PACIFIC RIM
COLLEGE

Confidential Patient Intake Form

The information that you provide in this form helps us to help you achieve your optimal state of health and wellness.

Personal Information

Today's Date:_____

Name: _____ Date of Birth:_____ Age:_____

Address: _____

_____ Height:_____ Weight:_____ Sex:_____

_____

Occupation:_____

Phone: _____

Email: _____ Do you live alone? Y / N

☐ Check here if you would like to receive our email newsletter, or any special events information.

Contacts

Physician(s) Information:

Name: _____
Phone: _____

Name: _____
Phone: _____

Emergency Contact:

Name: _____
Relation: _____
Phone: _____

Lifestyle Choices

Habits (please check all that apply, and provide the frequency and amount of use):

☐ Alcohol _____ ☐ Tobacco _____
☐ Caffeine _____ ☐ Sugar _____
☐ Recreational Drugs _____ ☐ Other _____

Diet (without going into great detail, please describe your daily diet, indicating which foods you consume most often):

_____
_____
_____

Exercise (please indicate your frequency of exercise):

☐ daily ☐ 3-4 times weekly ☐ 1-2 times weekly ☐ not at all

Please describe your typical routine and/or list your favourite activities:

_____
_____
_____

Medical Information

Health Concerns (please briefly describe the reason for today's visit):

_____

_____

_____

Health Conditions (please check all that apply, past and present):

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Candidiasis
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gallbladder problems
- ☐ German Measles
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hernia
- ☐ Herpes Simplex 1
- ☐ Herpes Simplex 2
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Kidney Disorders
- ☐ Liver Disorders
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Measles
- ☐ Menstrual Disorders
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Obsessive Compulsive Disorder
- ☐ Osteoarthritis
- ☐ Osteomalacia
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Disorders
- ☐ Psoriasis
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Urinary Tract Infections
- ☐ Venereal Disease
- ☐ Other_____

Family History:

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Dependencies
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Obesity
- ☐ Stroke
- ☐ Other_____
- ☐ Other_____

Allergies (Please list any allergies):

_____

_____

Hospitalizations (Please note circumstances):

_____

_____

Medications and Supplements:

Medication and/or Type	Dosage	Medications and/or Type	Dosage

Symptoms (Please check all that apply within the past three months; circle for emphasis):

General
☐ Insomnia
☐ Dream-disturbed sleep
☐ Excessive sleep
☐ Fatigue
☐ Dizziness
☐ Numbness
☐ Frequent chills
☐ Fever
☐ Premature hair loss
☐ Premature greying

Respiratory
☐ Cough
☐ Dry Cough
☐ Cough with phlegm
☐ Cough with blood
☐ Asthma
☐ Shortness of breath
☐ Common Cold
☐ Excessive phlegm

Circulatory
☐ Cold hands and feet
☐ Excessive bleeding
☐ Easy Bruising

Cardiovascular/Chest
☐ Chest pains/tightness
☐ Palpitations
☐ Irregular heartbeat
☐ Rapid heart rate
☐ Blood clotting disorder
☐ Right-sided rib pain

Digestive/Excretory
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Loose stools
☐ Constipation
☐ No daily bowel movement
☐ Hemorrhoids
☐ Rectal pain
☐ Excessive hunger
☐ Loss of appetite
☐ Weight loss
☐ Weight gain
☐ Abdominal bloating/gas
☐ Belching
☐ Acid reflux
☐ Hiccups
☐ Stomach pain
☐ Abdominal pain
☐ Food allergies/sensitivities

Nervous System
☐ Tremors
☐ Poor balance
☐ Seizures

Musculoskeletal
☐ Muscle cramps
☐ Body aches
☐ Joint pain
☐ Swollen joints
☐ Paralysis
☐ Neck and shoulder tension
☐ Hand and arm pain
☐ Hip and leg pain
☐ Foot and ankle pain
☐ Low back pain
☐ Upper back pain

Mental/Emotional
☐ Depression
☐ Easily stressed
☐ Anger
☐ Irritability
☐ Frequent sighing
☐ Fear
☐ Grief
☐ Worrying
☐ Anxiety
☐ Forgetfulness
☐ Cloudy thinking
☐ Obsessive behaviour
☐ Lack of motivation
☐ Nervous tics
☐ Abuse survivor

Head and Face
☐ Headache
☐ Migraines
☐ Jaw pain
☐ Facial tics
☐ Facial paralysis
☐ Dizziness

Eyes
☐ Degenerating vision
☐ Blurry vision
☐ Night blindness
☐ Visual spots
☐ Red eyes
☐ Eye pain

Nose
☐ Sinusitis
☐ Nasal polyps
☐ Post-nasal drip
☐ Nose bleeds
☐ Nasal discharge
☐ Poor sense of smell

Mouth and Throat
☐ Sore throat
☐ Hoarse voice
☐ Difficulty swallowing
☐ Mouth ulcers
☐ Dry mouth/throat
☐ Excessive thirst
☐ Lack of thirst
☐ Teeth pain
☐ Gum problems
☐ TMJ

Ears
☐ Ringing in the ears
☐ Poor hearing
☐ Earaches
☐ Ear infection

Skin
☐ Eczema
☐ Psoriasis
☐ Hives
☐ Acne
☐ Fungal infections
☐ Itchy skin
☐ Shingles
☐ Dry skin
☐ Dandruff
☐ Excessive sweating
☐ No sweating
☐ Numbness

Urinary/Genital
☐ Urinary tract infections
☐ Kidney stones
☐ Urinary incontinence
☐ Frequent daytime urination
☐ Frequent nighttime urination
☐ Painful urination
☐ Dribbling urination
☐ Foamy urine
☐ Bloody urine
☐ Genital pain
☐ Genital itching
☐ Venereal diseases

Men's Health
☐ Impotence
☐ Infertility
☐ Seminal emissions
☐ Premature ejaculation
☐ Decreased libido

Women's Health

☐ Painful intercourse ☐ Endometriosis ☐ Decreased libido
☐ Infertility ☐ Vaginal dryness ☐ Other_____

Menstruation:

How many days between periods?_____
Please indicate if you experience any of the following between periods:
☐ Vaginal discharge ☐ Bleeding ☐ Cramps/Pain

How many days in duration are your periods?_____
Please indicate the quality of blood:
☐ Light red ☐ Bright red ☐ Other_____
☐ Dark red ☐ Clotted ☐ Other_____

Please indicate the quantity of blood:
☐ Heavy flow ☐ Normal flow ☐ Scanty flow

If you experience any cramping, please indicate when?
☐ Before menstruation ☐ During menstruation ☐ After menstruation

Do you experience breast tenderness? Y / N
When?_____ Where?_____

Pregnancy:

How many pregnancies have you had?_____
Have you had any miscarriages? Y / N
Indicate any pregnancy-related difficulties:_____
_____

Are you currently pregnant? Y / N
Are you trying to become pregnant? Y / N

Are you currently using contraceptive(s)? Y / N
If yes, what type and for how long:_____

Menopause:

Please indicate your current status:
☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal

If applicable, at what age did menopause begin?_____
Please indicate any menopause-related symptoms:
☐ Hot flashes ☐ Vaginal dryness ☐ Mood swings
☐ Night sweats ☐ Insomnia ☐ Depression

Patient Signature: _____

Guardian Signature: _____
(If patient is under 16 years old)

Date: _____

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