

Intake form:

LAST NAME _____ FIRST NAME _____

APT # _____ STREET _____

CITY _____ POSTAL CODE _____

TEL. HOME _____ BUS. _____ Ext. _____

CELL PHONE: _____ E-MAIL: _____

BIRTHDATE (**DAY/MONTH/YEAR**) _____ MARITAL STATUS _____

OCCUPATION _____ HOURS PER WEEK _____

HOW DID YOU COME TO THIS CLINIC? _____

FAMILY HISTORY (Please indicate if alive or deceased, the cause of death and ages).

FATHER _____ MOTHER _____

PARTNER _____ CHILDREN _____

BROTHERS _____ SISTERS _____

MOTHER'S: MOTHER _____ FATHER _____

FATHER'S: MOTHER _____ FATHER _____

FAMILY HISTORY (Please indicate which relative suffered from each of these conditions)

_____ Heart Disease

_____ Diabetes

_____ Allergies

_____ Hypertension

_____ Arthritis

_____ Mental Illness

_____ Cancer

_____ Osteoporosis

_____ Intestinal Disease

_____ Alcoholism

_____ Drug Addiction

CURRENT MEDICATIONS (Please list all): _____

CURRENT SUPPLIMENTS (Please list all): _____

OTHER HEALTH CARE PROVIDERS (Please list all): _____

CONTEXT OF CARE OVERVIEW

1. Why did you choose to come to this clinic?

What do you know about our approach?

2. What three expectations do you have from this visit to our clinic?

1.

2.

3.

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are contributing to your concerns: (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

7. What do you LOVE to do (in text or pictures)?

Diet History:

HOW MANY GLASSES OF WATER DO YOU DRINK A DAY _____

DO YOU EAT THREE WELL BALANCED MEALS DAILY: _____

TYPICAL DAYS FOOD:

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

WATER/DRINK:

OILS:

WHAT ARE YOUR FAVOURITE FOODS: _____

DO YOU AVOID CERTAIN FOODS: _____

DO YOU EXPERIENCE ANY SYMPTOMS IF MEALS ARE MISSED: _____

DO YOU EXPERIENCE ANY SYMPTOMS AFTER MEALS: _____

BOWEL MOVEMENTS: 1 2 3 ____ : DAILY, EVERY 2 DAYS, EVERY __ DAYS