vitamindrip®

Adult Intake Form

Name _____ Date of 1st Visit_____

Date of Birth _____ Age _____ Gender: M F

Address _____

_____

City _____ Province _____ Postal Code _____

Phone (home) _____ (work &/or cell) _____

E-mail _____ Employer_____

Occupation _____ Hours per week_____

Marital Status: Married__Separated__Divorced__Widowed__Single__Partnership _____

Live with: Spouse____Partner____Parents____Children____Friends____Alone _____

Emergency Contact

Name_____ Phone_____

Relationship_____ Address _____

_____

Other Health Care Providers

1.	2.	3.
_____	_____	_____
_____	_____	_____
( )_____	( )_____	( )_____

List your health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please indicate any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that you have had. Include approximate dates.

_____

_____

_____

List any X-rays, CT scans, or other studies that you have had.

_____

_____

Medications

Check (✓) any of the following that you currently take or use.

☐ Laxatives	☐ Pain relievers	☐ Antacids
☐ Cortisone	☐ Appetite suppressants	☐ Antibiotics
☐ Tranquilizers	☐ Thyroid medication	☐ Sleeping pills
☐ Aspirin	☐ Diet pills	☐ Birth control pills

List any prescription medications, over the counter medications**, vitamins, minerals, herbs or other supplements** that you are taking.

_____

_____

_____

_____

Allergies

Are you sensitive or allergic to…
Any drugs? _____
Any foods? _____
Any environmentals? _____
Any chemicals?_____
Any supplements?_____

Diet

Describe a typical day's diet.
Breakfast_____
Lunch _____
Supper_____
Snacks_____
Beverages (and total quantity) _____

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

_____

Do you exercise? Y N If yes, what kind and how often? _____

_____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe. _____

How stressful is your life? How well do you handle these stressors? _____

For the following, **circle "Y" for yes, "N" for no, or "P" for in the past**

Average 6-8hrs sleep per night?	Y N	Do you have a religious or spiritual practice? ↳If yes, what?	Y N
Awake feeling well rested?	Y N		
Have a supportive relationship?	Y N		
Have a history of abuse?	Y N	Do you drink alcohol? ↳What type? ↳How many drinks per week?	
Do you use recreational drugs?	Y N P		
Treated for drug dependence?	Y N P	Do you smoke tobacco? ↳How many packs per day? ↳How many years?	
Do you eat three meals a day?	Y N		
Do you eat out often?	Y N	Exposed to significant tobacco smoke (i.e., 2nd hand smoke)?	Y N P
Do you drink coffee?	Y N P		
Do you drink black tea?	Y N P		
Do you drink cola/other sodas?	Y N P	Treated for alcoholism?	Y N P
Do you eat refined sugar?	Y N P	Do you add salt to your food?	Y N P

Review of Systems

Skin

Rashes?	Y N P	Lumps?	Y N P
Eczema, hives?	Y N P	Hair loss?	Y N P
Acne, boils?	Y N P	Dryness?	Y N P
Itching?	Y N P	Night sweats?	Y N P
Colour change?	Y N P	Change in a mole?	Y N P
Temperature change?	Y N P	Skin cancer?	Y N P

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems?	Y N P

Eyes

Impaired vision?	Y N P	Double vision?	Y N P
Glasses/contacts?	Y N P	Spots in vision?	Y N P
Eye pain?	Y N P	Blurred vision?	Y N P
Tearing or dryness?	Y N P	Colour blindness?	Y N P
Glaucoma?	Y N P	Cataracts?	Y N P
Sensitive to the sun?	Y N P	Discharge?	Y N P
Itching/redness?	Y N P	Blind spot?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P
Discharge?	Y N P	Infections?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose bleeds?	Y N P
Stuffiness?	Y N P	Hay fever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Loss of taste?	Y N P
Teeth grinding?	Y N P	Sore tongue/mouth?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Difficulty breathing?	Y N P

Spitting up blood?	Y N P	Pain on breathing?	Y N P
Asthma?	Y N P	Sputum?	Y N P
Pneumonia?	Y N P	Wheezing?	Y N P
Emphysema?	Y N P	Bronchitis?	Y N P
Shortness of breath?	Y N P	Pleurisy?	Y N P
Shortness of breath lying down?	Y N P	Tuberculosis?	Y N P
Shortness of breath at night?	Y N P	Last chest x-ray?	

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/low blood pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/fluttering?	Y N P
Rheumatic fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P	Past ECG (Echocardiogram)?	Y N P

Gastrointestinal

Trouble swallowing?	Y N P	Change in thirst?	Y N P
Nausea?	Y N P	Change in appetite?	Y N P
Vomiting?	Y N P	Indigestion?	Y N P
Vomiting blood?	Y N P	Heartburn?	Y N P
Blood in stool?	Y N P	Constipation?	Y N P
Abdominal pain or cramps?	Y N P	Diarrhea?	Y N P
Belching or passing gas?	Y N P	Gall bladder disease/gall stones?	Y N P
Black, tarry stools?	Y N P	Ulcer?	Y N P
Jaundice (i.e., yellow skin)?	Y N P	Hemorrhoids/fissures?	Y N P
Liver disease?	Y N P	Hernia?	Y N P
Undigested food in stools?	Y N P	Change in bowel movements?	Y N P
Mucous in Stools?	Y N P	Bowel movements – how often?	

Urinary

Pain on urination?	Y N P	Frequent infections?	Y N P
Increased frequency?	Y N P	Inability to hold urine?	Y N P
Frequency at night?	Y N P	Kidney stones?	Y N P
Urgency or hesitancy?	Y N P	Blood in urine?	Y N P
		Syphilis?	Y N P

Musculo-skeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P
Joint swelling?	Y N P	Backache?	Y N P

Blood/Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P
Extremity numbness?	Y N P	Extremity swelling?	Y N P
Extremity coldness?	Y N P	Extremity ulcers?	Y N P

Neurologic

Seizures/convulsions?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Speech problems?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P
Fainting?	Y N P	Involuntary movement?	Y N P

Endocrine

Hypothyroid?	Y N P	Diabetes?	Y N P
Hyperthyroid?	Y N P	Heat or cold intolerance?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P
Excessive thirst?	Y N P	Hypoglycemia?	Y N P
Excessive hunger?	Y N P	Excessive sweating?	Y N P

Excessive urination?	Y N P	Hormone therapy?	Y N P

Immune

Vaccinations?	Y N P	Reactions to vaccinations?	Y N P
Chronic fatigue syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

Mental/Emotional

Treated for emotional problems?	Y N P	Memory problems?	Y N P
Mood swings?	Y N P	Anxiety or nervousness?	Y N P
Poor concentration?	Y N P	Depression?	Y N P
Tension and/or stress?	Y N P	Considered/attempted suicide?	Y N P
Phobias?	Y N P	Insomnia?	Y N P