CCF Natural Health Care

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Client Intake Form

Name:	Telephone:	Date of Birth: (DD/MM/YYYY)	Age:
Occupation:	Sex: M / F / Other	Height:	Weight:
Home Address: City: Province: Postal Code:		Email:	
Family Doctor:	Emerg Number:	Referred by:	

Past Medical History

Significant Illnesses:	☐ Cancer ☐ Diabetes	☐ High Blood Pressure ☐ Heart Disease	☐ Hepatitis ☐ Rheumatic Fever	☐ Thyroid Disease ☐ Seizures	☐ Other:

Surgeries:

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

Birth History: (prolonged labour, forceps delivery, etc.)

Allergies: (drugs, chemicals, food)

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

Occupational Stresses: (chemical, physical, psychological, etc.)

Exercise:

Comments:

Average Daily Diet:	Morning:	Afternoon:	Evening:
Habits:	☐ Cigarettes ☐ Coffee ☐ Tea ☐ Cola ☐ Alcohol ☐ Drugs ☐ Sugar ☐ Salt ☐ Other:_______________		
Family Medical History:	☐ Cancer ☐ High Blood Pressure ☐ Stroke ☐ Asthma ☐ Alcoholism ☐ Other: ☐ Diabetes ☐ Heart Disease ☐ Seizures ☐ Allergies		

Main Health Concern

What brings you in today:

The onset and duration:

Past treatments and results:

Please check any conditions you are experiencing (past and present):

General Symptoms:	☐ Fatigue	☐ Night sweats	☐ Poor coordination	
☐ Poor appetite	☐ Cold feet	☐ Heavy sleep	☐ Poor sleep	
☐ Insomnia	☐ Chills	☐ Vertigo	☐ Sudden drop of energy at: ___________ (time)	
☐ Cold hands	☐ Localized weakness	☐ Cold abdomen	☐ Strong thirst (hot/cold drinks)_______________	
☐ Fevers	☐ Tremors	☐ Sweat easily	☐ Peculiar tastes/smells______________________	
☐ Cravings	☐ Cold back	☐ Change in appetite	☐ Bleed or bruise easily (where)_______________	
☐ Heavy appetites				
Skin & Hair:	☐ Ulcerations	☐ Hives	☐ Loss of hair	
☐ Rashes	☐ Pimples	☐ Dandruff	☐ Change in hair/skin texture	
☐ Eczema	☐ Purpura	☐ Itching	☐ Other hair/skin problem ___________________	
Head, Eyes, Ears, Nose & Throat:	☐ Gum problems	☐ Spots in eyes	☐ Night blindness	
	☐ Sores on lips/tongue	☐ Migraines	☐ Earaches	
☐ Dizziness	☐ Concussions	☐ Poor Vision	☐ Sinus problems	
☐ Eye strain	☐ Eye pain	☐ Blurry vision	☐ Copius saliva	
☐ Colour blindness	☐ Cataracts	☐ Nose bleeds	☐ Facial pain	
☐ Ringing in ears	☐ Poor Hearing	☐ Dry mouth	☐ Recurrent sore throats _________/month	
☐ Mucus	☐ Dry throat	☐ Grinding teeth	☐ Headaches (when/where)_________________	
☐ Teeth problems	☐ Jaw clicks	☐ Glasses	☐ Other head/neck problems_______________	
Cardiovascular:	☐ Blood clots	☐ Phlebitis	☐ Difficulty breathing	☐ Other
☐ High blood pressure	☐ Low blood pressure	☐ Chest pain	☐ Irregular heartbeat	
☐ Dizziness	☐ Fainting	☐ Cold hands/feet	☐ Swelling in hands/feet	
Respiratory:	☐ Coughing blood	☐ Tight chest	☐ Production of phlegm_____ colour?__________	
☐ Cough	☐ Asthma	☐ Other lung problems	☐ Difficulty in breathing when laying down	
☐ Pneumonia	☐ Bronchitis			
Gastrointestinal:	☐ Constipation	☐ Rectal pain	☐ Black stools	Bowel Movements:
☐ Nausea	☐ Pains or cramps	☐ Bloody stools	☐ Hemorrhoids	_______ Frequency
☐ Gas	☐ Vomiting	☐ Diarrhea	☐ Sensitive abdomen	_______ Colour
☐ Bad breath	☐ Belching	☐ Laxative use:___/week; type______		_______ Odour
				_______ Texture/form
Genito-Urinary:	☐ Frequent urination	☐ Blood in urine	☐ Urgency to urinate	☐ Unable to hold urine
☐ Pain on urination	☐ Kidney stones	☐ Venereal disease	☐ Impotency	☐ Other G/U problems
☐ Wake up to urinate -	How often______ / night;	time:_______		
Pregnancy & Gynecology:	☐ Miscarriages	☐ Clots	☐ Flow (describe):_________________________	
___ Number of pregnancies	☐ Irregular periods	☐ Vaginal sores	☐ Birth control (type/duration):_______________	
___ Number of births	☐ Premature births	☐ Breast lumps	☐ Last pap:________________________________	
___ Age at first menses	☐ Vaginal discharge	☐ Change to body/ psyche prior to menstruation	☐ Last menses:_____________________________	
___ Period (days)			☐ Menopause:______________________________	
Male-Reproductive:	☐ Burning	☐ Dribbling	☐ Frequent urination	☐ Libido:____________
☐ Tenderness	☐ Swelling	☐ Difficult urination	☐ Painful ejaculation	
Musculoskeletal:	☐ Muscle pain	☐ Back pain (where):	☐ Joint pains (where):	Other joint/bone problems:
☐ Neck pain		__________________	__________________	__________________
Neuropsychological:	☐ Treated for emotional problems	☐ Anxiety	☐ Concussion	Other neurological or psychological problems:
☐ Seizures		☐ Poor memory	☐ Easily stressed	
☐ Depression	☐ Areas of numbness	☐ Bad temper	☐ Consider/attempt suicide	__________________

Do you have any other problem areas which cause stress, fear or upset? Please list them.

Print Client Name | **Signature of Client** | **Date**

Practitioner: Catherine Carleton-Fitchett, ROHP | **Date**