



Patient Intake Form

Last Name	First Name & Initial(s)	Date of Birth (yyyy/mm/dd)
Address	Street	Apt.
City	Province	Postal Code
Phone (home)/Phone(cell)		Email
Family Physician	Referring Physician	<input type="radio"/> Same

Emergency Contact Person	Relationship	Phone
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Coverage: None Benefits: Motor Vehicle Accident

Provider: _____ Policy _____

ID/Certificate _____

Policy Holder _____

How did you hear about us?

Doctor Webpage Social Media Friend / Family Google Location Other

Medical History (include date of onset):

- | | | |
|---|--|--|
| <input type="radio"/> Pacemaker | <input type="radio"/> Lung Problems | <input type="radio"/> Viral Hepatitis |
| <input type="radio"/> Heart Problems | <input type="radio"/> Asthma | <input type="radio"/> Liver Disease (Fatty Liver) |
| <input type="radio"/> High Cholesterol | <input type="radio"/> HIV/AIDS | <input type="radio"/> Parkinson's Disease |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Chronic Fatigue/Fibromyalgia | <input type="radio"/> ADHD |
| <input type="radio"/> Stroke | <input type="radio"/> Thyroid Problems | <input type="radio"/> Allergies |
| <input type="radio"/> Osteoporosis/Osteopenia | <input type="radio"/> Skin Disease/Sensitivities | <input type="radio"/> Digestive Problems |
| <input type="radio"/> Cancer | <input type="radio"/> Epilepsy/Seizures | <input type="radio"/> Other _____ |
| <input type="radio"/> Diabetes | <input type="radio"/> Anxiety | _____ |
| <input type="radio"/> Currently Pregnant | <input type="radio"/> Depression | <input type="radio"/> Difficulty Sleeping at night |

- 1) Do you currently smoke? ___ Yes ___ No
- 2) Do you drink alcohol? ___ Yes ___ No If so, how many drinks do you consume a week? _____
- 3) Please list any surgeries (including internal pins/wires/artificial joints), past injuries or major dental work you've had

- 4) Please list your current medications (may also provide us a list of your current medications)

To the best of my knowledge, I certify that the information provided above is true and correct

Name of Patient	Signature	Date (yyyy/mm/dd)
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