# TRI·HEALTH
WELLNESS CENTRE

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**New Patient Intake Form**
**PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION**
**(PLEASE PRINT CLEARLY)**

**Name:** _____ **Date:** _____
**Date of birth:** ____/___/_____ **Age:** ____ **Gender:** ☐ **M** ☐ **F** **Ethnicity:** _____
(MM/DD/YYYY) (optional)

## CONTACT INFORMATION

**Address**:_____

**City:** _____ **Province:** _____ **Postal Code:** _____

**E-mail Address**:_____ **Home Phone:** _____

**Work Phone:** _____ **Other: (specify)**_____

**At which phone number may we leave messages relating to your visits?** _____

## EMERGENCY CONTACTS

**(1) Name:** _____ **Relation:** _____

**Phone: Home**_____ **Work**_____ **Other: (specify)**_____

**(2) Name:** _____ **Relation:** _____

**Phone: Home**_____ **Work**_____ **Other: (specify)**_____
**How did you hear about our Clinic?**:_____
**Referred by**:_____

## OTHER HEALTH CARE PROVIDERS

| MEDICAL DOCTOR | OTHER | OTHER |
|---|---|---|
| NAME & ADDRESS: | NAME & ADDRESS: | NAME & ADDRESS: |
| 1._____ | 2._____ | 3._____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| PHONE:(____)_____ | PHONE:(____)_____ | PHONE:(____)_____ |
| FAX: (_____)_____ | FAX: (____)_____ | FAX: (____)_____ |
| PERMISSION TO CONTACT: (circle one) YES or NO | TYPE OF PRACTITIONER: _____ | TYPE OF PRACTITIONER: _____ |

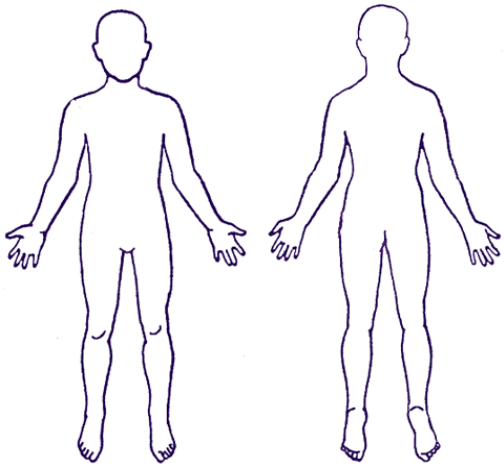
## MEDICAL HISTORY

**Please list your health concerns & goals. (What brings you in today? What would you like to work on?):**

_____
_____

On the diagram below, CIRCLE any areas of the body which are a concern for you (eg. painful/tender areas).
Please LIST your concerns next to any areas you have circled.

FRONT OF BODY BACK OF BODY



Please list your GOALS, or concerns you would like to improve on. How may I assist you in achieving these goals?

_____

How is your PRESENT state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
How was your PAST state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
If you are female are you currently pregnant? ((Please circle one:) Yes No

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations. (Please include approximate dates.)

_____

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

_____

Please list all CURRENT medications (prescription and over-the-counter), the daily dose and how long you have taken it?

| Medication | Dose/day | How long? | Medication | Dose/day | How long? |
|---|---|---|---|---|---|
| 1. | | | 5. | | |
| 2. | | | 6. | | |
| 3. | | | 7. | | |
| 4. | | | 8. | | |

Please list PAST prescription medications (prescription and over-the-counter), the daily dose and how long you have taken it?

| Medication | Dose/day | How long? | Medication | Dose/day | How long? |
|---|---|---|---|---|---|
| 1. | | | 5. | | |
| 2. | | | 6. | | |
| 3. | | | 7. | | |
| 4. | | | 8. | | |

Have you ever had a reaction to any medication(s)? (please check ✓ one:) ☐ Yes ☐ No

If yes, please explain: _____

Please list all CURRENT vitamins/minerals, herbs, or homeopathics you are taking, including the daily dose and how long you have been taking it?

| Medication | Dose/day | How long? | Medication | Dose/day | How long? |
|---|---|---|---|---|---|
| 1. | | | 5. | | |
| 2. | | | 6. | | |
| 3. | | | 7. | | |
| 4. | | | 8. | | |

How many times have you been treated with antibiotics? _____
For what reason(s) where the antibiotics given? _____

Please check ✓ off all IMMUNIZATIONS you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Tetanus booster; when? _____
- ☐ MMR (measles, mumps, rubella)
- ☐ Haemophilus influenza B
- ☐ Flu Shot
- ☐ Polio
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Smallpox

☐ Pneumococcal vaccine ☐ Chickenpox ☐ HPV

Other(s): _____ Adverse reactions? _____

Please check ✓ any CHILDHOOD ILLNESS you have had, and at what age:

| CONDITION | AGE | CONDITION | AGE | CONDITION | AGE |
|---|---|---|---|---|---|
| ☐ MEASLES | | ☐ WHOOPING COUGH | | ☐ SCARLET FEVER | |
| ☐ RUBELLA | | ☐ CHICKEN POX | | ☐ POLIO | |
| ☐ MUMPS | | ☐ RHEUMATIC FEVER | | ☐ ROSEOLA | |
| ☐ ASTHMA | | ☐ ECZEMA | | ☐ OTHER _____ | |
| ☐ OTHER_____ | | ☐ OTHER_____ | | ☐ OTHER_____ | |

Do you USE any of the following? (Please circle all that apply to you:)

| USE: | WHAT FORM? | FOR HOW LONG? | AMOUNT PER DAY, WEEK, OR MONTH? |
|---|---|---|---|
| ASPIRIIN | | | |
| LAXATIVES | | | |
| CORTISONE | | | |
| ANTACIDS | | | |
| DIET PILLS | | | |
| TRANQUILIZERS | | | |
| SLEEPING PILLS | | | |
| APPETITE SUPPRESSANTS | | | |
| ANTIBIOTICS | | | |
| BIRTH CONTROL PILLS | | | |
| IMPLANTS | | | |
| INJECTIONS | | | |
| ALCOHOL | | | |
| TOBACCO | | | |
| CAFFEINE | | | |
| RECREATIONAL DRUGS | | | |

Have you ever been treated for drug dependence? ☐ Yes ☐ No If yes, please list when: _____

Have you ever been treated for alcohol dependence? ☐ Yes ☐ No If yes, please list when: _____

## FAMILY HISTORY

Indicate if a close relative (parent, child, sibling) has had any of the following. Please indicate their age:

| CONDITION | WHO? | AGE | CONDITION | WHO? | AGE |
|---|---|---|---|---|---|
| Anemia (type) | | | Heart disease | | |
| Allergies | | | Hepatitis | | |
| Alcoholism | | | High blood pressure | | |
| Alzheimer's Disease | | | High cholesterol | | |
| Arthritis | | | Kidney disease | | |
| Asthma | | | Mental illness | | |
| Bleeding Disorders | | | Multiple sclerosis | | |
| Cancer (type) | | | Osteoporosis | | |
| Depression | | | Parkinson's Disease | | |
| Diabetes | | | Seizures | | |
| Drug abuse | | | Stroke | | |
| Epilepsy | | | Tuberculosis | | |

| | | | | | |
|---|---|---|---|---|---|
| Headaches/migraines | | | Other (specify) | | |

☐ I don't know my family medical history

## SLEEP HABITS

What time do you go to sleep? _____ What time do you wake up? _____
Do you have difficulty falling asleep? (please check ✓ one:) ☐ Yes ☐ No ☐ In the past
If yes, please specify:_____
Do you awake rested? (please check ✓ one:) ☐ Yes ☐ No
If no, please specify: _____
Do you sleep well? (please check ✓ one:) ☐ Yes ☐ No
If no, please specify: _____
On average, how many hours do you sleep per night? _____

## NUTRITIONAL HABITS

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

_____

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

_____

Do you eat 3 meals per day? (please check ✓ one:) ☐ Yes ☐ No

Please describe a typical day's diet: (include timing of each meal/snack and portion sizes)

| MEAL | TIME | CONTENTS | QUANTITY |
|---|---|---|---|
| BREAKFAST | | | |
| LUNCH | | | |
| DINNER | | | |
| SNACKS | | | |
| BEVERAGES | | | |

## EXERCISE HABITS

Do you exercise regularly? (please check ✓ one:) ☐ Yes ☐ No

What do you do for exercise, how much, and how often?

_____

## LIFESTYLE HABITS

Marital Status: _____ Do you have any children? ☐ Yes ☐ No
If yes, how many? (please include ages:)_____
Occupation: _____ Do you enjoy your work? _____
Main interests & hobbies: _____
What do you do to relax? _____
What is your overall stress level? (Please rate out of 10, 10 being the highest): ____/ 10
Please list the aspects of your life which are stressful to you:

_____

How well do you handle these stresses?

_____

Have you undergone any significant emotional traumas in your life? Please explain:

_____

How would you describe the emotional climate of your home?

_____

## ENVIRONMENTAL FACTORS

Are you exposed to significant tobacco smoke (work, home, etc.)? ☐ Yes ☐ No
Are you frequently exposed to animals (work, pets, etc.)? Circle one: ☐ Yes ☐ No If yes, please list: _____
How is your home heated? _____
Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

_____

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