



Health Intake Form

Filling this form out completely will help me to serve you better

Name: _____ Date: _____
Address: _____
Postal Code: _____
Phone: (H) _____ (W) _____ Email: _____
Date of Birth _____ Marital Status: _____
Number of Children _____ Occupation: _____
Referred By: _____
Family Doctor: _____ Date Last Seen: _____
Medical Diagnosed Conditions? _____

Major complaints in order of importance for you (Since When; and Possible Cause):

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

What are you currently doing for your health? Circle any that apply: Regular Exercise;
Supplements; Healthy Diet; Chiropractic/Osteopathy/Physiotherapy; Massage;
Acupuncture; Homeopathy; Relaxation/Meditation; Qigong/TaiChi; Medications;
Other: _____

Medications you are currently taking (Include Since When):

Supplements currently taken: _____

General Health History:

Last physical exam: _____ Weight: _____ Height: _____
Energy level (0 - 5): _____ Sleep Pattern (#hrs, regularity, feel rested?): _____

Work Pattern (i.e. # hours) _____
When was your last vacation? _____
What hobbies or activities do you enjoy? _____

What is your current level of overall stress (0 - 5 scale, 0 being none) _____

What is the major source of current stress? _____

How much of the following do you use?

Tobacco _____ Alcohol _____ Coffee _____ Pop _____

Recreational drugs _____

Any addiction concerns? _____

Any known allergies? _____

Have you been on antibiotics in the past year? _____



List past surgeries, hospitalizations, diseases, accidents, or major trauma with age at event:

Family History of Diseases (Physical and Psychological):

Relative Age if alive Age at death Diseases

Mother _____

Father _____

Brothers _____

Sisters _____

Grandparents _____

Aunts/Uncles _____

Review of systems: circle any of the following conditions that apply to you:

General: Recent weight change Weakness Fatigue Fever

Skin: Rash Lumps Cold Sores Itching Dryness Warts
Mole change Acne Boils Shingles

Head: Headache Head injury Dizziness other: _____

Eyes: Last eye exam _____ Pain Redness Excessive tears
Double vision Itchiness Blurred vision other: _____

Ears: Earaches Infections Hearing loss Tinnitus

Nose and Sinuses:
Frequent colds Discharge Hay fever Nosebleeds Sinusitis
other: _____

Mouth and throat:
Last dental exam: _____ Amalgam Fillings Root Canals
Teeth Removed Other: _____
Frequent sore throat Loss of taste Bleeding gums Sores

Neck: Lumps Swollen glands

Respiratory: Cough Wheezing Asthma Bronchitis Pneumonia
Other: _____

Cardiac: High blood pressure Low Blood Pressure Chest pain Palpitations
Heart disease other: _____

Gastrointestinal: Problem swallowing Indigestion Poor appetite Nausea Belching
Gas Change in bowel habits Constipation Diarrhea Abdominal pain

Urinary: High frequency Nighttime urination Urgency Infections
Hesitancy Incontinence other: _____



Male reproductive: Venereal disease Hernia Discharge Sores
Impotence Birth control?(type) _____
Loss of sexual interest _____ other: _____

Female Reproductive: Date of last Pap smear: _____
Last menses _____ Age at onset of menses _____
Length of cycle _____ Menopause Age at menopause _____
Menopausal symptoms _____
Hormone replacement therapy Type: _____
Number of pregnancies _____ Live births _____
Miscarriages _____ Abortions _____
Sexually active? _____ Birth control? _____ Type _____
Level of sexual interest? _____

Breasts: Pain Tenderness Lumps Nipple discharge
Musculoskeletal: Pain Stiffness Arthritis Gout Muscle spasms
Weakness Fractures other: _____

Blood vessels: Deep leg pain Varicose veins Leg cramps Cold hands/feet
Other: _____

Hematology: Anemia Easy bruising/bleeding
Neurology: Fainting Neuralgia Blackouts Seizures Convulsions
Weakness Paralysis Numbness Tingling Tremors
Loss of balance other: _____

Endocrine: Thyroid problems Diabetes Hypoglycemia Heat or cold intolerance
Other _____

Is there anything else that you would like me to know about you?

Thank You!!
Please bring with you to your first appointment.