



**Holistic Healing Arts**

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Reg. # RMO 01168*

## **Patient Intake Form**

Please fill out these forms to the best of your knowledge.

Full Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell: \_\_\_\_\_  
Email: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

### **Other Health Practitioners that you are seeing:**

1. \_\_\_\_\_ Reason: \_\_\_\_\_
2. \_\_\_\_\_ Reason: \_\_\_\_\_
3. \_\_\_\_\_ Reason: \_\_\_\_\_

### **How did you hear about us?**

Doctor\_\_ Other Health Practitioners\_\_ Website\_\_ Signage\_\_ Word of Mouth\_\_

Other: \_\_\_\_\_

This is a confidential record of your medical history and will be kept in this office. Information contained here in will not be released to any persons, unless by your permission.

**The Information in the following forms will assist us in treating you in the safest and most efficient way possible. If you have any questions concerning the requested information, please feel free to consult us. Your written permission is required to release any information; unless required, by law.**

## **Health and Lifestyle Information**

**What is your main health concern?**

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**Please list any other health concerns in order of importance, such as: Physical, Emotional, Mental, etc.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Please list any restrictions and/allergies.**

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**How much water do you drink per day?** \_\_\_\_\_

**How many and what type of alcoholic beverages do you consume per week?**

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**Do you smoke? Yes \_\_\_ No \_\_\_ How many cigarettes daily?** \_\_\_\_\_

**On average, how many hours do you sleep at night?** \_\_\_\_\_

**Do you have trouble falling asleep at night?** \_\_\_\_\_

**Do you wake up during the night? Yes\_\_\_ No \_\_\_ Any specific time or reason?**

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**Do you exercise regularly? Yes \_\_\_ No \_\_\_**

**What type of exercise and how often?**

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**Have you ever experienced pain or injury?** \_\_\_\_\_

Shoulders \_\_\_\_\_ Hips \_\_\_\_\_ Head \_\_\_\_\_ Sacroiliac \_\_\_\_\_ Arms \_\_\_\_\_ Legs \_\_\_\_\_

Neck \_\_\_\_\_ Pelvis \_\_\_\_\_ Elbows \_\_\_\_\_ Knees \_\_\_\_\_ Mid-Back \_\_\_\_\_

Hands \_\_\_\_\_ Feet \_\_\_\_\_ Lower back \_\_\_\_\_

**Briefly provide relevant details:**

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### **Health History:**

Circle yes or no, and explain, (dates, procedures, etc.) in the space below.

Have you ever been in a car accident? **Yes** \_\_ **No** \_\_

Have you ever experienced a hard fall onto your hands or buttocks? **Yes** \_\_ **No** \_\_

Have you ever experienced a concussion or other head injury? **Yes** \_\_ **No** \_\_

Have you ever had any surgical procedure? **Yes** \_\_ **No** \_\_

**List current Medication** (reasons for taking them):

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**List Supplements/Herbal Medicines** (reason for taking them):

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**Do you at the present time experience:** (If yes, please circle the related one s)

Yes \_\_\_ No \_\_\_

**Dizziness, weakness, fainting, vertigo, drop attack, or difficulty with bowel or bladder functions?** Yes \_\_\_ No \_\_\_

**Do you have any Bladder or Kidney problems?** (ie. Infection, Disease, etc.)

Yes \_\_\_\_\_ No \_\_\_\_\_

**Do you have any Stomach, Intestinal or any digestive problems?** Yes \_\_\_ No \_\_\_

**Poor appetite, Nausea or Vomiting?** Yes \_\_\_ No \_\_\_

**Do you have any numbness or pins and needles in any part of your body?**

Yes \_\_\_ No \_\_\_

(If yes, please explain).

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**Do you have any Respiratory disease or disorder?** (ie. Asthma, Pneumonia, bronchitis) Yes \_\_\_ No \_\_\_

**Cough, Shortness of breath, chest pain, or Palpitations?** Yes \_\_\_ No \_\_\_

(If yes, please explain)

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**Any significant weight changes in the past year?** Yes \_\_\_ No \_\_\_

**Do you have any of the following conditions? (Please circle yes or no.)**

Carpal Tunnel Syndrome **Yes**\_\_ **No**\_\_      Diabetes (Type 1 or Type 2) **Yes**\_\_ **No**\_\_

Tumor(s) Cancer(s)      **Yes**\_\_ **No**\_\_      Heart disease or problems      **Yes**\_\_ **No**\_\_

Allergies or Intolerances      **Yes**\_\_ **No**\_\_      High or Low blood pressure **Yes**\_\_ **No**\_\_

Epilepsy (Grand Mal or Petite Mal) **Yes**\_\_ **No**\_\_      Fibromyalgia      **Yes**\_\_ **No**\_\_

Seizures      **Yes**\_\_ **No**\_\_

Migraines      **Yes**\_\_ **No**\_\_ (What type) \_\_\_\_\_      Anxiety      **Yes**\_\_ **No**\_\_

Headache      **Yes**\_\_ **No**\_\_ (Type) \_\_\_\_\_      Osteoporosis      **Yes**\_\_ **No**\_\_

Herniated disk      **Yes**\_\_ **No**\_\_      Scoliosis      **Yes**\_\_ **No**\_\_

Arthritis      **Yes**\_\_ **No**\_\_ (Type) \_\_\_\_\_      Hepatitis      **Yes**\_\_ **No**\_\_

TMJ      **Yes**\_\_ **No**\_\_      Muscle strain      **Yes**\_\_ **No**\_\_

Whiplash      **Yes**\_\_ **No**\_\_ (Reason) \_\_\_\_\_

Tendon Strain      **Yes**\_\_ **No**\_\_

Any skin conditions **Yes**\_\_ **No**\_\_ (If yes, explain) \_\_\_\_\_

\_\_\_\_\_

**Are there any other conditions?** \_\_\_\_\_

\_\_\_\_\_

Have you ever consulted a Physician for any of the above conditions?      **Yes**\_\_ **No**\_\_

## Women's Health

Are you currently pregnant?                      **Yes** \_\_\_ **No** \_\_\_

Is your period regular?                            **Yes** \_\_\_ **No** \_\_\_

Do you experience low back pain?              **Yes** \_\_\_ **No** \_\_\_

Is your period painful?                            **Yes** \_\_\_ **No** \_\_\_

Length of monthly cycle (Number of days) \_\_\_\_\_

Average length of Period and flow (in days)

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**Do you have any Gynecological conditions?** (Endometriosis, Fibroids, Polyps, polycystic ovarian syndrome etc.) **Yes** \_\_\_ **No** \_\_\_

(Please explain)

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## Men's Health

**Do you have regular screening test done (blood work, prostate examination)?**

Yes \_\_\_ No \_\_\_

**Do you feel any burning or pain while urinating?** Yes \_\_\_ No \_\_\_

**How many times do you wake up in the night to use the bathroom?**

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