

Adult Intake Form

Please fill out this form and email it to drhanlon@ndoc.ca.

Note: If fonts are not loading in Acrobat, please open this form in your web browser.

Name:

Birth Date: Gender:

Address: City: Province:

Postal Code: Email:

Home Phone: () Work Phone: () Cell: ()

Preferred Method of Contact: Home Work Cell Email

Emergency Contact Name: Relationship:

Emergency Contact Phone: ()

Occupation:

Insurance Provider:

Names of Other Healthcare Providers:

1. Phone: ()

2. Phone: ()

How did you hear about Holistic Healing Arts:

What are your chief concerns? (Please list in order of importance to you):

1.

2.

3.

Previous treatments and results:

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Your Medical History

Please check all of the following that apply to you:

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other Major Illness | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> STD | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Significant Trauma (auto accidents, falls, other) | <input type="checkbox"/> HIV | <input type="checkbox"/> Other | |

Family Medical History

Please write the family member beside the checked category, eg. "mother":

- | | | | |
|------------------------------------|----------------------|--|----------------------|
| <input type="checkbox"/> Cancer | <input type="text"/> | <input type="checkbox"/> High Blood Pressure | <input type="text"/> |
| <input type="checkbox"/> Asthma | <input type="text"/> | <input type="checkbox"/> Depression | <input type="text"/> |
| <input type="checkbox"/> Diabetes | <input type="text"/> | <input type="checkbox"/> Heart Disease | <input type="text"/> |
| <input type="checkbox"/> Allergies | <input type="text"/> | <input type="checkbox"/> Thyroid Disease | <input type="text"/> |
| <input type="checkbox"/> Seizures | <input type="text"/> | <input type="checkbox"/> Kidney Disease | <input type="text"/> |
| <input type="checkbox"/> Stroke | <input type="text"/> | <input type="checkbox"/> Alcoholism | <input type="text"/> |
| <input type="checkbox"/> Arthritis | <input type="text"/> | <input type="checkbox"/> Other | <input type="text"/> |

Medical and Lifestyle Information

Date of last physical exam:

List all of your current prescription medications:

How many times have you been treated with antibiotics in the last 5 years:

Please indicate your level of stress (0= no stress, 5= moderate stress, 10= extremely stressful):

Financial Job Related Relationship Health

Family Members Spiritual Other

List all of the over-the-counter medications that you take (eg. Aspirin, Tums, Tylenol) and include dose and frequency:

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List all vitamins, minerals, herbs, Asian medicines, or homeopathic supplements you are taking and include dosage:

Do you have any known allergies (environmental, medicines)? Y N If yes what are they?

Do you have any food allergies or intolerances? Please list:

Do you get regular screening tests (Pap smear, breast, prostate, blood tests, etc.) done by another doctor? Y N

Check off any of the following if they are a CURRENT or RECURRING symptom.

General

- | | | |
|---|--|--|
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sudden decrease in energy | <input type="checkbox"/> Peculiar tastes or smells |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Cravings | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Strong thirst | |

Skin and Hair

- | | | |
|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Itching | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Recent moles | <input type="checkbox"/> Change in hair or skin texture | |

Head, Eyes, Ears, Nose and Throat (HEENT)

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Colour Blindness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Head or neck problems | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Jaw clicks |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Gums bleed easily |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Sores on lips, tongue or mouth |

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Respiratory

- | | | |
|---|--|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain with a deep breath | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Production of mucus | <input type="checkbox"/> Other |

Cardiovascular

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Swelling of ankles/feet |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blood clots | |

Gastrointestinal

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Gas/bloating | <input type="checkbox"/> Nausea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Diarrhea |

Genito-Urinary

- | | | |
|---|---|---|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Wake at night to urinate | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Other |

Gynecology & Pregnancy

Are you pregnant? Y N What is the first day of your last period?

Age of first period:

Date of last PAP: Normal cells Abnormal cells

Live pregnancies # Miscarriage # Abortion #

Birth control used. If yes, what type?

How many years have you been using the birth control pill?

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Musculoskeletal

- | | | |
|---|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Knee pain | <input type="checkbox"/> General muscle pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Other joint or bone problems | | |

Neuropsychological

- | | | |
|--|--|--|
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Depression | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Quick temper | <input type="checkbox"/> Susceptible to stress | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Lack of coordination | |