PATIENT/CLIENT INTAKE FORM

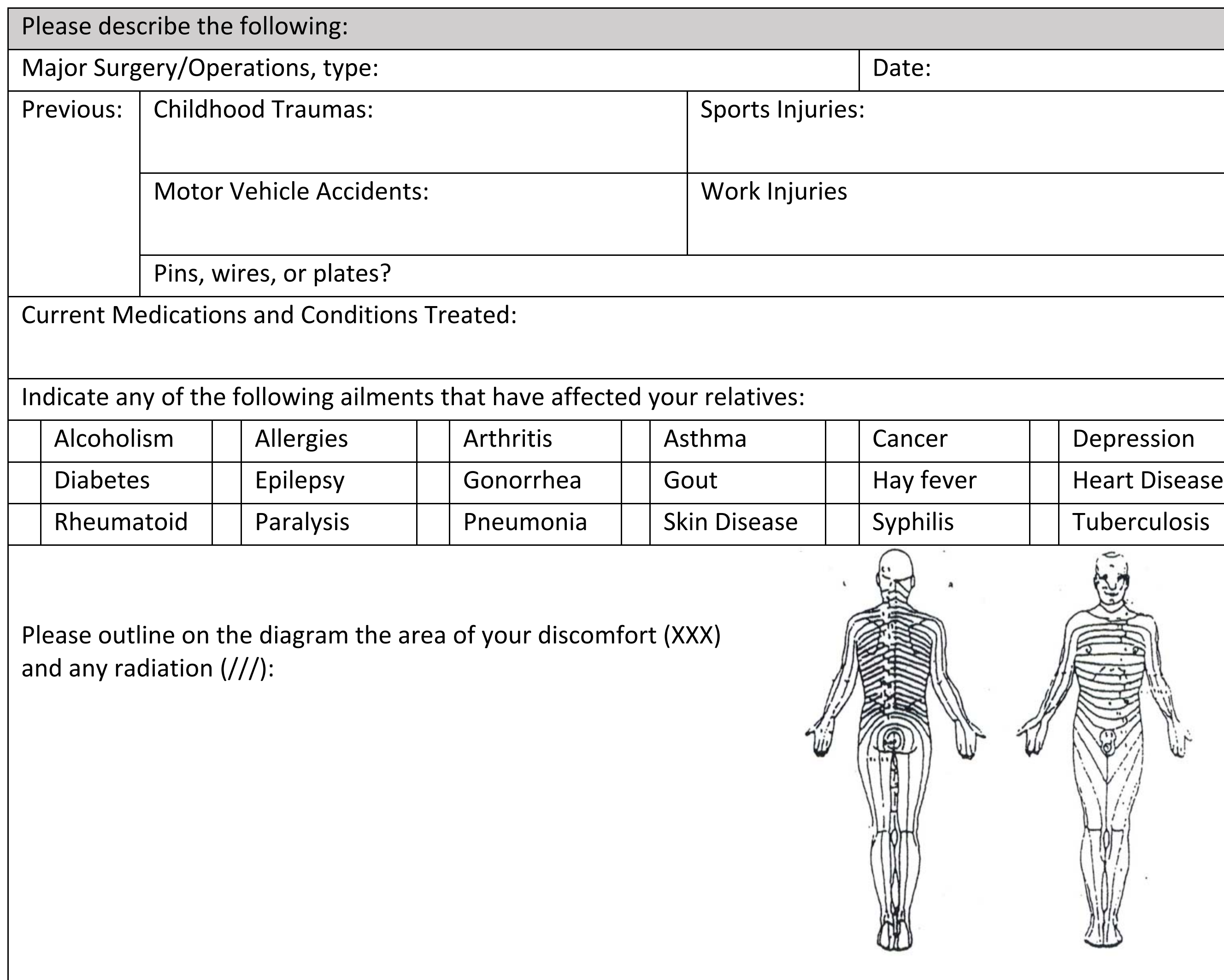
The following information needs to be gathered in order for us to formulate a safe and effective treatment plan for you. This information will be kept confidential and cannot be released without your written consent unless obliged by law. This information may be shared amongst other health information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

Full Name		
Gender: Male or Female	Date of Birth (MM/DD/YYYY):	
Cell Phone:	Home Phone:	Work Phone:
Email Address:		
Address:		Apt #:
City:	Province:	Postal Code:
Occupation:		
Who may we thank for referring you to our care?		
Are you currently seeing a health professional for your condition? YES / NO Please explain:		

General Health Background:					
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:		Other:		Allergies
Digestive/Uro-General:		**Muscles and Joints:**			Frequent Colds
	Poor Appetite		Stiffness		Chronic Pain
	Constipation		Swelling		Chronic Fatigue
	Liver/Gallbladder		Limitations in Movements		Dizziness
	Kidney/Bladder		Back Pain		Other:
	Difficult Digestion		Shoulder Pain	**Women:**	
	Diabetes		Neck Pain		PMS
	Hernia		Pain in Limbs		Menstruation
	Ulcer		Pins and Needles in Limbs		Pregnant
	Other:		Rheumatoid Arthritis		Other:
Skin:			Osteoarthritis	**Other:**	
	Sensitive Skin		Whiplash		Cancer/Tumours
	Rashes/Eruptions	**Injuries From Accidents:**			Depression
	Cold Sore				Anxiety
	Warts				HIV/AIDS

How much of the following substances do you use on a daily basis?							
	Tobacco		Alcohol		Coffee		Recreational Drugs
Do you exercise? If yes, how often?							

Past Health History:



Please describe the following:		
Major Surgery/Operations, type:		Date:
Previous:	Childhood Traumas:	Sports Injuries:
	Motor Vehicle Accidents:	Work Injuries
	Pins, wires, or plates?	
Current Medications and 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		Tuberculosis

Please outline on the diagram the area of your discomfort (XXX) and any radiation (///):

I agree to inform my practitioner of any concerns/changes to the status of my condition(s) and any changes to my health.

I understand that InsideOut Wellness Centre can provide courtesy notifications for my appointments via text, email, 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.

I understand that fees charged are due when the service is rendered.

I understand that the information I give on this form will be strictly confidential and will be kept very private in accordance with The Registered Health Practitioners Act and Privacy Legislation.

InsideOut Wellness Centre is the custodian of my file. My file will only be released with a duly executed authorization form signed by me.

Client Name (Printed): ______________________________

Client Signature: ______________________________ Date: ______________