Intake Form

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Name:_____ Date:_____

Age:_____ Date of Birth:_____ (M/D/Y) Sex (Circle): M F

Address:_____
Street City Postal Code

E-mail Address:_____

Home Telephone Number: _____ Cell phone number: _____

May we leave messages relating to your visits? Y / N Which Phone Number? _____

Occupation: _____ Employer:_____

Marital Status (Circle): Single Married Divorced Widowed Separated

Number of Children: _____

Emergency Contact Name and Relation: _____

Emergency Contact Phone Number: _____

How did you hear about me? (Please check one of the following)

- ☐ Absolute Wellness Centre staff (who?): _____
- ☐ Absolute Wellness Centre patient
- ☐ Friend
- ☐ Family member
- ☐ www.absolutechiropracticwindsor.ca
- ☐ Facebook
- ☐ Newsletter
- ☐ Other: _____

Referred by: _____

Other Health Care providers you are currently seeing (MD/Specialist/ND/Chiropractor, etc., name, address, phone number):

1. _____
   _____
   ( ) _____
2. _____
   _____
   ( ) _____
3. _____
   _____
   ( ) _____

Major complaints in order of Importance to you:

Complaint	Since	Possible Causes

If you are female are you currently pregnant? Yes No (Please circle one)
For women:
Date of first menses:_____ Number of pregnancies:____ Number of children:_____
Date of last PAP:_____

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, surgeries, injuries and any hospitalizations, along with approximate dates:

Condition/Illness/Surgery/Injury/Hospitalization	Date

What medications are you currently taking? (Prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

Medication/Supplement	Since	Dose

Do you have any allergies (medicines, environmental, etc.)? Yes No
If yes, please specify: _____

How many times (approximately) have you been treated with antibiotics? _____

Do you frequently use any of the following? (circle)
Aspirin / Laxatives / Antacids / Diet pills / Birth control: Pills / Implants / Injections

Alcohol—How much per day or week:_____
Tobacco—form and amount/day: _____
Caffeine—form and amount/day:_____
Recreational drugs—what and how often: _____

Please indicate what immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Tetanus booster: when? _____
- ☐ MMR (measles, mumps, rubella)
- ☐ Haemophilus influenza B
- ☐ Flu vaccine: When? _____
- ☐ Polio
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Smallpox
- ☐ Guardacil (HPV vaccine): when?_____

Other:_____

Please indicate if any caused adverse reactions: _____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) Y / N
When was the last time you visited your medical doctor? _____
Which of the following conditions have you had at any time in your life?

- ☐ Loss of consciousness
- ☐ Numbness/tingling
- ☐ Fever/chills
- ☐ Difficulty swallowing
- ☐ Hayfever/Allergies
- ☐ Rashes/eczema/dry skin
- ☐ Acne
- ☐ Cold sores
- ☐ Depression
- ☐ Anxiety
- ☐ Diabetes
- ☐ Fainting
- ☐ Seizures/convulsions
- ☐ Dizziness
- ☐ Frequent colds/flus
- ☐ Loss of weight
- ☐ Fatigue/weakness
- ☐ Headaches
- ☐ Head injury
- ☐ Weakness/loss of muscle strength
- ☐ Shoulder, elbow or wrist pain
- ☐ Hip, knee or ankle pain
- ☐ Sexual difficulties
- ☐ HIV/AIDS
- ☐ Vision problems
- ☐ TMJ concerns
- ☐ Earaches
- ☐ Ear infections
- ☐ Decreased hearing
- ☐ Easy bruising
- ☐ Boils/hives/abscesses
- ☐ Change in mole
- ☐ Night sweats
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Asthma/bronchitis
- ☐ Strep throat
- ☐ Sinusitis/sinus problems
- ☐ Sunstroke
- ☐ Tonsillitis
- ☐ Bleeding disorders
- ☐ Anemia
- ☐ Warts (genital/hands)
- ☐ Worms
- ☐ Pain on urination
- ☐ Blood in the urine
- ☐ Pelvic inflammatory disease
- ☐ Gall stones
- ☐ Chest pain
- ☐ Murmurs
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Heart problems
- ☐ Poor digestion
- ☐ Trouble swallowing
- ☐ Change in thirst
- ☐ Change in appetite
- ☐ Nausea/vomiting
- ☐ Belching or gas
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Stiff neck
- ☐ Backache
- ☐ Swollen joints
- ☐ Muscle spasms/cramps
- ☐ Alcoholism
- ☐ Herpes
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Urgency, frequency, or hesitancy of urination
- ☐ Anorexia/Bulimia

Men's Health:

- ☐ Prostate trouble
- ☐ Testicular masses
- ☐ Testicular pain
- ☐ Discharge or sores

Women's Health:

- ☐ Painful menstruation
- ☐ Painful intercourse
- ☐ Excessive flow/irregular cycle/cramps or backache/swollen or tender breasts/PMS (circle all that apply)
- ☐ Vaginal discharge
- ☐ Hot flushes
- ☐ Lumps in the breast. Do you do self-breast exams? _____

Have you lost any weight recently? How many lbs/kg? _____

Diet

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

_____
_____
_____

Do you have any dietary restrictions? (religious, vegetarian/vegan, etc.)

_____
_____
_____

Describe a **typical day's diet**:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (type and quantity): _____

Family History

Indicate if a close relative (parent, child, sibling, grandparent) has had any of the following:

- ☐ I don't know my family medical history

Condition	Please indicate which family member
Allergies	
Arthritis	
Asthma	
Heart disease	
High Blood pressure	
Cancer	
Diabetes	
Depression	
Drug Abuse/Alcoholism	
Kidney Disease	
Other Mental Illness (Please Specify)	
Other Autoimmune diseases (Please specify: Lupus, Inflammatory Bowel Disease, etc.)	
Other	

Environment

Occupation: _____

Hobbies: _____

What do you love to do?:_____

Do you exercise regularly? Y / N What do you do for exercise? How much? How often?

_____

_____

_____

How many people live in your home? Please specify. (spouse, children, roommates, etc.)

_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?_____

Are you regularly exposed to toxins or other hazards (home, work, hobbies, etc.)? Please describe.

_____

_____

Do you have a strong emotional support system? (family, friends, colleagues, etc.) Y / N

How would you describe the emotional climate of your home?

_____

_____

How stressful is your work? How stressful are other aspects of your life? How well do you handle these stresses?

_____

_____

_____

Is there anything else you feel is important that has not been covered?

_____

_____

_____

What expectations do you have from your FIRST VISIT?

What LONG TERM expectations do you have from working with me?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 1 to 10, with 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviours of lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

What behaviours or lifestyle habits do you currently engage in regularly that you believe are NOT supportive of your optimal health? (Please list)

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and would decrease compliance in adhering to your therapeutic protocol?