacles do you foresee?

_____
_____
_____
_____

6. Who is your support system?

_____
_____
_____
_____

7. What do you LOVE to do?

_____
_____
_____
_____

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