**Please complete this form and return on your first visit**

Name:

Address:

Telephone number: (H)      (W)

May we leave a message for you at these numbers?

Referred by:

Family medical doctor:

Other primary caregivers:

Emergency contact:

Relation:       Phone number:

**Personal Health Information**

Age:       Date of birthday: Click here to enter a date.

Sex:

Marital status:       Name of spouse/partner:

Number of children:

Occupation:       No. of hours worked/week:

Last physician or health care practitioner seen:

* When: Click here to enter a date.

Date of last physical exam:Click here to enter a date. Blood test done:

What is your main reason for coming in today:

|  |
| --- |
| **HEALTH CONCERNS** |
| **CONCERN** | **WHEN DID IT START** | **CURRENT TREATMENT** | **PAST TREATMENT** |
| Click here to enter text. | Click here to enter a date. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter a date. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter a date. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter a date. | Click here to enter text. | Click here to enter text. |

Have you ever seen a (*check all that apply*):

|  |  |  |
| --- | --- | --- |
| Naturopathic doctor [ ]  | Chiropractor [ ]   | Acupuncturist [ ]  |
| Massage therapist [ ]   | Osteopath [ ]  | Other complementary health care practitioner:       |

Approximate weight:      One year ago:

Comfort weight:      Height:

Are you currently working with a professional counsellor, psychologist, social worker, pastor or other therapist?

Have you in the past? When? Click here to enter a date.

**PRESCRIPTION MEDICATIONS**

Please list any prescription medications that you are currently taking

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION** | **PRESCRIBED FOR…** | **DOSE** | **DURATION** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

In the past 5 years, how often have you been prescribed antibiotics:

Do you currently take any of the following on a regular basis (*check all that apply*):

|  |  |  |
| --- | --- | --- |
| Aspirin [ ]  | Laxative [ ]  | Muscle relaxant [ ]  |
| Tylenol [ ]  | Antacid [ ]  | Sleeping pill [ ]  |

**SUPPLEMENTS**

Please list any supplements you are currently taking

| **MEDICATION** | **PRESCRIBED FOR…** | **DOSE** | **DURATION** |
| --- | --- | --- | --- |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**LIFESTYLE**

Do you use tobacco products:

* How often:

Are you exposed to tobacco products in your home or workplace:

Do you consume alcohol:

* How often:

Do you use recreational drugs:

* How often:

Do you exercise regularly:

* How often:

What type of activities do you do to relax?

Who do you currently live with (*check all that apply*):

|  |  |  |
| --- | --- | --- |
| Spouse[ ]  | Partner [ ]   | Parent/Guardian [ ]   |
| Friends[ ]   | Children [ ]  | Alone [ ]  |

How would you describe the emotional climate of your home:

What do you enjoy most in your life:

What are your main interests and/or hobbies:

What do you worry about most in your life: