Patient/Client Intake Form

The following information needs to be gathered in order for us to formulate a safe and effective treatment plan for you. This information will be kept confidential and cannot be released without your written consent unless obliged by law. This information may be shared amongst other health information custodians or circle of care for the purpose of your health care. Please feel free to ask any questions about the information being requested.

Last Name:_________________ Name: ___________________ Gender: M __ F __Date Of Birth: ________________
(mm/dd/yyyy)

For Office Use Only
Driver's License Number: ____ Photo Id: Y ___ N ___

Address: ___________________________________ Apt: ______ City: ______________________________
Postal Code: __________________ Home Phone: ___________________________Bus: _______________________
Cell: ______________________ Email: ___________________________ Occupation: __________________________
Who May We Thank For Referring You To Our Care? ____
name of family member, friend, co-worker, internet, yellow pages, street sign etc.
Are You Currently Seeing A Health Professional For Your Condition? Yes/No,
Please Explain: ____

HEALTH HISTORY (PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU)

RESPIRATORY	**CARDIOVASCULAR**	**GENERAL**
☐ Chronic Cough	☐ High Blood Pressure	☐ Headaches
☐ Shortness of breath	☐ Low Blood Pressure	☐ Vision Problems
☐ Smoker	☐ Poor Circulation	☐ Ear Aches
☐ Asthma	☐ Heart Disease	☐ Epilepsy
☐ Chronic Bronchitis	☐ Phlebitis	☐ Sinus Problems
☐ Other	**MUSCLES AND JOINTS**	☐ Allergies
DIGESTIVE/URO-GENERAL	☐ Stiffness	☐ Frequent Colds
☐ Poor Appetite	☐ Swelling	☐ Chronic Pain
☐ Constipation	☐ Limitation in Movements	☐ Chronic Fatigue
☐ Liver/Gallbladder	☐ Back Pain	☐ Dizziness
☐ Kidney/Bladder	☐ Shoulder Pain	☐ Other
☐ Difficult Digestion	☐ Neck Pain	**WOMEN**
☐ Diabetes	☐ Pain in Limbs	☐ PMS
☐ Hernia	☐ Pin & Needles in Limbs	☐ Menopause
☐ Ulcer	☐ Rheumatoid Arthritis	☐ Pregnant
SKIN	☐ Osteoarthritis	**OTHER**
☐ Sensitive Skin	☐ Whiplash	☐ Cancer/Tumors
☐ Rashes/Eruptions	**INJURIES FROM ACCIDENTS**	☐ Depression
☐ Cold Sore	☐	☐ HIV & AIDS
☐ Warts	☐	
☐	☐	

How much of the following substances do you use on a daily basis? Tobacco: ____Alcohol:______ Coffee: ______
Recreational Drugs: __________
Do you exercise: Yes: ______ how often? ________ No: ______
Allergies: ____
(Please discuss with your practitioner any concerns you may have that are not listed above.)

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PAST HEALTH HISTORY

PLEASE DESCRIBE:
Major Surgery/Operations, type: ________________________________ Date: __________________
Previous: Childhood Traumas: _________________________ Sports Injuries: ____________________
Motor Vehicle Accidents: ____________________ __Work Injuries: _____________________
Pins, wires, or plates? _____________________________
Current Medications & Conditions Treated: ____
INDICATE ANY OF THE FOLLOWING AILMENTS THAT HAVE AFFECTED YOUR RELATIVES:

Alcoholism	Allergies	Arthritis	Asthma	Cancer	Depression
Diabetes	Epilepsy	Gonorrhea	Gout	Hay fever	Heart Disease
Rheumatoid	Paralysis	Pneumonia	Skin Disease	Syphilis	TB

INFORMED CONSENT STATEMENT

I, ___________________________________ hereby attest and agree to the following:

1) I understand that all evaluations/analysis performed by Julie Canzio or InsideOut Wellness Centre are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits and attitudes. I further understand that said evaluations cannot determine specific disease conditions I may have and do not replace the diagnostic services offered by licensed medical physicians.
2) I understand Julie Canzio is not a medical doctor.
3) I understand that Julie Canzio neither claims nor implies that any instruction, advice, counsel, suggestions, recommendations, services or products she or her representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent or mitigate any disease condition; but are provided solely for the purpose of increasing energy, supporting the natural function of body systems and otherwise improving general health and fitness.
4) I certify that, Julie Canzio or InsideOut Wellness Centre have not suggested that I cease any medical care I may be undertaking. I understand that the decisions I make regarding my health care and the health care of those under my guardianship are my responsibility and certify that I will not hold Julie Canzio or InsideOut Wellness Centre responsible for the consequences of my decisions.
4) I certify that I am here on this and on any subsequent visit or contact, whether by mail, telephone, or in person, solely on my own behalf and not as an agent or representative of any federal, provincial or municipal government or private agency on a mission of investigation. I have read and understand the foregoing and agree to the terms and conditions set therein.
5) I understand that InsideOut Wellness Centre can provide courtesy notification for my appointments via text, e-mail or telephone. It is my responsibility to note the time and date of all my appointments. I understand that a minimum of 24 hours notice is required to change or cancel my appointment.

Practitioners/Therapist Name: _________________________________

Patient/Guardian Signature: ___________________________________Date: ___________________

Most services are covered by Extended Health Insurance. Please check with your benefits administrator at work.

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