INTAKE FORM

Please complete this form in full. All information is strictly confidential.

General Information

Name: _____ Date: _____

Address: _____ Birth date: _____

City: _____ Province: _____ Postal Code: _____

Occupation: _____ Home Phone: _____ Bus. Phone: _____

Height: _____ Weight: _____ Max. Weight: _____ When: _____

How did you hear about this clinic? _____

Focus *List major complaints in order of importance.*

Complaint	Since	Causes

Review of Symptoms

Only mark if a problem,

1=occasional difficulty 2=frequent difficulty 3=regular difficulty

1	2	3		1	2	3		1	2	3	
☐	☐	☐	weight loss or gain	☐	☐	☐	fevers	☐	☐	☐	gas
☐	☐	☐	fatigue	☐	☐	☐	dizziness	☐	☐	☐	abdominal pains
☐	☐	☐	hair loss	☐	☐	☐	ringing in ears	☐	☐	☐	nausea/vomiting
☐	☐	☐	sexual difficulties	☐	☐	☐	earaches	☐	☐	☐	difficult digestion
☐	☐	☐	poor endurance	☐	☐	☐	blurry vision	☐	☐	☐	fatty foods aggravate
☐	☐	☐	confusion	☐	☐	☐	eyestrain	☐	☐	☐	constipation
☐	☐	☐	nervousness	☐	☐	☐	nasal congestion	☐	☐	☐	diarrhea
☐	☐	☐	depression	☐	☐	☐	sinus pressure	☐	☐	☐	thin stool
☐	☐	☐	insomnia	☐	☐	☐	nosebleeds	☐	☐	☐	straining
☐	☐	☐	nightmares	☐	☐	☐	hayfever	____			number of bowel movements daily (#)
☐	☐	☐	muscle tension	☐	☐	☐	swollen glands				
☐	☐	☐	muscle cramps	☐	☐	☐	mucous problems	____			is this a change (y/n)
☐	☐	☐	numbness/tingling	☐	☐	☐	sores in mouth	☐	☐	☐	hemorrhoids
☐	☐	☐	cold hands/feet	☐	☐	☐	coated tongue	☐	☐	☐	bloody or black stools
☐	☐	☐	sweaty hands/feet	☐	☐	☐	bad breath	☐	☐	☐	night urination
☐	☐	☐	blackouts	☐	☐	☐	sore throats	☐	☐	☐	urinary problems
☐	☐	☐	itching	☐	☐	☐	dental problems	☐	☐	☐	burning on urination
☐	☐	☐	rashes	☐	☐	☐	neck pains	☐	☐	☐	bladder/kidney infection
☐	☐	☐	acne	☐	☐	☐	cough	☐	☐	☐	bedwetting
☐	☐	☐	eczema	☐	☐	☐	difficult breathing	☐	☐	☐	blood in urine
☐	☐	☐	psoriasis	☐	☐	☐	shortness of breath	☐	☐	☐	back pains
☐	☐	☐	warts	☐	☐	☐	coughing blood	☐	☐	☐	leg swelling
☐	☐	☐	change in mole	☐	☐	☐	heart palpitations	☐	☐	☐	bone or joint pains
☐	☐	☐	bruise easily	☐	☐	☐	chest pains	☐	☐	☐	arm/leg problems
☐	☐	☐	headaches	☐	☐	☐	breast lumps/pain	☐	☐	☐	joint swelling

Other: _____

I certify that the information given in this form is true and accurately reflects my past and present health status.

Client's Signature_____ Date _____