INTAKE FORM

_______ / _______ / _______

8787 WOODBINE AVE., UNIT 126, MARKHAM, ON, L3R 9S2
905-513-6888 | INFO@RIVERCLINIC.CA | WWW.RIVERCLINIC.CA

Health Record

ALL INFORMATION IS STRICTLY CONFIDENTIAL

NAME:	AGE:	DATE OF BIRTH: ___ (M) / ___ (D) / _____ (Y)
ADDRESS:	HEIGHT:	WEIGHT:
CITY:	PROV:	POSTAL CODE:
OCCUPATION:	EMAIL:	
TEL (CEL): TEL (HOME):	TEL (WORK):	
EMERGENCY CONTACT:	FAMILY PHYSICIAN:	
REFERRED BY:	☐ SINGLE ☐ PARTNER	☐ MARRIED
HAVE YOU RECEIVED ACUPUNCTURE: OR CHINESE HERBS BEFORE?	☐ WIDOWED ☐ SEPARATED	☐ DIVORCED

MAIN REASON(S) YOU ARE SEEKING TREATMENT: ____________________

____

WHEN DID THIS CONDITION BEGIN? ____________________

HAVE YOU BEEN GIVEN A DIAGNOSIS BY A DOCTOR? IF SO, WHAT? ____________________

Health History

SIGNIFICANT ILLNESSES:

☐ CANCER, TYPE ______________	☐ HEART DISEASE	☐ ALLERGIES / ASTHMA	☐ ANEMIA
☐ DIABETES	☐ RHEUMATIC FEVER	☐ AIDS / HIV +	☐ MENTAL ILLNESS
☐ HEPATITIS	☐ THYROID DISEASE	☐ ARTHRITIS	OTHER ILLNESSES: ____________
☐ HIGH BLOOD PRESSURE	☐ SEIZURES	☐ HERPES	____________

SURGERIES (YEAR): ____________________

SIGNIFICANT TRAUMAS (ACCIDENTS, FALLS, ETC.) OR ILLNESSES (YEAR): ____________________

ALLERGIES (FOODS, DRUGS, ETC.): ____________________

MEDICATIONS - PLEASE LIST ALL SUPPLEMENTS, PRESCRIPTION AND NON-PRESCRIPTION DRUGS YOU ARE CURRENTLY TAKING. PLEASE INCLUDE TYPE (PILLS, TABLETS, LIQUIDS, SPRAYS, SUPPOSITORIES, ETC.) AND SPECIFY DOSAGE:

____

____

____

OCCUPATIONAL STRESSES (CHEMICAL, PHYSICAL, PSYCHOLOGICAL): ____________________

DO YOU EXERCISE REGULARLY? ____________ DESCRIBE: ____________________

HABITS / FREQUENCY

____________ CIGARETTES / DAY	____________ RECREATIONAL DRUGS / WEEK
____________ ALCOHOL / WEEK	____________ GLASSES WATER / DAY
____________ CAFFEINE / DAY	____________ OTHER(S):

WHAT RELIEVES THE PAIN (HEAT / COLD / MASSAGES / REST / EXERCISES, ETC.)?

____

WHAT AGGRAVATES THE PAIN (WEATHER / HEAT / COLD, ETC.)?

____

ARE YOU PAIN FREE?

(NO PAIN) 1 2 3 4 5 (SEVERE PAIN)

ON THE FIGURES BELOW, PLEASE MARK THE AREAS OF PAIN / CONCERN:

RIGHT LEFT

SENSATIONS / PAIN:

☐ SHARP	☐ BURNING	☐ MOVES	☐ SHOOTING
☐ TINGLING	☐ DULL	☐ SEVERE	☐ NUMBNESS

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CURRENTLY SEEING THE FOLLOWING PROFESSIONAL:

- ☐ CHIROPRACTOR
- ☐ PHYSIOTHERAPIST
- ☐ MASSAGE THERAPIST
- ☐ NATUROPATH
- ☐ OTHER: ______________________

CARDIOVASCULAR:

- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ CHEST PAIN OR TIGHTNESS
- ☐ IRREGULAR HEARTBEAT
- ☐ HIGH CHOLESTEROL
- ☐ FAINTING
- ☐ COLD HANDS / FEET
- ☐ SWELLING IN HANDS / ANKLES / FEET
- ☐ HEART PALPITATIONS
- ☐ NECK STIFFNESS
- ☐ DIFFICULTY BREATHING
- ☐ POOR CIRCULATION
- ☐ OTHER: ______________________

RESPIRATORY:

- ☐ CHRONIC COUGH
- ☐ COUGHING BLOOD
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ PNEUMONIA
- ☐ HAY FEVER / ALLERGIES
- ☐ SINUS PROBLEMS
- ☐ TIGHT CHEST
- ☐ PRODUCTION OF PHLEGM ______ WHAT COLOR? ______________
- ☐ DIFFICULTY BREATHING WHEN LYING DOWN
- ☐ OTHER: ______________________

GASTROINTESTINAL:

- ☐ NAUSEA
- ☐ SENSITIVE ABDOMEN
- ☐ BLOODY STOOL
- ☐ GAS
- ☐ BAD BREATH
- ☐ DIARRHEA
- ☐ VOMITING
- ☐ HEMMORROIDS
- ☐ CONSTIPATION
- ☐ PAIN OR CRAMPS
- ☐ RECTAL PAIN
- ☐ ALTERNATING LOOSE / CONSTIPATION
- ☐ BELCHING
- ☐ ITCHY ANUS
- ☐ LAXATIVE USE: __________ / WEEK
  TYPE: ______________
- ☐ HICCUPS
- ☐ BLACK STOOL
- ☐ OTHER: ______________________

BOWEL MOVEMENTS:

FREQUENCY ______________

COLOR ______________

ODOR ______________

TEXTURE / FORM ______________

MUSCLE AND JOINTS:

- ☐ NECK PAIN
- ☐ MUSCLE PAIN
- ☐ BACK PAIN (WHERE): ______________
- ☐ BODY ACHES / STIFFNESS
- ☐ SPINAL CURVATURE
- ☐ DIFFICULTY WALKING
- ☐ BODY HEAVINESS
- ☐ WEAKNESS
- ☐ JOINT PAINS (WHERE): ______________________
- ☐ OTHER: ______________________

NEUROPSYCHOLOGICAL / EMOTIONS:

- ☐ SEIZURES
- ☐ FEARFUL
- ☐ POOR MEMORY
- ☐ CONCUSSION
- ☐ CONSIDERED / ATTEMPTED SUICIDE
- ☐ ANXIETY
- ☐ BAD TEMPER
- ☐ AREAS OF NUMBNESS
- ☐ TREATED FOR EMOTIONAL PROBLEMS
- ☐ DEPRESSION
- ☐ OVER THINKING
- ☐ EASILY STRESSED
- ☐ RELAXED / CALM
- ☐ ANGRY / FRUSTRATED
- ☐ MANIC
- ☐ ANXIOUS
- ☐ SADNESS
- ☐ IRRITABLE OFTEN / EASILY
- ☐ IMPATIENT
- ☐ GRIEF
- ☐ OTHER: ______________________

GENITO-URINARY:

- ☐ PAIN ON URINATION
- ☐ BLOOD IN URINE
- ☐ KIDNEY STONES
- ☐ GENITAL LESIONS / DISCHARGE
- ☐ UNABLE TO HOLD URINE
- ☐ EXCESSIVE OR SCANTY URINATION
- ☐ VENEREAL DISEASE
- ☐ IMPOTENCY
- ☐ URGENCY TO URINATE
- ☐ BEDWETTING
- ☐ PAIN / ITCHING GENITALIA
- ☐ DECREASED LIBIDO
- ☐ FREQUENT URINATION
- ☐ WAKE UP TO URINATE: HOW OFTEN? ______ / NIGHT; TIME: __________
- ☐ OTHER: ______________________

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EARS:

- ☐ RINGING IN EARS
- ☐ POOR HEARING
- ☐ EARACHES
- ☐ OTHER: ____________________

EYES:

- ☐ EYE STRAIN
- ☐ EYE PAIN
- ☐ POOR VISION
- ☐ NIGHT BLINDNESS
- ☐ COLOR BLINDNESS
- ☐ CATARACTS
- ☐ BLURRY VISION
- ☐ SPOTS / FLOATERS
- ☐ GLASSES
- ☐ RED / BURNING ITCHY EYES
- ☐ OTHER: ____________________

NOSE, THROAT, MOUTH, HEAD:

- ☐ TEETH PROBLEMS
- ☐ NOSE BLEEDS
- ☐ SINUS PROBLEMS
- ☐ DRY MOUTH / THIRST
- ☐ GUM PROBLEMS
- ☐ DRY MOUTH
- ☐ DRY THROAT
- ☐ SWOLLEN GLANDS
- ☐ GRINDING TEETH
- ☐ BITTER TASTE IN MOUTH
- ☐ COPIOUS SALIVA
- ☐ FACIAL PAIN
- ☐ MUCUS
- ☐ SORES ON LIPS OR TONGUE
- ☐ ENLARGED LYMPH GLANDS
- ☐ RECURRENT SORE THROATS: ________ / MONTH
- ☐ DIZZINESS
- ☐ MIGRAINES
- ☐ OTHER: ____________________

SKIN AND HAIR:

- ☐ ITCHING / DRYNESS
- ☐ HIVES
- ☐ HOT FLASHES
- ☐ EASILY / SPONTANEOUS SWEATING
- ☐ ECZEMA / PSORIASIS
- ☐ RASHES
- ☐ ACNE
- ☐ DANDRUFF
- ☐ ACNE
- ☐ CHANGES IN HAIR / SKIN TEXTURE
- ☐ NIGHT SWEATS
- ☐ NAILS BREAK EASILY
- ☐ BRUISE EASILY
- ☐ ULCERATIONS
- ☐ LOSS OF HAIR
- ☐ OTHER: ____________________

HOW WELL DO YOU SLEEP?

- ☐ SOUND / RESTFUL
- ☐ DREAM DISTURBED
- ☐ DIFFICULTY FALLING ASLEEP
- ☐ WAKE UP EASILY / EARLY
- ☐ INSOMNIA
- ☐ HEAVY SLEEP
- ☐ VIVID DREAMS / NIGHTMARES
- ☐ LIGHT SLEEP
- ☐ HOURS OF SLEEP PER NIGHT: ____________

ARE YOU STRESSED OR RELAXED? (RELAXED) **1 2 3 4 5** (STRESSED)

WHAT IS YOUR ENERGY LEVEL? (LOW ENERGY) **1 2 3 4 5** (HIGH ENERGY)

APPETITE?

- ☐ NORMAL / HEALTHY
- ☐ RAVISHING HUNGRY
- ☐ POOR APPETITE
- ☐ NEED TO EAT SEVERAL MEALS
- ☐ HUNGRY, BUT NO DESIRE TO EAT
- ☐ ANY TASTE IN MOUTH? ____________________

PREFERRED FLAVOUR: ☐ BITTER ☐ SWEET ☐ SPICY ☐ SALTY ☐ SOUR

PREFERRED DRINKS: ☐ WARM ☐ COLD ☐ OTHER: ____________

FOR WOMEN - PREGNANCY AND GYNECOLOGY

- ☐ NUMBER OF PREGNANCIES: ____________
- ☐ NUMBER OF BIRTHS: ____________
- ☐ PREMATURE BIRTHS: ____________
- ☐ MISCARRIAGES: ____________
- ☐ AGE AT FIRST MENSES: ____________
- ☐ LAST MENSES: ____________
- ☐ MENSES DURATION: ____________
- ☐ IRREGULAR PERIODS
- ☐ FLOW (DESCRIBE): ____________
- ☐ CLOTS
- ☐ LAST PAP SMEAR: ____________
- ☐ CURRENTLY PREGNANT
- ☐ BIRTH CONTROL TYPE: ____________
- ☐ VAGINAL SORES
- ☐ BREAST LUMPS
- ☐ CURRENTLY NURSING
- ☐ BIRTH CONTROL DURATION: ____________
- ☐ VAGINAL DISCHARGE
- ☐ MENOPAUSE: