

WINDS OF CHANGE HEALTH SERVICES
INTAKE FORM

PERSONAL INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex/gender: _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Home Telephone: _____ Other Telephone: _____

Email address: _____

How did you find out about Winds of Change? _____

Health Care Team:

Family Physician: _____ Phone: _____

Other Health Care Providers: _____ Phone: _____

CHIEF HEALTH CONCERNS: What are your health concerns in order of importance

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? Please list approximate dates and reasons:

ENVIRONMENT AND LIFESTYLE

Occupation / Employer: _____

Do you exercise regularly? Y N Weight in lbs. _____ IDEAL _____

What types: _____ How often? _____

What is your social support network? _____

Do you: Live alone Live with partner: Male or Female Live with friends Other

How would you describe the emotional climate of your home? _____

What causes you the most stress in life? _____

Rate the degree of stress this causes you? (Not a lot = 0 to Unbearable = 10) _____

What are your favorite activities? _____

GENERAL HISTORY:

(For the following list of symptoms: for currently experiencing and for those you've had in the past)

<p>SKIN:</p> <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Vitilago <input type="checkbox"/> Dryness <input type="checkbox"/> Hives <input type="checkbox"/> Boils <input type="checkbox"/> Acne <input type="checkbox"/> Warts <p>HEAD:</p> <input type="checkbox"/> Head injury <input type="checkbox"/> Headaches/migraines <input type="checkbox"/> Vertigo/Dizziness <input type="checkbox"/> Hair loss <input type="checkbox"/> Dandruff <p>EYES:</p> <input type="checkbox"/> Redness <input type="checkbox"/> Excessive tearing <input type="checkbox"/> Double/Blurred vision <input type="checkbox"/> Spots/floaters <input type="checkbox"/> Flashing lights <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Discharge/infection <p>EARS:</p> <input type="checkbox"/> Infection <input type="checkbox"/> Ringing <input type="checkbox"/> Hearing loss <p>NOSE & SINUSES:</p> <input type="checkbox"/> Frequent colds <input type="checkbox"/> Nasal stuffiness <input type="checkbox"/> Loss of smell <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Nasal Polyps <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Chronic runny nose <p>MOUTH & THROAT:</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Sores in mouth <input type="checkbox"/> Periodontal disease	<input type="checkbox"/> Thrush <input type="checkbox"/> Sore throat <input type="checkbox"/> Goiter or thyroid problems <input type="checkbox"/> Enlarged lymph nodes <input type="checkbox"/> Torticollis/stiff neck <p>RESPIRATORY:</p> <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Emphysema <input type="checkbox"/> Coughing blood <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Central chest pain <p>CARDIOVASCULAR:</p> <input type="checkbox"/> Left sided Chest pain <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> High blood pressure <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart murmurs <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Difficult breathing <input type="checkbox"/> Leg cramps <input type="checkbox"/> Thrombophlebitis <input type="checkbox"/> Edema/swollen ankle <input type="checkbox"/> Cold hands/feet <p>INTESTINAL</p> <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Heartburn/regurgitation <input type="checkbox"/> Indigestion <input type="checkbox"/> Bloating <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Excessive gas UP <input type="checkbox"/> Excessive gas DOWN <input type="checkbox"/> Ulcer <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Jaundice/hepatitis	<input type="checkbox"/> Colitis or Crohn's <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stool <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Eating disorder <p>GENTOURINARY:</p> <input type="checkbox"/> Urgency <input type="checkbox"/> Dribbling/leaking <input type="checkbox"/> Frequency <input type="checkbox"/> Incontinence <input type="checkbox"/> Burning pain <input type="checkbox"/> Urinary tract infxns <input type="checkbox"/> Kidney infxns <input type="checkbox"/> Kidney stones <input type="checkbox"/> STDs (HPV, etc.) <p>GENERALS:</p> <input type="checkbox"/> Weight loss/gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Night sweats <input type="checkbox"/> Profuse perspiration <input type="checkbox"/> Weakness <input type="checkbox"/> Insomnia <p>FEMALE:</p> <input type="checkbox"/> PMS <input type="checkbox"/> Menopause <input type="checkbox"/> Low libido <input type="checkbox"/> Yeast infections <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Painful periods <input type="checkbox"/> Irregular Periods <input type="checkbox"/> Excessive discharge <input type="checkbox"/> Miscarriage(s) <input type="checkbox"/> Pregnancy(s) <input type="checkbox"/> Abortion(s) <input type="checkbox"/> Endometriosis Age at 1 st period: <input type="checkbox"/> Uterine fibroids <input type="checkbox"/> Cervical Dysplasia <input type="checkbox"/> Fibrocystic Breasts	<p>MALE:</p> <input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Prostatitis/infxn <input type="checkbox"/> Discharge <input type="checkbox"/> Low libido <input type="checkbox"/> Erectile dysfunction <p>HAEMATOLOGICAL</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Varicose/spider veins <input type="checkbox"/> Past transfusions <input type="checkbox"/> Hep. A, B, or C <input type="checkbox"/> HIV <p>MUSULOSKELETAL</p> <input type="checkbox"/> Muscle pains <input type="checkbox"/> Joint pains <input type="checkbox"/> Osteo or Rheumatoid arthritis <input type="checkbox"/> Back pain <input type="checkbox"/> Muscle spasms/cramps <input type="checkbox"/> Joint swelling <input type="checkbox"/> Gout <p>NEUROLOGICAL:</p> <input type="checkbox"/> Fainting/Black outs <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors <input type="checkbox"/> Pins & needles <input type="checkbox"/> Loss of balance <input type="checkbox"/> Paralysis <input type="checkbox"/> Speech problems <input type="checkbox"/> Memory loss <p>Sleep problems:</p> <input type="checkbox"/> Falling asleep <input type="checkbox"/> Staying asleep <p>MENTAL/EMOTIONAL:</p> <input type="checkbox"/> Nervousness/anxiety <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Irritability/anger <input type="checkbox"/> Depression/sadness <input type="checkbox"/> Fears and phobias:
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HEALTH HISTORY:

Do you have any allergies (foods, environmental, medications)? Please List

Please list all current medications:

(Include all prescriptions, over the counter, vitamins, herbs, homeopathics)

Did you have any adverse effects from vaccinations? Y N

Approximately how many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (For yes)

- Laxatives
- Antacids
- Diet pills
- Aspirin / Tylenol / Advil / Ibuprophen (circle which ones)
- Caffeine: types and amount per day _____
- Tobacco/cigarettes: How much per day _____
- Alcohol: How much per day or week _____
- Recreational drugs: what and how much? _____

Do you get regular screening tests done by a doctor? (Pap, blood, etc.) Y N

Have you lost or gained an abnormal amount of weight lately? Y N

Do you have any dietary restrictions? (Religious, vegetarian, vegan, etc.) _____

Describe your typical day’s diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (and amounts consumed): _____

FAMILY HEALTH HISTORY: (for present or “P” for in the past)

Please indicate if a close relative (parent, grandparent, or sibling) has had any of the following)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |

Any other medical conditions – Please List _____

Is there any other information that has not been covered which you feel is important to your health care?

What previous complementary/alternative treatments have you tried & what was your experience?

Clinical Nutrition

Acupuncture

Herbal medicine

Supplements

Homeopathy

Chiropractic

Massage

Physiotherapy

Iridology

Sho Tai

Reiki, craniosacral therapy or bowen

Others

Looking back to your chief complaints on page 1, list each one here and provide any details you can:

How much time do you expect it will take to recover?

What do you expect from me?

What is your budget or financial plan to afford this care?

Do you have extended health care coverage?

How did you come to be this way? What factors or experiences contributed to your situation now?

(Please use the back of the page to answer this question)