INTEGRATIVE HEALTH INSTITUTE

Good health enables empowered, authentic living.

# Integrative Medicine – Intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. It should take 15-20 minutes. Please email completed form to **info@integrativehealthinstitute.ca** prior to your first appointment.

## Contact Information:

| | | | |
|---|---|---|---|
| Name | | Occupation | |
| Gender | | Employer | |
| Date of Birth | | Work Phone # | |
| E-mail Address | | Emergency Contact | |
| Home Phone # | | Emergency Contact # | |
| Cell | | Contact Relationship | |
| Home Address | | OHIP Number | |

Would you like to receive communication via email:
Appointment reminders and communication from our front desk staff about your appointment ☐
Communication from your integrative practitioners about your care ☐
Our Monthly newsletter including seminars and special events ☐

**How did you hear about the Integrative Health Institute? (If another person, please provide name)**

_____

## Care Co-ordination:

| | | | |
|---|---|---|---|
| Medical Doctor | | Specialist | |
| Medical Doctor # | | Specialist # | |
| Medical Doctor Address | | Specialist Address | |
| Email | | Email | |
| Dentist | | Specialist | |
| Dentist # | | Specialist # | |
| Dentist Address | | Specialist Address | |
| Email | | Email | |

## Please List any other Medical Providers:

| Type of Medical Provider | Name | Phone # | Address |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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## Health Priorities / Chief Concerns:

List your main heath concerns (or reasons for visiting the clinic) in order of importance

1. _____
2. _____
3. _____
4. _____

Have you received integrative care before? ☐Massage ☐Chiropractic ☐Naturopathic Medicine ☐Counselling ☐Physiotherapy Other:_____

Did another health care practitioner refer you for treatment? Name:_____

Do you currently feel pain or discomfort?_____

Have you had a similar symptom in the past?

_____

How was this past symptom treated?_____

Does the Pain Travel? ☐

What is the nature of the pain (i.e stabbing, dull, burning, pins and needles, aching, stiff & tight):

_____

Does anything aggravate or relieve the pain?: _____

Does the pain wake you from your sleep? ☐

Is the pain worse in the morning?: ☐

Does the pain get better during the day?: ☐

Does your work or daily activities interfere with the pain?:_____

Is there anything else that you think may be important?: _____

_____

## Medical History:

How would you describe your general state of health? ☐excellent ☐good ☐fair ☐poor

**Medical conditions:** Please indicate any serious illnesses, conditions, or reasons for hospitalizations

| Medical Condition/ Hospitalization | Date of Diagnosis/ Diagnosed by whom | Is the condition still present | Symptoms |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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**Allergies or Food sensitivities:** Please indicate any allergies and/or serious food sensitivities

| Allergy/Sensitivity | Severity of reactions |
|---|---|
| | |
| | |
| | |
| | |

**Medications/Supplements:** Please list all current medications/supplements

| Medication/Supplement | Dose (if known)/ Length of Use | Prescribing Physician | Condition it is treating |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Past Medications/Supplements:** Please list all past medications/supplements in the last 5 years.

| Medication/ Supplement | Dose (if known)/ Length of Use | Prescribing Physician | Condition it is treating |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you taken anti-biotics within the last 5 years? __Y __N

**Vaccinations:** Please indicate which vaccinations you have received.

| Vaccination against: | | Age | Side Effects / Hospital Admittance |
|---|---|---|---|
| Measles, Mumps, Rubella (MMR) | | | |
| Diphtheria, Pertussis, Tetanus (DPT) | | | |
| Haemophilus Influenza B (Hib) | | | |
| Chicken Pox (Varicella Zoster) | | | |
| Rabies | | | |
| Hepatitis A | | | |
| Hepatitis B | | | |
| Tetanus | | | |
| Polio | | | |
| Flu | | | |
| Other: | | | |

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## Review of Systems

Please list conditions or concerns that involve the following systems:

SKIN *(eg. eczema, psoriasis, hives, rashes)* _____

HEAD *(eg. headaches)* _____

EYES *(eg. itching, pain, infection, corrective lenses)* _____

EARS *(eg. wax, discharge, hearing impairment)* _____

NOSE *(eg. sinus problems, pain, nose bleeds)* _____

MOUTH *(eg. difficult dentition, cavities, loss of taste, problems swallowing)* _____

NECK *(eg. stiffness, tenderness, hoarseness, tonsillitis, swelling)* _____

HEART *(eg. rheumatic fever, murmurs, chest pain)* _____

LUNGS *(eg. cough, asthma, wheezing)* _____

GASTROINTESTINAL *(eg. vomiting, swallowing, diarrhea, constipation)* _____

URINARY *(eg. pain, increased frequency, blood)* _____

MALE *(eg. hernias, pain or masses in scrotum/testes)* _____

FEMALE *(eg. urgency, menstruation/menarche, discharge, pain or masses in ovaries/uterus*

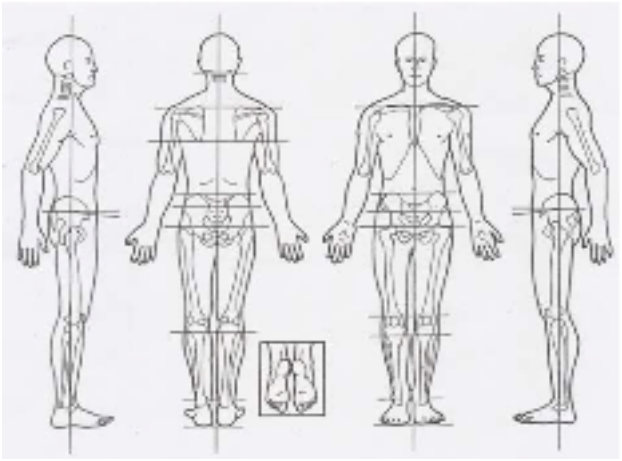
_____

MUSCLE AND SKELETON *(eg. joint pain, stiffness, weakness, back pain, fractures)*

_____

NEUROLOGICAL *(eg. seizures, paralysis, clumsiness, memory, vision changes, speech problems, sensation alteration)* _____

Please indicate where you are feeling discomfort. Provide as much detail as possible.



**Integrative Health Institute**
**46 Sherbourne Street, 2nd Floor I Toronto ON I M5A2P7 I 416.260.6038**

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**Do you use/have any of the following?**

| Substance | | How often/ How much/ What brand/type |
|---|---|---|
| Alcohol | | |
| Cigarettes | | |
| Recreations Drugs | | |
| Aspirin/Tylenol/Advil | | |
| Laxatives | | |
| Ant-acids | | |
| Diet Pills | | |
| Coffee | | |
| Black Tea | | |
| Green Tea | | |
| Birth control pill | | |
| Birth control implants | | |
| Birth control injections | | |
| Metal implants | | |
| Mercury Fillings | | How many? |
| Resin fillings | | How many |
| Other | | |

What was the date of your last physical exam? _____
Have you ever had and abnormal lab test results? Please indicate results:_____

## Female:

Are you currently or could you be pregnant: ☐Y ☐N How many weeks: _____

Have you ever been pregnant?

☐Y ☐N How many times: ____ How many vaginal births: _____ C-Sections: _____

How old were you when you had your first period: ____ Have your periods been regular: _____

Have you taken/used: **The birth control pill/when:**_____ **The patch/when:**_____ **An IUD/ when:**_____ **Depo Provera injections/when:**_____ **Other:** _____

Are you currently: ☐**Pre-menopausal** ☐**Transitioning through menopause** ☐**Post-menopausal**

Have you/are you, taking HRT: ☐Y ☐N How long: _____

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## Family History:

| Illness | | Family Member | Complications / Severity |
|---|---|---|---|
| Allergies | | | |
| Asthma | | | |
| Diabetes | | | |
| Heart Disease | | | |
| Cancer | | | |
| Depression | | | |
| Other mental illness | | | |
| Kidney disease | | | |
| Infertility | | | |
| Post-partum depression | | | |
| High Blood pressure | | | |
| Other | | | |
| Family History Unknown | | | |

## Lifestyle

Do you identify as: ☐straight ☐homosexual ☐bi-sexual ☐trans-gendered other: _____

Do you have a strong emotional support network: ☐Y ☐N Who: _____

Have you experienced any major trauma or loss in the past 5 years? _____

Have you experienced any other trauma or loss in your life? _____

How would you currently rate your level of stress at this time?

☐Minimal ☐Average ☐Considerable ☐Unbearable

What are the major causes of stress in your life at this time: (check all that apply):

☐financial ☐career ☐personal ☐marriage/relationship ☐health ☐family ☐spiritual

other (please elaborate): _____

How does your stress manifest itself: _____

What type of coping mechanism to you employ to manage your stress?

_____

What do you do for exercise/movement? (Indicate type, frequency and time of day):

_____

Do you have a history of concussion? ☐Y ☐N Date:_____

How many hours per night do you sleep: _____ nap: _____ Do you wake rested in the morning: ☐Y ☐N

How old is your mattress _____? Describe the comfort level of your pillow _____

What is your occupation: _____ Do you enjoy your work: ☐Y ☐N ☐Sometimes

How many hours per day do you spend on the following: Driving _____ Watching TV _____ Reading _____ In front of a computer _____ Work _____

When was your last vacation: _____ Do you actively participate in a spiritual discipline (church, synagogue, meditation, etc…) ☐Y ☐N

## Dietary Habits

What time of day do you eat the following: Breakfast: _____ Lunch: _____ Dinner: _____ Snacks: _____

Do you consume the following (circle all that apply and indicate frequency): Fresh Vegetables: _____ Fresh Fruit: _____ Cold-water Fish: _____ Tuna: _____ canned goods: _____ Pop: _____ Milk: _____ Coffee: _____ Water: _____ Juice: _____ Processed Foods: _____ Microwavable meals: _____ Red meat: _____ Cheese: _____ Chocolate: _____ Aspartame: _____ Deli meats: _____ Fast Food: _____ Margarine: _____

Do you crave (circle all that apply): Sugar ☐ I Chocolate ☐ I Salt ☐ I Crunchy foods ☐ I Other: _____

Do you have regular bowel movements: ☐Y ☐N Do you have to strain for a bowel movement: ☐Y ☐N

Do you regularly have loose stools: ☐Y ☐N

Do you associate digestive difficulties with any particular foods: ☐Y ☐N Which foods: _____

_____

How many bowel movements do you have per day? _____

## Additional Information

If there is any other relevant information pertaining to your health that was not covered in this intake please state it below: