

ACCEPTING NEW PATIENTS

PREVENTATIVE MEDICINE - ACUPUNCTURE – HOMEOPATHY – COLONICS - MASSAGE

To help us serve your health needs, please complete the following information as accurately as possible. Thank you!

PERSONAL INFORMATION

Name _____ Age _____ M ___ F ___ Today's Date (Mo/Day/Year) _____

How would you prefer to be addressed in our office? _____ Birth Date (Mo/Day/Year) _____

Home Address _____ City _____ Postal Code _____

Occupation _____ Work Phone _____ Home Phone _____

Email Address _____

Spouse's Name _____ Children (name(s)/age) _____

If the above is a child: Father's Name _____ Mother's Name _____

B.C. Care Card # _____ Do you have Extended Coverage? Yes ___ No ___

Who referred you to our office? _____

NOTE: *This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us in writing to do so. Please complete this questionnaire as thoroughly as possible. Thank you.*

1. What health concerns/problems brought you to this office today? _____

2. Has anything recently changed or become worse? _____

3. What questions do you have that you would like answered? _____

4. What kind of help do you want or expect to be provided? _____

5. Are you being treated for any condition by a physician now? Yes ___ No ___

Condition _____ Physician _____

CURRENT MEDICATIONS

Please list all your prescription medications (such as sleeping pills, birth control pills), non-prescription medications (such as aspirin, antacids, laxatives, antihistamines) vitamins, herbs, etc., that you take more than occasionally.

KNOWN ALLERGIES

Please list any known allergies to medicines (such as penicillin, sulpha drugs, aspirin), or other substances (such as pollens ragweed), foods, chemicals, etc.

HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES (Date/Reason for hospitalization)

PERSONAL HEALTH HABITS

Height _____ Current Weight _____ lbs Ideal weight _____ lbs. Maximum Weight _____ Year _____

Smoker: Yes__ No__ Smoked for _____ years Amount per Day _____ Year Stopped, If Applicable _____

Alcohol Use: Yes__ No__ Type of Alcohol Preferred _____ Frequency _____

Recreational Drug Use: Yes __ No __ Type _____ Frequency _____

Coffee: Yes__ No__ _____ Cups per day Tea: Yes__ No__ _____ Cups per day

Diet: Are there any food groups you avoid? Yes__ No__ If "Yes", what _____

Do you exercise regularly? Yes__ No__ Type _____ Duration _____ Frequency _____

Hobbies _____

Blood Type (if known): A__ B__ AB__ O__ Additional Information _____

Women: Are you currently pregnant? Yes __ No __ _____

MEDICAL HISTORY

Please check only those that pertain to YOU personally.

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Female Gynecological Problems | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gallstones | <input type="checkbox"/> STI (ie. AIDS, syphilis, gonorrhea, herpes) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gum/Teeth Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back, Muscle, Joint Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bladder/Urinary Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Liver Problems | Other _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Problems | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Overweight | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychological Difficulties | _____ |
| <input type="checkbox"/> Fatigue, chronic | <input type="checkbox"/> Rheumatic Fever | _____ |

FAMILY MEDICAL HISTORY

	Age	Health Problems	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Brothers And Sisters				
Children				

*Please return this form to the front desk when you have it completed.
Thank you!*