Scott Health Centre
Dr. Linda Brown, B.A., N.D., CBP, R.BIE
PATIENT INTAKE FORM

Name:_____ **Date:**_____

Address:_____ **Apt.#**_____
Number Street

_____
City Province Postal Code

Home#_____ **Bus.#**_____

Cell#_____ **E-Mail Address:**_____

Date of Birth: _____/_____/_____ **Age:**_____ **Height**_____ **Weight:**_____

Physician:_____ **Referred by:** _____
Name please

How much are you willing to change in pursuit of good health?

_____

Main problem(s) you would like us to help you with?

_____

_____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

_____

How long has it been since you first noticed your symptoms?

_____

Have you been given a diagnosis for the problem? If so, what and by whom?

_____

What kinds of treatment have you tried?

_____

What other therapies are you receiving at this time?

_____

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.):_____

Allergies (drugs, foods, hay fever, etc):_____

PAST MEDICAL HISTORY:

***Significant Illnesses* (Circle): Cancer, Diabetes, High Blood Pressure, Heart disease, Hepatitis, Rheumatic fever, Thyroid Disease, Seizures, Other**_____

Surgeries:_____

Significant Trauma (auto accidents, falls etc.):_____

Occupation: _____ **Since when?** _____

Is it Stressful? _____ **Do you enjoy your work?** _____

Occupational Stresses (Chemical, Physical, Psychological, etc.):

_____

Exercise (Type and Frequency):

_____

AVERAGE DAILY DIET:

Morning:_____

Afternoon:_____

Evening:_____

Snacks:_____

HABITS (Circle all that apply):

Cigarettes, Coffee, Soft Drinks, Alcohol, Drugs, Sugar, Artificial Sweeteners, Salt, Other _____

FAMILY MEDICAL HISTORY (Circle):

Diabetes, Cancer, High blood pressure, Heart disease, Stroke, Seizures, Asthma, Allergies, Alcoholism Other:_____

NEUROPSYCHOLOGICAL (Circle):

Seizures	**Areas of numbness**	**Poor memory**	**Concussion**
Depression	**Anxiety**	**Bad temper**	**Easily stressed**
Treated for emotional problems		**Considered/attempted suicide**	

Other neurological or psychological problems:_____

GASTROINTESTINAL:

Bowel movements: Frequency _____ **Colour** _____ **Odour** _____

Mucus/Blood? _____ **Texture/Form** _____ **Pain or cramps?** _____

Laxative use: _____ **per week?**

Bad Breath? _____ **Appetite** _____ **Thirst** _____

How much *plain* water do you drink per day?

_____

PREGNANCY and GYNECOLOGY:

Number of pregnancies _____ **Number of births** _____ **Premature births** _____ **Miscarriages** ____

Are you having fertility issues? _____

Age of first menses ____ Length of Flow _____(days) Irregular Periods? _____ Colour of Blood _____

Flow (heavy/light?) _____**Last PAP** _____**Last Menses** _____

Clots _____ **Vaginal discharge** _____ **Vaginal sores** _____**Birth control type:** _____

PMS symptoms prior to/during menses: _____

Menopause _____ **(age) Menopausal Symptoms** _____

Rate your energy level from 0 – 10 (with 10 as the highest) _____ **Sudden energy drop** _____ **(time)**

Do you normally feel Hot, Cold or Average? _____

Do you get regular physical exams? _____ **Any abnormalities?** _____

Do you have weight issues? _____ **Thyroid issues?** _____

What are your goals for treatment?

_____

It is my pleasure to help you on your journey to Good Health!