700 Eagleson Road,
Kanata, ON
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(613) 599-9822
www.GetBackToHealth.com

Patient Intake Form

Name:	Phone: Home	Work
Street	Age Ht.	Wt.
City	Birthdate	Sex
Province	Postal Code	Occupation:
Physician:	Referred by:	Emergency #:
Main Problem:		Onset:
Other concurrent Therapies		

PAST MEDICAL HISTORY (include date):
Significant Illnesses: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Heart Disease __ Hepatitis __ HIV
___ Rheumatic Fever ___ Thyroid Disease ___ Seizures ___ Stroke ___ Blood Disorders ___ Other
Surgeries:
Significant Trauma (auto accidents, falls, etc.)
Allergies: (drugs, chemicals, foods)
Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.)
Occupational Stresses (chemicals, physical, psychological, etc.)
Exercise:
Comments:

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other ________
Family Medical History: ___ Diabetes ___ Cancer ___ High Blood Pressure ___ Heart Disease ___ Stroke
___ Seizures ___ Asthma ___ Allergies ___ Alcoholism ___ Other ______________________________
Notes ____
____
____

GENERAL

- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Poor sleep
- ☐ Heavy sleep
- ☐ Insomnia
- ☐ Fatigue
- ☐ Tremors
- ☐ Vertigo
- ☐ Cold hands
- ☐ Cold feet
- ☐ Cold back
- ☐ Cold abdomen
- ☐ Chills
- ☐ Fevers
- ☐ Night sweats
- ☐ Sweats easily
- ☐ Cravings
- ☐ Localized weakness
- ☐ Poor coordination
- ☐ Sudden energy drop at _______ (time)
- ☐ Peculiar tastes/smells ________________
- ☐ Strong thirst (cold/hot drinks) ________________
- ☐ Bleed or bruise easily (where) ________________

____
____

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of hair
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Dry skin/hair
- ☐ Oily skin/hair
- ☐ Change in hair/skin texture
- ☐ Purpura
- ☐ Other hair or skin problem ________________

____
____

HEAD, EYES, EARS, NOSE AND THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Mucus
- ☐ Dry throat
- ☐ Dry mouth
- ☐ Copius saliva
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Grinding teeth
- ☐ Facial pain
- ☐ Gum problems
- ☐ Spots in eyes
- ☐ Recurrent sore throats ______/ month
- ☐ Sores on lips or tongue
- ☐ Headaches (where and when) ______________________
- ☐ Other head or neck problems ______________________

____
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CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Dizziness
- ☐ Blood clots
- ☐ High cholesterol
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Phlebitis
- ☐ Chest Pain
- ☐ Cold hands/feet
- ☐ Difficulty breathing
- ☐ Irregular heartbeat
- ☐ Swelling in hands/feet
- ☐ Other

____

____

RESPIRATORY

- ☐ Cough
- ☐ Pneumonia
- ☐ Production of phlegm __________ what colour _____________
- ☐ Coughing blood
- ☐ Difficulty in breathing when lying down
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tight chest
- ☐ Other lung problems

____

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GASTROINTESTINAL

- ☐ Nausea
- ☐ Gas
- ☐ Bad breath
- ☐ Constipation
- ☐ Pain or cramps
- ☐ Vomiting
- ☐ Belching
- ☐ Rectal pain
- ☐ Bloody stools
- ☐ Laxative use: _______/week; type _________
- ☐ Diarrhea
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Sensitive abdomen

Bowel Movement:

__________ Frequency

__________ Colour

__________ Odor

__________ Texture/form

____

____

GENITO-URINARY

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Wake up to urinate How often _______/night; time _________
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Venereal disease
- ☐ Urgency to urinate
- ☐ Impotency
- ☐ Other G/U problems

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PREGNANCY AND GYNECOLOGY

- ☐ Pregnant Yes or No
- ☐ Duration
- ☐ Vaginal discharge - colour _____; thickness _____; odour _____
- ☐ Breast lumps
- ☐ Birth control - type and duration _______________
- ☐ Premature births
- ☐ Irregular periods
- ☐ Miscarriages
- ☐ Flow (describe) _____

Last menses _______

- ☐ PMS symptoms ____________________________
- ☐ Period (days) _______
- ☐ Clots - colour _______
- ☐ Vaginal sores

Menopause _________

____

____

MUSCULOSKELETAL

- ☐ Neck pain (where) ______________
- ☐ Muscle pain (where) ______________
- ☐ Back pain (where) ______________
- ☐ Joint pains (where) ______________
- ☐ Other joint of bone problems?

____

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Depression
- ☐ Treated for emotional problems
- ☐ Other neurological or psychological problems?
- ☐ Areas of numbness
- ☐ Anxiety
- ☐ Poor memory
- ☐ Bad temper
- ☐ Concussion
- ☐ Easily stressed
- ☐ Considered/attempted suicide

____

____

Further Comments: ____

____

____

Signature ______________________ Date ______________________