Adult Intake Form

Please fill out this form and email it to drbitner@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:

- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Surgeries
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Other Major Illness
- ☐ Asthma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ STD
- ☐ Allergies
- ☐ Rheumatic Fever
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Alcoholism
- ☐ Significant Trauma (auto accidents, falls, other)
- ☐ HIV
- ☐ Other

Family Medical History

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

☐ Cancer		☐ High Blood Pressure	
☐ Asthma		☐ Depression	
☐ Diabetes		☐ Heart Disease	
☐ Allergies		☐ Thyroid Disease	
☐ Seizures		☐ Kidney Disease	
☐ Stroke		☐ Alcoholism	
☐ Arthritis		☐ Other	

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

- ☐ Change in appetite
- ☐ Poor sleep
- ☐ Fatigue
- ☐ Chills
- ☐ Fevers
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Sudden decrease in energy
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Peculiar tastes or smells
- ☐ Bleed or bruise easily

Skin and Hair

- ☐ Rashes
- ☐ Dryness
- ☐ Skin cancer
- ☐ Recent moles
- ☐ Eczema
- ☐ Itching
- ☐ Ulcerations
- ☐ Change in hair or skin texture
- ☐ Hair loss
- ☐ Dandruff
- ☐ Pimples

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

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

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Respiratory

- ☐ Difficulty breathing
- ☐ Asthma
- ☐ Coughing blood
- ☐ Cough
- ☐ Pain with a deep breath
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Production of mucus
- ☐ Other

Cardiovascular

- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Swelling of hands
- ☐ Irregular heartbeat
- ☐ Varicose veins
- ☐ Swelling of ankles/feet
- ☐ Dizziness
- ☐ Blood clots

Gastrointestinal

- ☐ Indigestion
- ☐ Abdominal pain or cramps
- ☐ Rectal pain
- ☐ Gas/bloating
- ☐ Nausea
- ☐ Hemorrhoids
- ☐ Bad breath
- ☐ Vomiting
- ☐ Blood in stool
- ☐ Constipation
- ☐ Laxative use
- ☐ Diarrhea

Genito-Urinary

- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Decrease in flow
- ☐ Urgency to urinate
- ☐ Sores on genitals
- ☐ Pain on urination
- ☐ Blood in urine
- ☐ Urinary tract infections
- ☐ Wake at night to urinate
- ☐ Kidney stones
- ☐ 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

- [ ] Neck pain
- [ ] Knee pain
- [ ] General muscle pain
- [ ] Back pain
- [ ] Foot/ankle pain
- [ ] Muscle weakness
- [ ] Hand/wrist pain
- [ ] Hip pain
- [ ] Shoulder pain
- [ ] Other joint or bone problems

Neuropsychological

- [ ] Loss of balance
- [ ] Depression
- [ ] Concussion
- [ ] Quick temper
- [ ] Susceptible to stress
- [ ] Seizures
- [ ] Poor memory
- [ ] Dizziness
- [ ] Areas of numbness
- [ ] Anxiety
- [ ] Lack of coordination