Aurora Integrative Medical

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Print

Intake Questionnaire

Name: _____ _____ _____
(First) (Last) (Middle)

Date of Birth: (Month): _____ (Day):_____ (Year): _____ Age: _____ Sex: _____

Phone (home): _____ Phone (mobile): _____

Phone (business): _____ Email: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Occupation: _____ Hours per week: _____ Employer: _____

Relationship Status: _____ Partner's Name: _____

Names & ages of children: _____
_____

Emergency Contact Name: _____ Phone: _____
Emergency Contact Relationship to you: _____

Are you under the care of another primary care physician? (eg. MD, ND, Specialist)? Yes ☐ No ☐
Name of Doctor/Clinic: _____ Phone Number: _____

How did you hear about Aurora Integrative Medical?
☐ *Internet Search* ☐ *Friend* ☐ *Family* ☐ *Newspaper* ☐ *Other (please specify):* _____

Do you have any known allergies to medications/foods/inhalants? Yes ☐ No ☐ If yes, please list:
_____

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Confidential Health and Lifestyle Questionnaire

Please complete this questionnaire with care, as this will help us determine the most effective treatment plan for you.

What are your **main reason(s)** for coming in?

_____

_____

What are your most **important health concerns**? (list in order of importance)

_____ _____

_____ _____

_____ _____

What are the most significant **measures** which you have taken to **improve** your health concerns?

_____

_____

Please list **diagnoses** and types of **treatments** you have received:

_____

_____

What do you feel is causing any health problems you have?

_____

Have you had any recent bloodwork/labwork? Y ☐ N ☐ Please list nature of tests & date(s) if known:

_____

Please list any **medications** you are presently taking with doses and the date you started taking them:

_____

_____

_____

Please list any **supplements** and herbal medicines you are taking (include brands & dosages if known):

_____

_____

_____

Please indicate the occurrence of the following, with brief details and dates:

- Hospitalization/Surgeries _____
- Accidents _____
- Major illness _____
- Traumatic event _____

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DIETARY

Do you restrict any foods from your diet? If so, what foods and why?

_____

_____

Do you have a history of on/off dieting? Y☐ N☐ Have you ever abused laxatives or diet pills? Y☐ N☐
Do you have a bowel movement everyday? Y☐ N☐
Do you have frequent constipation? Y☐ N☐ How often?_____ Diarrhea? Y☐ N☐ How often?_____
How much water do you drink everyday? (not including tea, juice etc - just water!) _____
Do you drink coffee? Y☐ N☐ How many cups? _____ Black tea? Y☐ N☐ How many cups? _____
Do you smoke? Y☐ N☐ How many cigarettes / day? _____ When did you start smoking?_____
Do you drink alcohol? Y☐ N☐ How often and how much? _____

Please list the type and duration of **exercise** that you typically do in one week:

_____

_____

SLEEP

Number of hours of sleep per night: _____ Time to bed: _____ Time awake: _____
Do you have difficulty falling asleep? Y☐ N☐ Difficulty staying asleep (waking at night)? Y☐ N☐
Do you wake feeling refreshed? Y☐ N☐ Is your sleep poor? Y☐ N☐ If so, why? _____

STRESS

What would you say your **stress** level is: ☐MINIMAL ☐ MODERATE ☐ HIGH ☐ SEVERE
What are the major sources of your stress?

_____

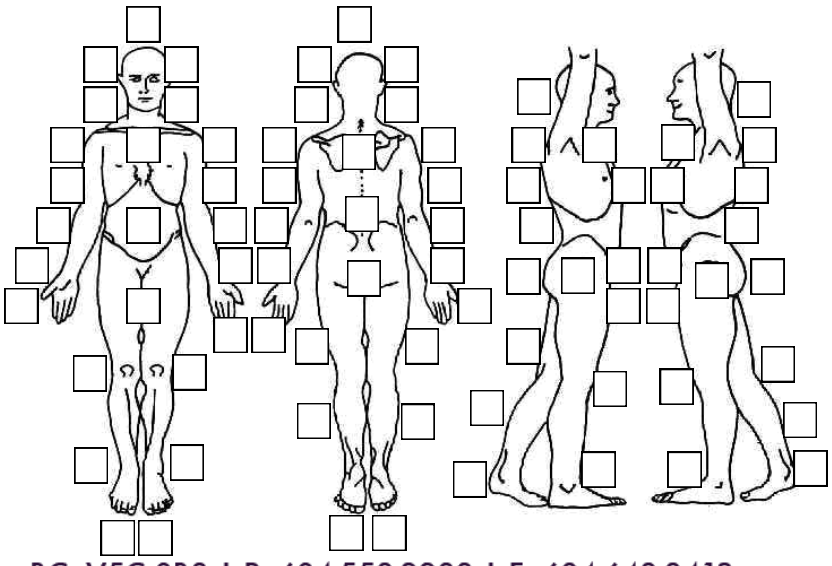
How do you deal with stress? _____
Do you practice meditation or relaxation techniques? _____

GENERAL

Height: _____
Weight (if known): _____

PHYSICAL SYMPTOMS

Please use this area to indicate with an "X" any area you are feeling pain, swelling, numbness, or other symptoms. Also include areas where your skin has changed colour or texture.



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FAMILY HISTORY

Please list health history of family members including conditions such as cancer, diabetes, celiac, stroke, mental illness, arthritis, asthma, learning disability etc.

Family Member	Age if Alive	Age at Death	Conditions
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings			

TREATMENT

What is your present **level of commitment** to changing any underlying causes of your signs and symptoms related to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

What behaviors or lifestyle habits do you engage in regularly that you believe **support** your health:

_____

_____

What behaviors or lifestyle habits do you engage in regularly that you believe are **self-destructive**:

_____

_____

What potential **obstacles** do you foresee in addressing the lifestyle factors which are undermining your health and making it difficult for you to follow through?

_____

Who do you know that will sincerely **support** you consistently with the beneficial lifestyle changes you will be making?

_____

What do you **LOVE** to do?

_____

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Review of Symptoms

Please indicate the symptoms that you have felt / are feeling.

General
- ☐ Headaches
- ☐ Appetite changes
- ☐ Weight change ↑☐ ↓☐ _lbs
- ☐ Poor sleep
- ☐ Chills and fevers
- ☐ Night sweats

Immune System
- ☐ Frequent colds / flu
- ☐ Never get sick
- ☐ Chronic phlegm
- ☐ Corticosteroid use
- ☐ Recent vaccinations
- ☐ Bad reaction to vaccination

Skin and Hair
- ☐ Rashes; Itching; Hives
- ☐ Eczema or Psoriasis
- ☐ Acne
- ☐ Loss of hair; Dandruff
- ☐ Nail changes
- ☐ Irregular moles

Eyes Ears Nose Throat
- ☐ Impaired hearing
- ☐ Ear aches; infections
- ☐ Ringing in ears
- ☐ Ear wax build up
- ☐ Sinus infections
- ☐ Sore throats / tonsillitis
- ☐ Post nasal drip
- ☐ Nosebleeds
- ☐ Eye strain; blurry vision
- ☐ Night or color blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Itchy / red eyes
- ☐ Facial pain / tics
- ☐ Jaw pain or clicks
- ☐ Mercury fillings? #_____?
- ☐ Sores in mouth

Cardiovascular
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Dizziness / fainting
- ☐ Chest pain
- ☐ Angina
- ☐ Anemia
- ☐ Easy bruising / bleeding
- ☐ Varicose veins
- ☐ Cold hands or feet
- ☐ Swelling of limbs

Muscles, Bones & Joints
- ☐ Neck Pain
- ☐ Back pain
- ☐ Muscle spasms / cramps
- ☐ Muscle weakness
- ☐ Arthritis; Bursitis
- ☐ Joint pain / stiffness

Respiratory
- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Sputum / Phlegm
- ☐ Pneumonia / Bronchitis
- ☐ Asthma
- ☐ Coughing blood
- ☐ Wheezing
- ☐ Unresolved grief

Liver
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Indigestion of fatty food
- ☐ Burning feet
- ☐ Sensitive to fumes / chemicals / smells
- ☐ Brown spots on skin
- ☐ Chronic anger / frustration

Gastrointestinal
- ☐ Stomach ulcers
- ☐ Hiatal hernia
- ☐ Indigestion / Heartburn
- ☐ Gas or burping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Antacid use
- ☐ Abdominal pains

Colon Flora/Leaky Gut
- ☐ Coated or fuzzy tongue
- ☐ IBS or colitis
- ☐ Bad breath - chronic
- ☐ Itching or burning anus
- ☐ Skin eruptions / bumps
- ☐ Yeast infections
- ☐ Frequent illness
- ☐ Autoimmune disease (family or self)
- ☐ High dairy intake
- ☐ Antibiotic use

Date of last antibiotic use:
_____

Adrenals
- ☐ Low blood pressure
- ☐ Frequent illness / colds
- ☐ Easily exhausted
- ☐ Chronic fatigue
- ☐ Slow start in morning
- ☐ Trouble sleeping
- ☐ Retaining water
- ☐ Under a lot of stress?
- ☐ Tired in afternoon
- ☐ Crave salt
- ☐ Crave sugar / sweets
- ☐ Dark circles under eyes
- ☐ Abrupt stop of menstruation

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Genito-Urinary

- [ ] Frequency or urgent urination
- [ ] Pain on urination
- [ ] Recurrent urinary tract infections
- [ ] Waking at night to urinate
- [ ] Incontinence
- [ ] Kidney stones
- [ ] Infections
- [ ] Sores on genitals
- [ ] Blood in urine
- [ ] STIs

Neurological

- [ ] Poor memory
- [ ] Lack of coordination/balance problems
- [ ] Seizures
- [ ] Concussions
- [ ] Numbness - hands/feet

Emotional

- [ ] Depression
- [ ] Irritable
- [ ] Mood swings
- [ ] Anxiety
- [ ] Diagnosed mental illness
- [ ] Alcohol/Drug abuse
- [ ] Emotional eating
- [ ] Insomnia
- [ ] Nightmares

Endocrine

- [ ] Thyroid abnormalities
- [ ] Sweating - excessive or lack of
- [ ] Shaky/dizzy with delayed meals
- [ ] Hormone therapy (past or present)
- [ ] Excessive thirst/hunger/urination

Male

- [ ] Testicular pain or mass
- [ ] Impotence
- [ ] Prostate problems

Female - Menstrual Cycle

Age menses began: _____

- [ ] Regular cycle length
- [ ] Irregular cycle length
- [ ] Bleeding between periods
- [ ] Painful periods / cramping
- [ ] PMS - emotional
- [ ] Excessive flow
- [ ] Missed periods

Number of days in average cycle _____
Date of last menstrual period _____

Female - Menopause

- [ ] Menopause

If yes, at what age: _____

- [ ] Perimenopausal
- [ ] Hot flashes
- [ ] Night sweats
- [ ] Vaginal dryness

Female - Gynecological

- [ ] Breast tenderness
- [ ] Breast lumps/discharge
- [ ] Pain during intercourse
- [ ] Vaginal discharge
- [ ] Vaginal itching
- [ ] Vaginal yeast infections
- [ ] Sexually active
- [ ] Sexual difficulties
- [ ] Hysterectomy
- [ ] Birth Control - type: _____
- [ ] Past Birth Control use: _____
- [ ] History of abnormal PAP test(s)

Date of last PAP test _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____