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		
Date of Birth (MM/DD/YYYY):		Gender: Male or Female
Cell Phone:	Home Phone:	Work Phone:
Email Address:		
Address:		Apt #:
City:	Province:	Postal Code:
Occupation:		
Height:	Weight:	
Who may we thank for referring you to our care?		
General Health Background:		
General Allergies:		
Seasonal Allergies:		
Are you currently on any medications?		
Are you currently taking any supplements?		
Have you had any major surgeries?		
Have you ever experienced any major injuries?		
Have you ever experienced any major traumas?		

What are your main sources of stress? Rate them on a scale from 1-10, with 10 being the most stressful.

	Family Members		Occupation		Relationships		School
	Financial		Health		Social Factors		Other:

How do you manage your stress?
Have you been diagnosed with any major health conditions?
How long has it been since you've felt well?
What are your three main health concerns?

Lifestyle Assessment:			
	How many hours do you sleep daily?		
	What time do you go to sleep?		
	Do you usually wake up during the night?		
	Do you wake up feeling rested?		
	How many bowel movements do you typically have in a day?		
	Do you consume caffeinated beverages on a daily basis? If so, how many?		
	Are you sensitive to fragrances?		
	Do you smoke? If yes, for how long?		
	How many alcoholic beverages do you drink in a week?		
Are there any foods that you're sensitive to?			
How many rounds of antibiotics have you taken throughout your life thus far?			
Do you currently have any amalgam or mercury fillings?			
How often do you travel outside of Canada?			
Symptomatology: Are you experiencing any of the following:			
	Ear Infections	At what age?	How often?
	Strep Throat	At what age?	How often?
	Tonsil Infection	At what age?	How often?
	Yeast Infections	At what age?	How often?
	Athlete's Foot/Jock Itch	At what age?	How often?
	Urinary Tract Infection	At what age?	How often?
	Mononucleosis	At what age?	

Within the last year, which of the following symptoms apply to you?			
	Do you experience bloating?		Do you experience any bloating after meals?
	Do you experience constipation?		Are your stools hard to pass?
	Do you experience gas?		Do you have intestinal or abdominal pain?
	Do you experience anxiety?		Do you ever experience an unsettled stomach?

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.

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: _____