

PATIENT INTAKE FORM

GENERAL INFORMATION

Patient Name:	Date:	
Address:	Postal Code:	
Phone (Home):	Phone (Bus.):	E-mail:
Date of Birth:	Occupation:	
Personal Health Number:	Is this covered by: <input type="checkbox"/> DVA <input type="checkbox"/> RCMP <input type="checkbox"/> Not Applicable	
Is this visit the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is it: <input type="checkbox"/> ICBC <input type="checkbox"/> WCB	
Marital status: <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> divorced/separated <input type="checkbox"/> in a relationship <input type="checkbox"/> widowed <input type="checkbox"/> other		
Number of children and their ages:	If yes, do they live with you?	
Emergency Contact:	Phone:	
Family Doctor:	Phone:	
How did you hear about us? <input type="checkbox"/> word of mouth <input type="checkbox"/> referral <input type="checkbox"/> website <input type="checkbox"/> newspaper ad <input type="checkbox"/> other		
If other, please describe:		

HEALTH INFORMATION

What is your main area of concern? Have you had these symptoms before?

What activities or movements aggravate or relieve your symptoms?

Is this condition getting: better worse constant comes and goes

Is this condition interfering with your: work sleep daily routine If yes, please describe:

Have you had any previous accidents or injuries? Yes No If yes, please describe:

Are you currently taking any medications and or supplements? Yes No

Medications: name, amount and what you understand it to be prescribed to you for. Please describe.

Vitamins/Minerals/Herbs: please list brand names, amount taken and specific reasons why (if you know).

Any previous illness or condition? Yes No If yes, please describe.

Do you have any allergies or drug reactions? Yes No If yes, please describe.

Have you had any recent /past surgeries or trauma? If so what was it and when did it happen?

Do you smoke? Yes No

Do you drink coffee? Yes No How many cups a day?

Recreational Drugs: Yes No

Do you drink alcohol? Yes No How much?

How many cups of water do you drink in a day?

Work: describe your current job; for example, how many hours a week? Is it primarily sedentary? Or highly physical? Please use a percentage; for example, 25% sitting, 50% walking and 25% lifting boxes of about 20 pounds.

Do you stretch? If so how often and what areas?

Diet - are you on a specific diet? Yes No If yes, please describe. If NO, please describe a typical Weekday breakfast, lunch and dinner; and a typical Weekend breakfast, lunch, dinner:

Exercise Program (Type and Frequency):

Are you pregnant? Yes No If yes, when are you due?

Do you wear: Heel lifts Sole lifts Inner soles Arch supports

Do you have any of the following? (Please check all that apply)

Gen'l

Disease/Condition

- Abdominal Surgery
- Alcoholism
- Anemia
- Anxiety
- Appendicitis
- Arthritis
- Autoimmune Disease
- Binge eat/drink
- Bleeding Disorder
- Blood Clots
- Breathing Difficulties
- Cancer
- Chills
- Cholesterol - High
- Colon Problems
- Convulsions
- Diabetes
- Difficulty with Speech
- Dizziness
- Eating Disorder
- Eczema
- Epilepsy
- Fainting
- Fatigue
- Fever
- Glaucoma
- Hand Trembling
- Headache
- Heart Disease
- Hernia
- HIV Positive
- Hyperthyroid
- Infertility
- Influenza
- Kidney Disease
- Fainting
- Fatigue
- Fever
- Glaucoma
- Hand Trembling
- Headache
- Heart Disease
- Hernia
- HIV Positive
- Hyperthyroid
- Infertility
- Influenza
- Kidney Disease
- Liver Disease
- Loss of Coordination
- Loss of Memory
- Loss of sleep
- Loss of weight
- Low Back Pain
- Measles
- Mental Illness
- Mumps
- Nervousness
- Pleurisy
- Pneumonia
- Polio
- Rectal Surgery
- Seizures
- STD
- Stutter/Stammer
- Weakness

Eye/Ear/Nose/Throat

- Asthma
- Crossed Eye
- Deafness
- Difficulty Swallowing
- Double Vision
- Ear Pain
- Hearing Loss
- Nose Bleeds
- Sinus Problems
- Sore Throat
- Thyroid Problems

Cardio/Respiratory

- Aortic Aneurysm
- Bronchitis
- Bruise Easy
- Chest Pain
- Chronic Cough
- Coughing/Spitting Blood
- Difficulty Breathing
- High Blood Pressure
- Low Blood Pressure
- Pain over Heart
- Poor Circulation
- Previous Heart Problems
- Rapid Heartbeat
- Slow Heart Rate
- Stroke
- Swollen Ankles
- Varicose Veins
- Wheezing

For Men Only

- Lump in Testicles
- Penis Discharge

Gastro-Intestinal

- Bloating
- Colon Trouble
- Constipation
- Diarrhea
- Gallbladder Trouble
- Gas
- Heartburn
- Hemorrhoids
- Liver Trouble
- Nausea
- Poor Appetite
- Poor Digestion
- Rectal Bleeding
- Stomach Ache
- Vomiting
- Vomiting Blood

Genito-Urinary

- Blood in Urine
- Frequent Urination
- Inability to Control Urine
- Kidney Infection
- Painful Urination
- Prostate Trouble

For Women Only

- Abnormal Pap Smear
- Birth Control
- Excessive Menstrual
- Hot Flashes
- Irregular Cycle
- Irregular Flow
- Menstrual Cramps
- Painful Periods

Family History with any of the above? Yes No

I authorize the practitioners at Woodgrove Pines Clinic to share my health records amongst themselves in order to more effectively manage my health concerns and gain insight from the different health care providers within the clinic.
This consent is optional and not necessary for treatment at our clinic.

SIGNATURE

Dated this _____ day of _____ 20 _____

Name (please print)

Signature