1Stop Healthcare CLINIC

Adult Intake

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

(Please print clearly)

Name _____ Date _____

Date of birth _____ (M/D/Y) Preferred Pronoun ☐ He ☐ She ☐ Other_____

Address:_____ Apt/unit #_____

City _____ Province _____ Postal Code_____

E-mail Address:_____

Telephone number: Home:_____ Work:_____ Cell:_____

May we leave messages relating to your visits? Which Phone Number_____

Emergency contact: Name: _____

Phone number(s):_(_____)_____ or_(_____)_____ Relation:_____

How did you hear about our Clinic? Please check one of the following:

- ☐ A patient of the clinic (please provide name) _____
- ☐ My medical doctor/Specialist (please provide name) _____
- ☐ Other Health Care Provider (please provide name):_____
- ☐ Advertising (newspaper, TTC, brochure)
- ☐ Social Media (Facebook, Twitter etc.)
- ☐ CCNM Website
- ☐ CCNM Student, staff or faculty
- ☐ Information Session
- ☐ External Sports Medicine event
- ☐ CCNM E-Newsletter
- ☐ Other: _____

How would you identify your gender?

☐ Women ☐ Man ☐ Non binary ☐ Prefer to self-disclose _____

Other health care providers you are seeing:

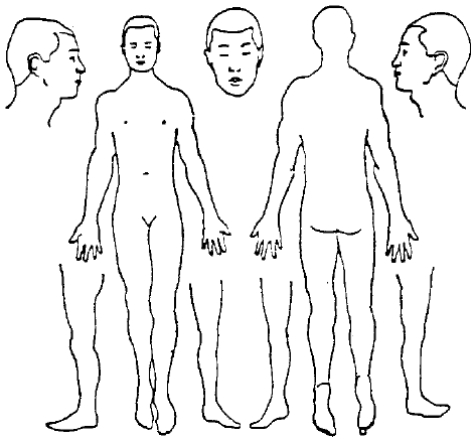
Name:_____	Name:_____	Name:_____
Specialty:_____	Specialty:_____	Specialty:_____
Ph (_____)_____	Ph (_____)_____	Ph (_____)_____
Date of last visit: _____	Date of last visit: _____	Date of last visit: _____

Have you ever consulted (Please check all that apply):

☐ Naturopathic doctor ☐ Acupuncturist ☐ Nutritionist ☐ Counselor

Health Goals

What are your health concerns and goals, in order of importance to you:

Please list most important health concerns and goals in their order of significance:	Prior diagnosis of this problem? If so, what?	**Indicate Painful or distressed areas:**
1.		
2.		
3.		
4.		
5.		

Are you currently pregnant? ☐ Yes ☐ No Due date_____
Are you currently lactating? ☐ Yes ☐ No

Medical history

How would you describe your general state of health?

◯ Excellent ◉ Good ◯ Fair ◯ Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Do you have any allergies (medicines, environmental, etc.)?

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Please list all <u>current</u> medications/natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

1) _____ 3) _____ 5) _____
2) _____ 4) _____ 6) _____

Please list <u>past</u> prescription medications/natural health products:

_____
_____

Please indicate Yes (Y), No (N) or Past (P) regarding use of the following:

Aspirin, Tylenol, Advil or other pain relievers: _____
Laxatives: _____ Antacids: _____ Diet pills: _____
Birth control:_____
Antibiotics: _____
Alcohol—how much/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) ☐ Haemophilus influenza B ☐ Hepatitis A
☐ Tetanus booster; when? ☐ "Flu" ☐ Hepatitis B
_____
☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Smallpox
Other _____
Please indicate if any caused adverse reactions: _____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? ☐ Yes ☐ No
Last time you had blood work done_____

Personal and Family History

Please place a "**Y"** in the "yes" box next to each condition that applies to you and/or one of your family members. Please indicate all who the condition applies to: "**Self**" if it relates to you and/or Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**), your child (**C**). Please indicate **Past** if the condition is resolved, or **Current** if it is on-going and current

	Yes	Relation	Past or Current Condition		Yes	Relation	Past or Current Condition
Alcoholism/Drug addiction				High Blood pressure			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				Headaches			
Asthma				Kidney disease			
Cancer				Stroke			
Diabetes				Tuberculosis			
Eczema				Osteoporosis			
Epilepsy				Others:			
Depression/other Mental Illness							

☐ I don't know my family medical history

Diet

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

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

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

_____

Environment

Occupation _____
Hobbies_____

Do you exercise regularly? What do you do for exercise, how much, how often?

_____
_____
_____

Are you exposed to significant tobacco smoke (work, home, etc.)?
Are you frequently exposed to animals (work, pets, etc.)?
How is your home heated?_____

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

_____
_____

Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)? _____

How would you describe the emotional climate of your home?

_____
_____

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

_____
_____
_____

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

_____
_____
_____