Dr. Mojan Zehtabchi (ND)
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1-(844)-DIAL-DRZ
1-(844)-342-5379

Adult Intake Form

Personal Information:

Full name: _____

Date of Birth_____/_____/_____ Today's Date: _____/_____/_____

Gender: Occupation: _____

Address: _____

Province: _____ City: _____ Postal Code: _____

Telephone number: Home: (____) ____ - ____ Work: (____) ____ - _____

Mobile: (____) ____ - ____

May we leave you phone messages/call to confirm and cancel appointments? Yes☐ No☐

Marital status: Single☐ Married☐ Separated☐ Divorced☐ Widowed☐

Number of dependents: _____

How did you hear about the clinic?_____

Who were you referred by? _____

Emergency Contact:

Name: _____ Relationship:_____

Phone Number: (____) ____ - ____

Other Health Care Providers:

Name of family doctor: _____ Phone: (____) ____ - ____

Name of specialists/doctors: _____ Phone: (____) ____ - ____

Name of specialists/doctors: _____ Phone: (____) ____ - ____

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Last physical exam (MM/YY): _____ Last Blood work: (MM/YY): _____

Medical History:

Please list you HEALTH CONCERNS/GOALS by the order of importance:

Concern/Goal	Since
1.	
2.	
3.	
4.	
5.	

Please indicate any TRAUMATIC EVENT (surgery, trauma), illnesses, injuries and hospitalization along with approximate dates:

Traumatic event	Date
1.	
2.	
3.	

Medications, Supplements and Allergies:

Please list all your current MEDICATIONS/SUPPLEMENTS: (prescription, over the counter, Vitamins, minerals, herbs, homeopathics, etc

Item	Dose	Frequency	Taken For	Date Started

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In the last five years, how many courses of antibiotics have you taken: _____

When was the most recent course of antibiotics: _____

Please list any ALLERGIES or MEDIC ALERT warnings (food, drugs, herbs, environmental):

1.	Reaction:
2.	Reaction:
3.	Reaction:
4	Reaction:
5.	Reaction:

Please answer the following as it best describe you currently (please include amount, type, frequency, and duration of use if applicable):

	Y/N		Number	Other
Smoke		Cigarettes per day:		Have you smoked in the past? For How Long? Are you exposed to second hand smoke?
Recreational Drugs		How many per Week:		
Drink Water		Glasses per day:		
Drink Coffee		Cups per day:		
Drink Tea		Cups per day:		What type of tea?
Drink Pop/Soda		Cups per day:		
Drink Alcohol		Glasses Per week:		What Type of alcoholic beverage:
Exercise		Hours per week:		Type of exercise:
Work		Hours per week:		Occupation: Do you enjoy your job? Shift work?
Watch TV		Hours per day:		
Screen time (Computer/Cell)		Hours per day:		
Antacids		How often:		
Laxatives		How often:		

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Stress		On scale of 1-10 (1=low, 10=high)		What is the main stressor in your life? (e.g. Financial, Job related, marriage, family, Health, unfulfilled expectations, etc)
Energy		On scale of 1-10 (1=low, 10=high)		
Sleep		Hours per night:		Is your sleep Solid or interrupted? Do you wake up refreshed in the morning?

Review of Systems

Y: A conditions you have now
P: A condition you have had in the past

1. SKIN			**Comments**
Rashes	Y	P	
Eczema, Hives	Y	P	
Acne/ Boils	Y	P	
Itching	Y	P	
Colour Changes	Y	P	
Lumps	Y	P	
Night Sweats	Y	P	
Dryness/Moisture	Y	P	
Temperature	Y	P	
Nail Changes	Y	P	
Change in mole	Y	P	
Skin Cancer	Y	P	

2. HEAD			**Comments**
Headache	Y	P	
Head injury	Y	P	
Dizziness	Y	P	

3. EYES			**Comments**
Impaired Vision	Y	P	
Glasses/Contacts	Y	P	
Eye Pain	Y	P	
Tearing/Dryness	Y	P	
Double vision	Y	P	
Glaucoma	Y	P	
Cataracts	Y	P	
Blurring	Y	P	
Bothered by sun	Y	P	
Itching	Y	P	
Redness	Y	P	
Discharge	Y	P	
Blind spot	Y	P	

4. EARS			**Comments**
Impaired hearing	Y	P	
Earache	Y	P	
Dizziness	Y	P	
Discharge	Y	P	
Infections	Y	P	

5. NOSE & IMMUNE SYSTEM			**Comments**
Frequent colds	Y	P	
Nose bleeds	Y	P	

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Stuffiness	Y	P	
Hay fever	Y	P	
Sinus problems	Y	P	

6. MOUTH & THROATS			**Comments**
Frequent sore throat	Y	P	
Sore tongue/mouth	Y	P	
Gum Problems	Y	P	
Hoarseness	Y	P	
Dental Cavities	Y	P	
Loss of taste	Y	P	

7. URINARY			**Comments**
Pain on Urination	Y	P	
Increased Frequency	Y	P	
Frequency at Night	Y	P	
Inability to Hold Urine	Y	P	
Frequent Infections	Y	P	
Kidney Stones	Y	P	
Blood in Urine	Y	P	
Urgency	Y	P	
Hesitancy	Y	P	

8. RESPIRATORY			**Comments**
Cough	Y	P	
Sputum	Y	P	
Spitting up Blood	Y	P	
Asthma	Y	P	
Bronchitis	Y	P	
Pneumonia	Y	P	
Pleurisy	Y	P	
Emphysema	Y	P	
Wheezing	Y	P	
Difficulty Breathing	Y	P	

Pain on Breathing	Y	P	
Shortness of Breath (SOB)	Y	P	
SOB at night	Y	P	
SOB lying down	Y	P	
Tuberculosis	Y	P	
Tuberculin Test	Y	P	
Last chest X-Ray			

9.NECK			**Comments**
Lumps	Y	N	
Swollen Glands	Y	N	
Goiter	Y	N	
Pain or Stiffness	Y	N	

10. CARDIOVASCULAR			**Comments**
Heart disease	Y	P	
Angina	Y	P	
High blood pressure	Y	P	
Chest Pain	Y	P	
Murmurs	Y	P	
Swelling in Ankles	Y	P	
Palpitation/Fluttering	Y	P	
Cyanosis (Blue lips/Nails)	Y	P	
Rheumatic Fever	Y	P	
Past ECG	Y	P	
Other:			

11. GASTROINTESTINAL			**Comments**
Trouble swallowing	Y	P	
Nausea	Y	P	
Vomiting	Y	P	
Heartburn	Y	P	
Change in Thirst	Y	P	
Change in Appetite	Y	P	
Blood in Stool	Y	P	

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Belching or Passing gas	Y	P	
Vomiting blood	Y	P	
Jaundice (Yellow skin)	Y	P	
Liver Disease	Y	P	
Gallbladder Disease	Y	P	
Ulcer	Y	P	
Indigestion	Y	P	
Diarrhea	Y	P	
Rectal Bleeding	Y	P	
Hemorrhoids	Y	P	
Black, Tarry stool	Y	P	
Abdominal pain	Y	P	
Food Allergy	Y	P	
Hernias	Y	P	

12. BREASTS			**Comments**
Lumps	Y	P	
Pain/Tenderness	Y	P	
Nipple Discharge	Y	P	
Do you self-exam	Y	P	

13. MUSCULOSKELETAL			**Comments**
Arthritis	Y	P	
Joint Pain and Stiffness	Y	P	
Broken Bones	Y	P	
Weakness	Y	P	
Joint Swelling	Y	P	
Backache	Y	P	
Muscle Spasm/Cramp	Y	P	

14. PERIPHERAL VASCULAR			**Comments**
Deep leg pain	Y	P	
Cold hands/feet	Y	P	
Varicose veins	Y	P	
Thrombophlebitis	Y	P	
Leg Cramps	Y	P	
Extremity numbness	Y	P	
Extremity Coldness	Y	P	
Extremity Swelling	Y	P	
Extremity Ulcers	Y	P	

15. NEUROLOGICAL			**Comments**
Fainting	Y	P	
Seizures/ Convulsions	Y	P	
Paralysis	Y	P	
Muscle Weakness	Y	P	
Numbness/Tingling	Y	P	
Memory Loss	Y	P	
Involuntary Movement	Y	P	
Loss of Balance	Y	P	
Speech Problems	Y	P	

16. ENDOCRINE			**Comments**
Heat/Cold Intolerance	Y	P	
Thyroid Trouble	Y	P	
Excessive Thirst	Y	P	
Excessive Hunger	Y	P	
Excessive Urination	Y	P	
Excessive Sweating	Y	P	
Diabetes	Y	P	
Hypoglycemia	Y	P	
Hormone Therapy	Y	P	

17. BLOOD/ LYMPHATIC			**Comments**
Anemia	Y	P	
Easy Bleeding/Bruising	Y	P	
Lymph Nose Swelling	Y	P	
Past Transfusion	Y	P	

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18. MALE REPRODUCTIVE			Comments
Hernias	Y	P	
Testicular Masses	Y	P	
Testicular Pain	Y	P	
Sexual Difficulties	Y	P	
Venereal Disease	Y	P	
Discharge/Sores	Y	P	
Date of Last Prostate Exam			

19. FEMALE REPRODUCTIVE		
Age Menses began		
Average Number of Days		
Length of Cycle		
Bleeding between periods	Y	P
Are Cycles Regular	Y	P
Pain During Intercourse	Y	P
Painful Menses	Y	P
Excessive Flow	Y	P
PMS	Y	P

EMOTIONAL			Comments
Depression	Y	P	
Mood swings	Y	P	
Anxiety/ Nervousness	Y	P	
Tension	Y	P	
Phobias	Y	P	
Alcohol/ Drug Abuse	Y	P	
Insomnia	Y	P	

Birth Control	Y	P
What type?		
Number of Pregnancies		
Number of Live births		
Number of miscarriages		
Number of Abortions		
Difficulty Conceiving	Y	P
Vaginal Discharge	Y	P
Vaginal Itching	Y	P
Are you Currently pregnant	Y	N
Are you Breastfeeding?	Y	N
Are you trying to conceive	Y	N
Are you taking Birth Control Pills Type:	Y	N
Date of Last Mammogram		
Date of last Pap Smear test		
Date of last bone density test		
Date of last menstrual period		

Family History:

	Mother	Father	Gr. Parents	Siblings	Children
Asthma					
Cancer Type:					
Depression					
Anxiety					

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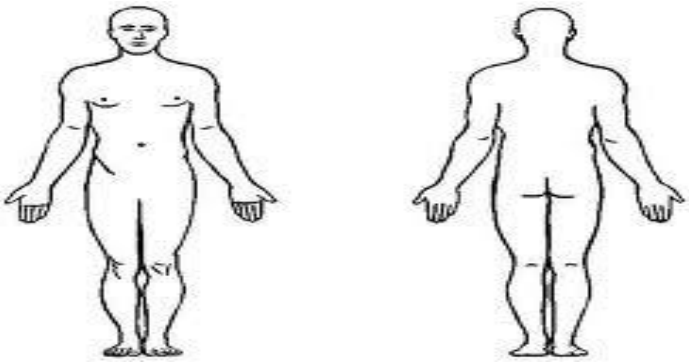
Mental Illness					
Diabetes					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Lung Disease					
Osteoporosis					
Thyroid Illness					
Substance Abuse					
Other Health Concerns					

Pain:

Please mark the areas where you have pain:



Past Medical History:

Please check the following conditions you have had:

	Yes	Never	Comments
Anemia			
Asthma			
Arthritis			
Cancer			Type:
Cold Sores			
Diabetes			
Heart Disease			
High Blood Pressure			
High Cholesterol			

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Anxiety			
Depression			
Other Mental Illness			
Thyroid Conditions			
Stroke			
Multiple Sclerosis			
Gout			
Kidney Disease			
Lung Disease			
Osteoporosis			
Thyroid Illness			
Substance Abuse			
Other Health Concerns			

Social History and Lifestyle:

Dietary Intake:

Please List a Typical day's diet including beverages:

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Beverages: _____

Do you have any dietary Restrictions? (Allergy, religious, Vegetarian, vegan, etc):

_____

Do you have Any Pets? ☐ Yes ☐ No

Have you ever been neglected or abused, Physically, emotionally or sexually? ☐Yes ☐No

Are you currently living in an unsafe environment? ☐Yes ☐No

Do you practice safe sex? (i.e. use condoms) ☐Yes ☐No

Do you have more than one sexual partner? ☐Yes ☐No

Sexual Partners: ☐Men ☐Women ☐Both ☐None

Please describe the emotional climate of your home: _____

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_____

_____

Health Maintenance:

When was the last time you	**Date/ Findings**
Visited the dentist	
Had blood work	
Had a blood sugar test	
Had a Cholesterol test	
Had a Liver Panel test	
Had a Hormone Panel test	
Had tetanus booster	
Had EKG	
Had Chest X-Ray	
Had colon cancer screening:	
Type: ☐ Colonoscopy ☐Flexible Sigmoidoscopy ☐ occult ☐Blood stool test	

Note to all patients: Please bring in your medications and supplements to first appointment

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Signature _____ Date _____

Thank you for taking the time to fill out this extensive health intake form.
All the above information is important in developing the best treatment plan for you.