Dr. Margret A. Holland, B.Sc., N.D.

Intake Form

Date of Appointment: ___/___/___ (dd / mm / yy) Name: _____ (Last) (First) (Middle)

Date of Birth: ___/___/___ (dd / mm / yy) Sex: ___M ___F Health No.: _____

Address: _____ (Street#/P.O.Box) (Apt#)

_____ (City) (Province) (Postal Code)

_____ (Home phone) (Work Phone) (Fax)

_____ (Email)

Occupation: _____ ___Full Time ___Part Time

Employer: _____

Are you: ___Single ___Married ___Separated ___Divorced ___Widowed

___Living with a partner ___other

Emergency Contact: _____ (Name) (Relationship)

_____ (Day Phone) (Evening Phone)

Do you have children? **Yes/No** If yes, how many? ____

Referred By/How did you hear about our office?: _____

When was your last physical? _____ (Month) (Year)

Who is your family physician? _____ (Name) (City)

When did you last visit a dentist? _____ (Month) (Year)

Who is your regular dentist? _____ (Name) (City)

Do you have mercury fillings? **Yes/No** Number of fillings ____

When did you last visit an optometrist? _____ (Month) _____ (Year)

Who is your regular optometrist? _____ (Name) _____ (City)

Are you under the care of any specialists? **Yes/No** _____ (Name) _____ (Specialty) _____ (City)

Are you receiving other health care? Yes/No: _____

Please list your major health concerns in order of importance

Complaint	Since	Possible Cause(s)	

What medications/supplements are you currently taking (prescription/over-the-counter/supplements/vitamins/mineral etc)?

Medication/Supplement	Since	Adverse Effects	

List all surgeries you have had:

	Procedure	Year	Complications?

List any major injuries you have sustained:

	Injury	Year	Long Term Effects

Which of the following conditions have you had? (Check all that apply)

☐ Abscesses	☐ Depression	☐ Hepatitis	☐ Mononucleosis	☐ Rheumatic Fever	☐ Syphillis
☐ Alcoholism	☐ Diabetes	☐ Herpes Genitalia	☐ Mumps	☐ Rubella	☐ Thyroid Disease
☐ Allergies	☐ Emphysema	☐ High Blood Pressure	☐ Parasites	☐ Scarlet Fever	☐ Tonsillitis
☐ Amnesia	☐ Epilepsy	☐ Influenza	☐ Pelvic Inflammatory	☐ Sexual Abuse	☐ Tuberculosis
☐ Arthritis	☐ Gall Stones	☐ Kidney Disease	Disease	☐ Skin Disease	☐ Typhoid
☐ Asthma	☐ Gonorrhoea	☐ Leukemia	☐ Peritonitis	☐ Strep Throat	☐ Venereal Warts
☐ Cancer	☐ Gout	☐ Malaria	☐ Pleurisy	☐ Sinusitis	☐ Whooping Cough
☐ Chicken Pox	☐ Hay Fever	☐ Measles	☐ Pneumonia	☐ Sunstroke	☐ Worms
☐ Cold Sores	☐ Heart Disease	☐ Miscarriage	☐ Prostatitis	☐ Stroke	☐ Yellow Fever

Which of the following do you currently use? (amount, how often, how much, how long)

Alcohol _____ Tobacco _____
Hormones _____ Coffee _____
Cortisone _____ Laxatives _____
Sedatives _____ Antacids _____
Recreational Drugs _____

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc) while at work, home, or travelling? **Yes/No**

Which of the following ailments listed, or any others, have affected your parents or siblings

☐ Alcoholism	☐ Depression	☐ Gallstones	☐ Hepatitis	☐ Osteoporosis	☐ Strep Throat
☐ Allergies	☐ Diabetes	☐ Glaucoma	☐ Kidney Disease	☐ Pneumonia	☐ Stroke
☐ Arthritis	☐ Easy Bleeding	☐ Gout	☐ Mental Illness	☐ Rheumatic Fever	☐ Thyroid Disease
☐ Asthma	☐ Eczema	☐ Hay Fever	☐ Mononucleosis	☐ Sickle Cell Anemia	☐ Tuberculosis
☐ Cancer	☐ Emphysema	☐ Heart Disease	☐ Multiple Sclerosis	☐ Skin Diseases	☐ Venereal Disease
☐ Chronic Bronchitis	☐ Epilepsy	☐ High Blood Pressure	☐		

Any other medical conditions? _____

_____

_____

The general state of your health is:

_____ Excellent
_____ Good
_____ Average
_____ Fair
_____ Poor

On average, describe your energy level (10 = highest & 1 = lowest) _____
When during the day is energy the best? _____ and worst _____

Do you exercise? **Yes/No** What forms? _____
How often? _____

What are your interests or hobbies? _____

_____

How Often? _____

How many meals do your generally eat each day? _____
Who cooks and prepares your food? _____
Is it comfortable to chew your food well? **Yes/No**

List the primary foods included in your diet for:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

List the foods you exclude from your diet: _____
Why are these foods excluded? _____

_____

_____

List any of the foods that you crave (eg: chocolate, sweets, salty, sour, breads, rich/fatty or spicy foods): _____

Have you had a bad reaction to any foods? _____

Are you satisfied with your diet as it is now? **Yes/No**

Do you tend to be thirsty: **Yes/No**
How much WATER do you drink each day: _____
Do you prefer beverages: _____Hot _____Cold _____Room Temperature

How many times do you urinate each day? _____
Do you get up in the night to urinate? **Yes/No**

How often do you have a bowel movement? _____

On average, how many hours sleep do you get per night? _____hrs
Do you sleep well? **Yes/No**

Women Only

Age of first period: _____
Number of pregnancies: _____
Number of children: _____
Length of Cycle: _____
Length of Menses (period): _____

Have you had any adverse effects from a vaccination? **Yes/No**
If Yes, which one(s): _____

Have your weight changed lately? **Lost/Gained/No Change**
How many pounds? _____

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (**Yes/No**)

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Is there anything else I need to know about you personally, about your health condition, or about the circumstances relating to you or your condition?