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Phone: 604.738.2205

Date_____

Name_____Email_____
Address_____
City_____Province_____Postal Code_____
Telephone(home)_____(work)_____(cell)_____
Birthdate_____ Age_____ Sex: F M
Care Card number_____
How did you hear about the clinic?_____
Live alone___ with spouse/partner___ parents___ children___ friends___
Occupation_____Hrs/wk_____Retired_____
Other healthcare providers: MD_____
Naturopath_____Chiropractor_____
Others_____
Person to contact in an emergency_____
Relation to you_____ Phone_____

What are your most important health concerns? List in order of importance:

1. _____
2. _____
3. _____
4. _____

Medical History (date where possible)

General Health_____ Childhood illnesses: Mumps_____ Chicken pox_____
Measles_____ German Measles_____ Rheumatic Fever_____ Mononucleosis_____
Accidents, falls, injuries_____
Surgeries_____
X-rays, CAT Scans, MRIs, EEGs, EKGs_____

Asthma/Hayfever/Hives__Anemia__High Blood Pressure__Heart Disease__Diabetes__
Stroke__Thyroid Disease__Liver Disease__Kidney Disease__Cancer__Epilepsy__
Tuberculosis__Depression__Anxiety__Bipolar__Schizophrenia__Venereal Disease__

Immunizations

Polio	Y	N	Pertussis	Y	N
Diphtheria	Y	N	Measles/Mumps/Rubella	Y	N
Tetanus	Y	N	Other_____		

Family History – please indicate if Father(F), Mother (M), Sister(S), Brother(B),Child(C)
Asthma/Hayfever/Hives__Anemia__High Blood Pressure__Heart Disease__Diabetes__
Stroke__Thyroid Disease__Liver Disease__Kidney Disease__Cancer(type)_____
Epilepsy__TB__Depression__Anxiety__Bipolar__Schizophrenia__Venereal Disease__

Current Medications (circle any medications that you take)
Pain Relievers (Aspirin, Tylenol) Cortisone Anti-depressants Thyroid meds
Heart/Cholesterol/Diuretics Laxatives Sleeping Pills

Antacids (Rolaids, Tums) Antibiotics Anti-Anxiety
Other (including over the counter)_____

Vitamins/Supplements_____
_____

Exercise/Frequency **Hobbies**
_____ _____
_____ _____
_____ _____

Diet (Please list what you typically eat in a day)
Breakfast_____
Lunch_____
Dinner_____
Snacks_____
Drinks_____

Current Medical History
Height_____ Weight_____ Is this a change Y N
Allergies (food, drugs, allergens)_____

Review of Systems
Skin/Hair
Rashes__ Eczema/hives__ Acne/boils__
Itching__ Colour changes__ Lumps__
Recent moles__ Hair loss__ Dandruff__

Head
Head injuries__ Jaw/TMJ problems__ Headaches__

Eyes
Double vision__ Eye strain/pain__ Glaucoma__
Spots/Blurring__ Night Blindness__ Glasses__
Tearing/Dryness__ Colour Blindness__ Cataracts__

Ears
Impaired hearing__ Ringing__ Earaches__
Dizziness/fainting__

Nose/Sinuses
Frequent colds__ Congestion__ Nosebleeds__
Sinus problems__ Loss of smell__
Sinusitis__

Mouth/Throat
Sore throat Hoarseness__ Sore tongue__
Teeth grinding__ Gum problems__ Cavities__

Neck
Lumps__ Swollen glands__ Goiter__
Pain/stiff neck__

Respiratory

Cough__ Phlegm(colour)__ Bronchitis__
Coughing up blood__ Asthma__ Wheezing__
Shortness of breath__at night__ Pain on breathing__
Pneumonia__
Emphysema__ Pleurisy__

Cardiovascular/Circulation

High/Low blood pressure__ Irregular heartbeat__ Murmurs__
Chest pain__ Angina__ Blood clots__
Swelling in ankles__ Varicose veins__ Phlebitis__
Cold hands/feet__ Deep leg pain__

Gastrointestinal

Indigestion__ Bloating/gas__ Heartburn__
Ulcer__ Constipation__ Diarrhea__
Chronic laxative use__ Nausea__ Vomiting__
Abdominal pain/cramps__ Trouble swallowing__ Bad breath__
Jaundice (yellow skin) Gall bladder disease__
Bowel movements: How often?_____ Is this a change? Y N

Urinary

Pain on urination__ Frequency__at night__ Urgency__
Decreased flow__ Inability to hold urine__ Blood__
Change in colour__ Kidney stones__

Female reproductive

Age menses began____ Menses length_____ Cycle length____
PMS_____ What symptoms?_____
Menstrual cramps__ Heavy menses__ Light menses__
Irregular cycles__ Bleeding between periods__
Sexually active__ Birth control/protection (what?)_____
Sexual difficulties__ Painful intercourse__ Infertility__
Number of pregnancies__ Live births__ Miscarriages__ Abortions__
Vaginal discharge__ Vaginal sores__
Menopausal symptoms__ What symptoms?_____
Breast tenderness__ Nipple discharge__ Breast lumps__

Male Reproductive

Testicular pain__ Testicular masses__ Hernias__
Sexually active__ Birth control/Protection (what?)_____
Sexual difficulties__ Prostate disease__ Discharge/sores__

Musculoskeletal

Joint pain or stiffness__ Where?_____
Arthritis__ Where?_____
Weakness__ Where?_____
Muscle cramps/spasms__ Broken bones__ Sciatica__

Neurologic

Fainting__ Seizures__ Paralysis__
Numbness/tingling__ Memory loss__

Endocrine

Change in thirst__ Change in appetite__ Hypothyroid__

General

Sleep well	Y	N	Awake rested	Y	N
Hours sleep/night	_____				
Enjoy your work	Y	N	Take time off	Y	N
Travel in past 10 years	Y	N	Where?_____		
Spend time outside	Y	N	Eat three meals/day	Y	N
Drink coffee/tea/cola	Y	N	Smoke cigarettes	Y	N
Drink alcohol	Y	N	Ever treated for drug dependence	Y	N

Watch television for _____hours/day Read for _____hours/day

Level of stress in life recently high medium low

Any history of toxic exposure (what?)_____

How does your condition affect you?_____

Do you have any insight into why it is happening, and if so what?_____

_____

What do you enjoy most in your life?_____

Anything else you would like to add?_____