CLIENT INTAKE: FULL MEDICAL (ADULT)

Thank you for taking the time to complete this form. It helps us to understand your whole health picture and will assist us in providing you with the best care possible.

Date:______________________

Family History

Full Name: ____

Date of Birth (MM/DD/YYYY):_____________ Age:_____ Sex: M | F

Marital status: [ ] Single [ ] Married [ ] Divorced
[ ] Separated [ ] Living with Partner [ ] Widowed

Do you have any children? Y | N

If yes, list age and sex: __________ __________ __________ __________ __________

Medical History

Name of medical doctor: ______________________________ Telephone:_______________________

Date of last visit: _______________________ Date of last physical: _______________________

Are you under the care of any specialists? Y | N

Specialists' name(s):_______________________________

Specialty:____

Contact:____

Please list your health concerns in order of importance.

Concern	Since	Concern	Since
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Have any of these issues changed or worsened over time? Y | N

What effect have these issues had on your life?____

How would you describe your general state of health?____

Please list any major trauma, injury, illness or accident (mental, emotional or physical) you have sustained.

Incident	Date	Long-term effects

Please list any surgical procedures you have undergone.

Procedure	Date	Complications / Results

Please list any other forms of treatment that you have used and describe their effectiveness.

Childhood Illnesses & Vaccinations: (check all that apply):

[ ] Chicken pox [ ] Measles [ ] Mumps [ ] Rubella (German Measles) [ ] Roseola
[ ] Mononucleosis [ ] Scarlet fever [ ] Tuberculosis [ ] Whooping Cough [ ] Impetigo
[ ] Ear Infections [ ] Strep Throat [ ] Polio [ ] Rheumatic Fever [ ] Other

Were you vaccinated as a child? Y | N If so, any side effects?________________________________

Any additional vaccinations (i.e. Hepatitis A or B, “Flu shot”, HPV vaccine, etc)?____________________

Recent travel to high-risk areas? Y | N If so, where?____

Medications / Supplements / Drugs

Please list all current mediations and supplements you take including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathic remedies, etc.

Drug / Supplement	Used For	Date Started	Dosage/Frequency

How often did you take antibiotics as a child?____

In the last 5 years, how many courses of antibiotics have you taken? ______________________________

Most recent course? ____

Which of the following have you used/do you currently use?

	Amount	Frequency	Duration
Tobacco			
Alcohol			
Recreational Drugs			
Steroids			
Laxatives			
Antacids			
Sedatives			
Cortisone			
Coffee			
Other			

Family History

Please indicate if any of your immediate family (parents, siblings, maternal & paternal grandparents) suffers from or has suffered from any of the following conditions - I do not know my family history (   )

Condition	Family Member(s)	Condition	Family Member(s)
Alcoholism / drug use		Asthma	
Colitis		Diabetes	
Kidney disease		Overweight / obesity	
Allergies / hay fever		Arthritis	
Depression / mental health		Heart disease	
Liver disease		Prostate cancer	
Breast cancer		Colon cancer	
High blood pressure		Hyper / hypothyroidism	
Stroke		Other cancer	

Any other conditions of concern in your family?____

Allergies, Sensitivities, Exposures

Please list any known or suspected allergies, sensitivities and/or intolerances.

Drugs	Food	Environmental/Chemical

Have you ever been exposed to toxic substances such as pesticides, herbicides, solvents, or sprays? Y|N

If yes, please give us the details:____

____

Have you ever been exposed to heavy metals such as lead, mercury, arsenic, cadmium, or second hand smoke? Y | N

If yes, please give us the details:____

____

Have you ever had to lower the regular dose of prescription, over-the-counter medication, homeopathic or herbal formula because you were too sensitive to the regular dose? Y | N

Do you avoid caffeine in the afternoon or altogether because it keeps you up at night? Y | N

Do you smell odours that others cannot? Y | N
If so, which odours?____

____

Do you have a sudden onset of symptoms (headaches, rashes, nausea, fatigue, shortness of breath, etc.) when exposed to chemicals, mold, dust, pollen, or other environmental allergens? Y | N
If so, please explain: ____

____

Lifestyle Factors

Energy
On a scale of 1 to 10, (10=highest)
Rate your energy: /10
Rate your stress level: /10
What time of day is your energy the best?______________________ worst? ____________________

What affects your energy? (+/-)

How do you manage your stress? ____

____

Exercise
Do you exercise regularly? Y | N What forms of exercise?________________________________

How often and at what intensity? ____

Hobbies
What are your interests/hobbies?____

How often do you enjoy them? ____

Sleep
How many hours of sleep do you get per night? ___________hours

Difficulty falling asleep? Y | N
Do you wake during the night? Y | N How often?________________________
Do you feel rested on waking? Y | N
Do you take naps? Y | N For how long?______________________

Diet & Digestion
Height:______________ Current weight: ________ Desired weight if different?____________

Max. Weight?________ When? _______________ Min. Weight? ________ When?_______

Have you gained or lost any weight in the past 6-12 months? Y | N If so, how much?_____________

Please recall what you eat in a typical 24-hour period:

Breakfast	
Lunch	
Dinner	
Snacks	

Are there any foods you exclude from your diet? For what reason? ________________________________

____

Are there any foods that you crave specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy)

At what times? ____

____

How much water do you drink daily?

What is the primary source of your drinking water (bottled, filtered, tap, well, etc.)?

What other beverages do you drink, and how much? ___________________________________

How often do you urinate? Every ______hour(s)

How often do you have a bowel movement (per day or week)?

FEMALE (if applicable)
Age at menarche (first menses)?__________________ Age at menopause (if reached)?___________

Number of days for typical menstrual flow__________ Number of days in menstrual cycle?________

Date of last menses?_________Number of pregnancies?_________ Number of live births?________

Any history of miscarriage, abortion, c-section, breech birth, twins?

With any previous pregnancies, were there any difficulties or complications to pregnancy or delivery?

Is there any chance you are pregnant now? Y | N
Are you currently lactating? Y | N
Do you perform regular (monthly) self breast exams? Y | N
Any history of breast lumps or masses? Y | N

Do you go for a yearly PAP test? Y | N Last PAP test? ____________________

Any history of irregular PAP test (please explain)? Y | N

MALE (if applicable)
Do you go to a doctor or ND for an annual physical exam? Y | N
Date of last physical exam:___________

Do you get regular screening lab tests? Y | N
Last DRE (digital rectal exam)?

Any irregularities found?

Is there any other information relevant to your health that has not been addressed?

PATIENT INFORMED CONSENT

i. Diagnosis and Treatment

I,____, hereby acknowledge that I have been fully informed about the traditional diagnostic and treatment therapies which are insured under the Alberta Health Care Insurance Act and are available to me to treat condition(s) for which I am presently consulting **Dr. Tracy Thomson/Dr. Saskia Acton.**

I understand the choice(s) that I have to receive those traditional diagnostic and treatment therapies. I confirm my understanding that it is my personal decision to choose complementary/alternative diagnostic and treatment therapies which are not insured under the Alberta Health Care Insurance Act. I fully understand that these complementary/alternative therapies are based on an integrated approach to the treatment of my present or any other medical conditions for which I may consult **Dr. Tracy Thomson/Dr. Saskia Acton** on an on-going basis.

Where applicable and where indicated, I confirm that I have consulted with my family physician and/or with other specialists and that I have followed the advice provided to me by them. I confirm that I have fully informed **Dr. Tracy Thomson/Dr. Saskia Acton** of the advice provided to me by my regular physician and/or the other specialists and that, where necessary, I have presented **Dr. Tracy Thomson/Dr. Saskia Acton** with written documentation from them on my conditions.

I hereby confirm that it is my personal and fully informed decision to consent to uninsured complementary/alternative diagnostic and treatment therapies as described in the Alberta Medical Association's guidelines as discussed with me by **Dr. Tracy Thomson/Dr. Saskia Acton** and as followed at Gaia Collaborative Medicine Inc. I have, in no way, been coerced by **Dr. Tracy Thomson/Dr. Saskia Acton** or any other staff at the clinic in reaching my decision and signing this Informed Consent.

ii. Payment

I hereby acknowledge and agree that, if I am eligible to receive benefits under the Alberta Health Care Insurance Act for insured services provided to me by the physician(s) at Gaia Collaborative Medicine Inc. (including the initial medical examination) the physicians are entitled to claim benefits under the Alberta Health Care Insurance Act.

I further acknowledge and agree that I have reviewed the current fees for the uninsured alternative/complementary diagnostic and treatment therapies which are to be provided to me by the physician(s) at Gaia Collaborative Medicine Inc. in the treatment of my current or future condition(s) and that these fees have been satisfactorily explained to me. I hereby agree to pay for any uninsured services provided to me by the physician(s) at Gaia Collaborative Medicine Inc. in my diagnosis and / or treatment.

Name: ________________________________

Signature: _____________________________ **Date:________________**

Witnessed by:_________________________

Signature: _____________________________ **Date:________________**