CONFIDENTIAL INTAKE FORM **(please print)**

Personal Details:

_____

Last Name First Name DOB (year/month/date)

_____

Address City Province Postal Code

_____

Email address Home Phone Number Mobile Phone Number

_____

Gender (M/F) Occupation Marital Status

Emergency Contact

_____

Name Relationship Phone Number

Who referred you? _____

Health Information:

_____

Name of Medical Doctor Date of Last Appointment Date of Last Physical

_____

Insurance Provider Policy Number

Do you have a pacemaker or any metal implants (e.g. screws)? If so, explain:

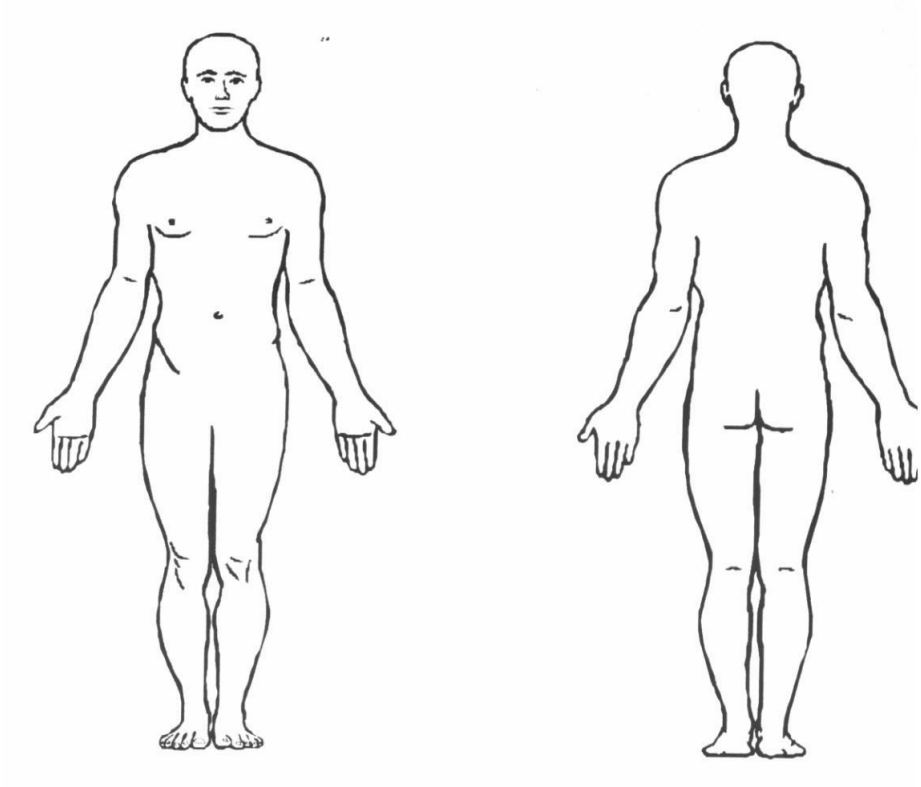
_____

If female, when was your last period? _____

Do you have any bleeding disorders? _____

Do you have any diseases or illnesses? _____

Please CIRCLE & NUMBER areas & levels of PAIN:
(10-Most painful 1-Least painful)



Patient Symptoms:

What is your principal problem, or the one area of greatest concern?

_____

Secondary problem(s)?

_____

What treatments, if any have you received for your complaint(s)?

_____

What benefited you the most? _____

What, if anything, aggravates your problem? _____

Do you take any medications, or vitamin supplements?_____

_____

Medical History/ Other: Please check any of the following that pertain to you:

Head/ Eye/ Ears/ Throat/ Teeth

	headaches, migraine		Asthma		Cough
	dizziness, vertigo		allergies		Ringing in the ears
	sinus problem		Visual disturbance		Other:

Sleep/ Energy/ Emotions/ Spirituality

	insomnia		Depression		Mental health issue
	Frequent dreams		Anxiety		Addictions
	sinus problem		Irritable		Special needs
	Low/ high energy		Fearful		
	Cold hands/feet		Over thinking		
	Hot hands/ feet		Restlessness		
	Day/ night sweats				Other:

Digestion/ Intestinal/ Bladder/ Endocrine/ Reproductive/ Neurological

	Heartburn		Frequent urination		Weight gain/ loss
	Gas, bloating		Diverticulitis		Gallbladder
	Cramping, pain		Chrones		Thyroid
	Diarrhea		Bladder infection		Prostate
	Constipation		Kidney stones		Ovary
	Diabetes		Nausea/ vomit		Uterus
	Cancer/ tumor/ lumps		hepatitis		Appetite loss /increase
	Seizures		Brain injury		Other

Circulatory/ Lymphatic/ Joint/ Skin

	Neuropathy		Decrease range of motion		Shortness of breath
	numbness		Stiffness		
	tingling		Weakness, dystrophy		Surgeries:
	Swelling		Chest pain		
	Arthritis		Varicose vein		Injuries:
	High/ low blood pressure		Heart problem		
	Irregular heart beat		Stroke		Other:
	Rashes		Eczema/ psoriasis		
	Skin discoloration		Moles/ freckles		

Women:

Describe your menstrual cycle_____
Do you have any OBGYN issues? _____
Are you on hormone treatment? _____contraceptive medication?_____
Number of pregnancies? _____ Live births/miscarriages?_____
Describe labor and deliveries: _____