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CENTRE FOR PREVENTIVE MEDICINE
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ADULT INTAKE FORM

Name _____ Date of First Visit _____

Address _____

City _____ Province _____ Postal Code _____

Telephone (home) _____ (cell/work) _____

Age _____ Date of Birth _____ Gender: female _____ male _____

Education _____

Married _ Single _____ Partnership _____ Divorced _____ Widowed _____

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___

Occupation _____ Hours per week _____ Retired _____

Employer _____

Work address _____

Alberta Health Care Number _____

How did you hear about the Centre? _____

Has any other family member already been a patient at the clinic? _____

Next of Kin or other to reach in an emergency _____

Relationship _____ Phone _____

Address _____

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN I HAVE A COMPLETE UNDERSTANDING OF YOUR HEALTH. PLEASE COMPLETE THIS SURVEY AS THOROUGHLY AS POSSIBLE. MARK ANYTHING THAT YOU DON'T UNDERSTAND WITH A QUESTION MARK. THANK YOU FOR TAKING RESPONSIBILITY FOR YOUR HEALTH! I LOOK FORWARD TO HELPING YOU ACHIEVE OPTIMAL HEALTH!

Instructions: indicate the symptoms which apply to you using the following scale:

(0) if " never (1) if "rarely" (2) if "time to time" (3) if "often"

SECTION A

<input type="text"/> 1. Lower bowel gas several hours after eating	<input type="text"/> 9. Excessive belching/burping
<input type="text"/> 2. Burning stomach sensation, eating relieves	<input type="text"/> 10. Bad breath
<input type="text"/> 3. Coated tongue	<input type="text"/> 11. Alternating diarrhea/constipation
<input type="text"/> 4. Indigestion 1/2-1hr after eating:(may be up to 3/4 hrs)	<input type="text"/> 12. Have pets i.e. dogs, cats, farm animals, etc.
<input type="text"/> 5. Carbonated drinks 3+ per week	<input type="text"/> 13. Rectal itching
<input type="text"/> 6. Difficult bowel movements	<input type="text"/> 14. Can't gain weight
<input type="text"/> 7. Ulcers?/Colitis?/Gastritis?	<input type="text"/> 15. International travel
<input type="text"/> 8. Stomach bloating after eating	<input type="text"/> 16. Stomach/intestinal cramping/diarrhea
Total: _____	

SECTION B

<input type="text"/> 17. Afternoon headaches	<input type="text"/> 26. Thirsty much of the time
<input type="text"/> 18. Get "shaky" if hungry	<input type="text"/> 27. History of diabetes
<input type="text"/> 19. Faintness if meals delayed	<input type="text"/> 28. Excessive frequent urination
<input type="text"/> 20. Heart palpitates if meals missed or delayed	<input type="text"/> 29. Blurred vision/failing eyesight
<input type="text"/> 21. Eat when nervous	<input type="text"/> 30. Breath smells sweet
<input type="text"/> 22. Awaken after few hours of sleep	<input type="text"/> 31. Tingling, numbness, prickling sensation in extremities.
<input type="text"/> 23. Hard to get back to sleep	
<input type="text"/> 24. Crave candy or coffee in afternoon	
<input type="text"/> 25. Abnormal craving for sweets or snacks	
Total: _____	

SECTION C

<input type="text"/> 32. Bruise easily, "black & blue spots"	<input type="text"/> 44. Hands & feet go to sleep easily
<input type="text"/> 33. Sign frequently	<input type="text"/> 45. Numbness in extremities
<input type="text"/> 34. Aware of "breathing heavily"	<input type="text"/> 46. Tendency to anemia
<input type="text"/> 35. Open window in closed room	<input type="text"/> 47. Tension under breastbone or feeling of tightness, worse in exertion
<input type="text"/> 36. Susceptible to colds & fevers	<input type="text"/> 48. Blushing with no apparent cause
<input type="text"/> 37. Swollen ankles, worse at night	<input type="text"/> 49. Black stool (no iron supplementation)
<input type="text"/> 38. Muscle cramps, worse during night	<input type="text"/> 50. Poor concentration
<input type="text"/> 39. Shortness of breath on exertion	<input type="text"/> 51. Slurred speech
<input type="text"/> 40. Nosebleeds	<input type="text"/> 52. Headaches
<input type="text"/> 41. Ringing in the ears	<input type="text"/> 53. Weakness/fatigue
<input type="text"/> 42. Heart palpitations	<input type="text"/> 54. Out of breath frequently i.e., going up stairs
<input type="text"/> 43. Dull pain in chest or radiating into left arm, worse on exertion	<input type="text"/> 55. Nervousness
Total: _____	

SECTION D

<input type="checkbox"/> 56. Pain under right side of rib cage	<input type="checkbox"/> 66. Laxatives used often
<input type="checkbox"/> 57. Frequent skin rashes	<input type="checkbox"/> 67. History of gall bladder attacks or gallstones
<input type="checkbox"/> 58. Bitter metallic taste in mouth in morning	<input type="checkbox"/> 68. History of hepatitis
<input type="checkbox"/> 59. Bowel movements painful and difficult	<input type="checkbox"/> 69. History of jaundice
<input type="checkbox"/> 60. Low energy, weakness, and exhaustion	<input type="checkbox"/> 70. Sneezing attacks
<input type="checkbox"/> 61. Upset from greasy/fatty foods	<input type="checkbox"/> 71. Itchy skin, worse at night
<input type="checkbox"/> 62. Bruises easily	<input type="checkbox"/> 72. Dry, flaky skin, hair
<input type="checkbox"/> 63. Frequent headaches	<input type="checkbox"/> 73. General feeling of poor health
<input type="checkbox"/> 64. Stools light coloured	<input type="checkbox"/> 74. Aching muscles
<input type="checkbox"/> 65. Pain between shoulder blades	<input type="checkbox"/> 75. Swollen feet and/or legs
Total: _____	

SECTION E

<input type="checkbox"/> 76. Impaired hearing	<input type="checkbox"/> 86. Slow pulse, below 65
<input type="checkbox"/> 77. Decrease in appetite	<input type="checkbox"/> 87. Cold hands and feet
<input type="checkbox"/> 78. Ringing in ears	<input type="checkbox"/> 88. Gains weight easily
<input type="checkbox"/> 79. Constipation	<input type="checkbox"/> 89. Weight gain around hips
<input type="checkbox"/> 80. Puffy hands/face	<input type="checkbox"/> 90. Outer third eyebrow thinning
<input type="checkbox"/> 81. Tired/sluggish	<input type="checkbox"/> 91. "Emotional"
<input type="checkbox"/> 82. Miscarriages	<input type="checkbox"/> 92. Flush easily
<input type="checkbox"/> 83. Infertility	<input type="checkbox"/> 93. Night sweats
<input type="checkbox"/> 84. Mental sluggishness/forgetfulness	<input type="checkbox"/> 94. Hair loss
<input type="checkbox"/> 85. Headache upon rising; wears off during day	
Total: _____	

SECTION F

<input type="checkbox"/> 95. Hip and joint pain	<input type="checkbox"/> 98. Bone loss/osteoporosis in family
<input type="checkbox"/> 96. Receding gums and/or dental cavities	<input type="checkbox"/> 99. Crunching, creaking joints.
<input type="checkbox"/> 97. Tendency towards slouching/weak	
Total: _____	

SECTION G

<input type="checkbox"/> 100. Exposure to fumes i.e., paint, salon, car	<input type="checkbox"/> 104. Skin disorders i.e., psoriasis, eczema, etc.
<input type="checkbox"/> 101. Use pesticides on garden	<input type="checkbox"/> 105. Loss of hair
<input type="checkbox"/> 102. Live near power lines/high tension wires	<input type="checkbox"/> 106. Hormone disorders
<input type="checkbox"/> 103. Have mercury amalgams (silver) in mouth	<input type="checkbox"/> 107. History of cancer/personal or familial
Total: _____	

SECTION H

<input type="checkbox"/> 108. Muscle aches, stiffness, cramping, & pains	<input type="checkbox"/> 111. Fatigue, sluggishness
<input type="checkbox"/> 109. Chiropractic adjustments don't hold	<input type="checkbox"/> 112. Upper or lower back pain
<input type="checkbox"/> 110. Whiplash and/or ligamental trauma/strain	<input type="checkbox"/> 113. Stiff neck and shoulders
Total: _____	

SECTION I

<input type="checkbox"/>	114. Low blood pressure	<input type="checkbox"/>	125. Feeling unrefreshed upon awakening
<input type="checkbox"/>	115. Chronic fatigue	<input type="checkbox"/>	126. Allergies
<input type="checkbox"/>	116. Low energy, lack of stamina	<input type="checkbox"/>	127. Exhaustion-muscular & nervous
<input type="checkbox"/>	117. General malaise, unhappiness	<input type="checkbox"/>	128. Respiratory disorders
<input type="checkbox"/>	118. Tendency to hives	<input type="checkbox"/>	129. Swollen ankles
<input type="checkbox"/>	119. Arthritic tendency	<input type="checkbox"/>	130. Dizzy when standing up "too fast"
<input type="checkbox"/>	120. Excessive perspiration	<input type="checkbox"/>	131. Decreasing appetite
<input type="checkbox"/>	121. Colds/flu often	<input type="checkbox"/>	132. Irritable
<input type="checkbox"/>	122. Weakness after illness	<input type="checkbox"/>	133. Bright lights irritate
<input type="checkbox"/>	123. Dark circles under the eyes		
<input type="checkbox"/>	124. Crave salty foods		
			Total: _____

SECTION J

FEMALE ONLY		MALE ONLY	
<input type="checkbox"/>	134. Painful menses	<input type="checkbox"/>	146. Tired too easily
<input type="checkbox"/>	135. Premenstrual tension	<input type="checkbox"/>	147. Urination difficult
<input type="checkbox"/>	136. Very easily fatigued	<input type="checkbox"/>	148. Night urination frequent
<input type="checkbox"/>	137. Depressed feeling	<input type="checkbox"/>	149. Pain on inside of legs or heel
<input type="checkbox"/>	138. Menstruation excessive and prolonged	<input type="checkbox"/>	150. Feeling of incomplete bowel evacuation
<input type="checkbox"/>	139. Painful breasts (monthly)	<input type="checkbox"/>	151. Prostate trouble
<input type="checkbox"/>	140. Lumpy breasts/worst at menses	<input type="checkbox"/>	152. Leg nervous at night
<input type="checkbox"/>	141. Haven taken birth control pills	<input type="checkbox"/>	153. Diminished sex drive
<input type="checkbox"/>	142. Menopause, hot flashes, etc.		
<input type="checkbox"/>	143. Menses scanty or irregular		
<input type="checkbox"/>	144. Acne, worse at menses		
<input type="checkbox"/>	145. Vaginal discharge/yeast, etc.		
			Female Total: _____
			Male Total: _____

SECTION K

<input type="checkbox"/>	154. Chronic cough	<input type="checkbox"/>	163. Bronchitis (frequent)
<input type="checkbox"/>	155. Pain around ribs	<input type="checkbox"/>	164. Infections settle in lungs
<input type="checkbox"/>	156. Shortness of breath	<input type="checkbox"/>	165. Sensitive to smog
<input type="checkbox"/>	157. Chest pain	<input type="checkbox"/>	166. Asthma
<input type="checkbox"/>	158. Difficulty breathing	<input type="checkbox"/>	167. Wheezing
<input type="checkbox"/>	159. Post nasal drip	<input type="checkbox"/>	168. Smoker
<input type="checkbox"/>	160. Sinus and nasal congestion	<input type="checkbox"/>	169. Chronic lung congestions
<input type="checkbox"/>	161. Coughing up phlegm	<input type="checkbox"/>	170. Breathes through mouth
<input type="checkbox"/>	162. Coughing up blood	<input type="checkbox"/>	171. Shallow breather
			Total: _____

SECTION L

<input type="checkbox"/>	172. Throat infection	<input type="checkbox"/>	180. Cough with mucous
<input type="checkbox"/>	173. Poor wound healing	<input type="checkbox"/>	181. Swollen tongue
<input type="checkbox"/>	174. Slow to recover from colds or flu	<input type="checkbox"/>	182. Dark areas under the eyes/cheeks
<input type="checkbox"/>	175. Gets boils or sties	<input type="checkbox"/>	183. Sore throat
<input type="checkbox"/>	176. Swollen lymph glands	<input type="checkbox"/>	184. Post nasal drip
<input type="checkbox"/>	177. Catch colds or flu easily	<input type="checkbox"/>	185. Ear aches and infections
<input type="checkbox"/>	178. Bumpy skin on arms	<input type="checkbox"/>	186. Herpes/cold sores
<input type="checkbox"/>	179. Inflamed or bleeding gums		
			Total: _____

SECTION M

<input type="checkbox"/> 187. Frequent urination	<input type="checkbox"/> 196. Strong smelling urine
<input type="checkbox"/> 188. Rose coloured (bloody) urine	<input type="checkbox"/> 197. Mild back pain
<input type="checkbox"/> 189. Dripping after urination	<input type="checkbox"/> 198. Interrupted urine stream
<input type="checkbox"/> 190. Difficulty passing urine	<input type="checkbox"/> 199. Tingling in joints
<input type="checkbox"/> 191. Cloudy urine	<input type="checkbox"/> 200. Joint and muscle pain/cramping
<input type="checkbox"/> 192. Rarely need to urinate	<input type="checkbox"/> 201. Can't hold urine
<input type="checkbox"/> 193. Frequent bladder infections	<input type="checkbox"/> 202. Dark circles under eyes
<input type="checkbox"/> 194. Painful/burning when urinating	<input type="checkbox"/> 203. Frequent urge to urinate but passes only small amounts
<input type="checkbox"/> 195. Urination when cough or sneeze	
Total: _____	

SECTION N

204. Medications you are currently taking:

205. How often do you take (or have taken) antibiotics? Y / N # _____

206. Reactions to vaccinations? Y / N

207. How many silver amalgams do you have in your mouth? Y / N Root canals? Y / N Crowns/bridges? Y/N

208. Were your wisdom teeth impacted? Y / N Other dental problems? Y / N

209. Allergies? Y / N List main ones

210. Are you experiencing bone loss or osteoporosis? Y / N

211. Do you smoke? Y / N

212. Diagnosed for parasites? Y / N

213. Diagnosed or history of Candida? Y / N

214. Exposure to pesticides? Y / N

215. Drink 6-8 glasses of water daily? Y / N

216. Hormone replacement medications? Y / N

IMPORTANT: Please list your five main health complaints in the **order of importance**:

1 _____

2 _____

3 _____

4 _____

5 _____