Initial Visit Form

Date: _____

Legal Last Name:_____ Legal First Name:_____ Middle Initial: _____

Preferred Name: _____ Gender: _____ Birthdate (DD/MM/YY):_____ Age: _____

Care Card #: _____ Street Address: _____

City: _____ Province: _____ Postal Code: _____ Email :_____

Occupation: _____ Cell Ph #: (_____)_____ Home Ph #: (_____)_____

How did you hear about the clinic? _____

Emergency Contact Information:

First Name: _____ Last Name: _____

Relation to you (eg. spouse): _____ Cell Ph #: _____

Home phone: _____ Work Phone: _____

Are you currently under the care of a Medical Doctor/MD? Y / N For what reason?: _____

If so, please provide practitioner name: _____

Phone number: _____ Clinic Address: _____

Please list the any other health care practitioners you have visited in the last 12 months:

Name	Designation (eg., acupuncturist etc.)	For what reason?	Are you still seeing them?
			Y / N
			Y / N
			Y / N

Health History

Please list any **allergies** or **sensitivities**:_____

_____

Please list any **medical diagnoses**: _____

_____

Please list any **past medical conditions**:_____

_____

Please answer if applicable:

Are you currently **pregnant** or **breastfeeding?** Y / N

Do you or your partner **plan to become pregnant** in the next 12 months?: Y / N

Please list any **current medications** and/or **supplementation**:

Name/Brand	Dosage	How long have you been taking it?

How often do you:

Activity	Frequency (circle one)	Number of times per day, week or month
Drink 8 oz (1 cup) of coffee	Daily / Weekly / Monthly / Never	
Drink 1 unit of alcohol (1 oz of 40 % alcohol, 4 oz of wine, 8 oz of beer)	Daily / Weekly / Monthly / Never	
Do 30 minutes of continuous aerobic exercise (leaving you at least slightly out of breath)	Daily / Weekly / Monthly / Never	
Lift weight	Daily / Weekly / Monthly / Never	
Drink 8 oz (1 cup) of water	Daily / Weekly / Monthly / Never	
Eat out	Daily / Weekly / Monthly / Never	
Smoke 10 cigarettes	Daily / Weekly / Monthly / Never	

Family History

Please indicate any blood relations that have one or more of the following health conditions:
For example, if my grandmother and sister had heart disease: *Heart disease:* (Y) / N *grandma and sister*

Asthma: Y / N _____ Allergies: Y / N _____
Heart Disease: Y / N _____ High Blood Pressure: Y / N _____
Stroke: Y / N _____ Diabetes: Y / N _____
Ulcers: Y / N _____ Acid reflux: Y / N _____
IBS/ IBD Y / N _____ Depression: Y / N _____
Bipolar disorder: Y / N _____ Dysthymia: Y / N _____
Alzheimer's: Y / N _____ Dementia: Y / N _____
Parkinson's: Y / N _____ Cancer: Y / N _____
Osteoporosis: Y / N _____ Glaucoma: Y / N _____
Macular degeneration: Y / N _____

Other health conditions in family: _____

Health Issues:

Please explain your **most** concerning health issue:

_____

_____

When did it start?_____(yyyy/mm/dd) What happened then?: _____

How often is it present? (circle 1):

Constantly / Every Day / > 2x a week / 1 x a week / >2 x a month / 1 x a month / < 1x a month

Other time frame: _____

What are the symptoms?: _____

What makes it better?:_____

What makes it worse?: _____

Where is it located?

_____

Do the symptoms change? If so, how and to where?

_____

Rate the intensity (indicate on the graph):

1 2 3 4 5 6 7 8 9 10

No ---------- Unbearable Intensity

Can you correlate this health issue with anything else in your life? (eg. Accident, other symptoms, certain food, stress, an activity, season etc)?

_____

_____

Have you tried anything so far that didn't work? If so, what, and what happened?_____

_____

Please explain your **second most** concerning health issue:

_____

_____

When did it start?_____(yyyy/mm/dd) What happened then?: _____

How often is it present? (circle 1):

Constantly / Every Day / > 2x a week / 1 x a week / >2 x a month / 1 x a month / < 1x a month

Other time frame: _____

What are the symptoms?: _____

What makes it better?:_____

What makes it worse?: _____

Where is it located?

_____

Do the symptoms change? If so, how and to where?

_____

Rate the intensity (indicate on the graph):

1 2 3 4 5 6 7 8 9 10

No ---------- Unbearable Intensity

Can you correlate this health issue with anything else in your life? (eg. Accident, other symptoms, certain food, stress, an activity, season etc)?

_____

_____

Have you tried anything so far that didn't work? If so, what, and what happened?_____

_____

Please explain your **third most** concerning health issue:

_____

_____

When did it start?_____(yyyy/mm/dd) What happened then?: _____

How often is it present? (circle 1):

Constantly / Every Day / > 2x a week / 1 x a week / >2 x a month / 1 x a month / < 1x a month

Other time frame: _____

What are the symptoms?: _____

What makes it better?:_____

What makes it worse?: _____

Where is it located?

_____

Do the symptoms change? If so, how and to where?

_____

Rate the intensity (indicate on the graph):

1 2 3 4 5 6 7 8 9 10

No ---------- Unbearable Intensity

Can you correlate this health issue with anything else in your life? (eg. Accident, other symptoms, certain food, stress, an activity, season etc)?

_____

_____

Have you tried anything so far that didn't work? If so, what, and what happened?_____

_____

General Health Information:

BM

On average, how often do you have a bowel movement? (circle one)

3 x or more/ day 2 x/ day 1 x/day every other day every 2 days every 3 or more days

Do you ever find blood in your stool? Yes / No If so, is it dark or bright? _____

Do you ever find mucus in your stool? Yes / No If so, how much? _____

Urine

On average, how often do you urinate during the day? (circle one)

4 x/hr 2 x /hr 1 x/hr every couple of hours a couple times a day

What colour does your urination tend to be? (circle one) Light / dark / other:_____

Do you have pain or burning on urination? Yes / No

Energy

On average, what is your energy level? (indicate on the graph)

1 2 3 4 5 6 7 8 9 10

Can't ---------- Exuberant
get out of bed

On average, what is your stress level? (indicate on the graph)

1 2 3 4 5 6 7 8 9 10

None ----------Overwhelming

When you are stressed, what are the top two emotions that tend come up?:_____

_____

Explain any coping mechanisms that you use to help you deal with stress: _____

_____

Do you have an appetite? Yes / No / I'm always hungry Do you get thirsty? Yes / No / I'm always thirsty

Compared to others, you tend to be (circle one): Warmer than most / Colder than most

If you could change one thing with your health, what would it be?:_____

_____

Complete this sentence: If I were at my optimal health, it would allow me to_____

_____

_____

Indicate if you **currently have** or **have had** any of the following conditions/symptoms in the past 6 or 12 months

EENT	Now	6 mos	12 mos
Earache			
Dizziness/Vertigo			
Ringing in ears			
Excessive ear wax			
Conjunctivitis			
Blood shot eyes			
Circles under eyes			
Itchy/watery eyes			
Dry eyes			
Near sightedness			
Far sightedness			
Floaters in eyes			
Loss/change of vision			
Nasal discharge			
Nose bleeds			
Sneezing			
Sore throat			
Loss of voice			
Hoarse voice			
Cold sores			
Canker sores			
Bleeding gums			
Jaw pain			
Toothache			

Lungs/Heart/Skin	Now	6 mos	12 mos
Cough			
Excess sputum			
Bloody sputum			
Difficulty breathing			
Shortness of breath			
Pain in chest			
Pain down left arm			
Palpitations			
High blood pressure			
Dry skin			
Flaky skin			
Acne			
Psoriasis			
Eczema			

Mental/Emotional	Now	6 mos	12 mos
Anxiety			
Depression			
Addictions			
Mental fatigue			
Anger/irritability			
Hopelessness			
Fear			
Joy			

GI	Now	6 mos	12 mos
Heartburn			
Gas			
Bloating			
Nausea			
Pain in abdomen			
Vomiting			
Diarrhea			
Constipation			
Visible food in stool			
Mucus in stool			
Blood in stool			
Anal fissures			
Hemorrhoids			
Pain passing stool			
Incomplete passing of stool			
Decreased enjoyment of food			
Decreased desire to eat			
Food cravings			

Musculoskeletal	Now	6 mos	12 mos
Joint pain/stiffness			
Muscle pain/stiffness			
Numbness/tingling in arms			
Numbness/tingling in legs			
Muscle twitching			
Muscle cramps			
Headaches			
Migraines			
Physical tiredness			

Urinary/Sexual	Now	6 mos	12 mos
Urinary urgency			
Urinary frequency			
Burning urination			
Difficulty urinating			
Cloudy urine			
Pink/red urine			
Low libido			
Premature ejaculation			
Testicular pain			
Irregular menses			
PMS			
Menstrual cramping			
Heavy bleeding/clots			
Spotting between cycles			
Hot flashes			
Night sweats			
STI			

Fill in if applicable: Age of first menses _____

Average length of cycle _____ days

# of pregnancies ____ # of births ____ # of Miscarriages ____ # of Abortions _____ Age of final menses _____