Please complete this form before your first visit

Name: _____

Date of birth: _____ **(mm/dd/yy)** **Sex: M F**

Address: _____

_____

Email address: _____

Phone number: _____

May we leave messages relating to your visits? Y N

Emergency contact: Name/relation _____

Phone number: _____

How did you hear about my practice? _____

_____

Would you be interested in our: Chiropractor O | RMT O

Other health care providers you are seeing:

1. _____
2. _____
3. _____
4. _____

What are your main health concerns?:

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

If you are female are you currently pregnant? Yes No Maybe (please circle one)

Medical History (*We will go further into detail during the intake)*

How would you describe your general state of health?

Excellent Good Fair Poor

Please indicate any serious conditions, illness or injuries and any hospitalizations, along with approximate dates.

_____

_____

_____

_____

Do you have any allergies (medicines, environmental, etc...)?

_____

_____

_____

Please list all current medications (prescription, OTC, vitamins, herbs, homeopathics, etc…)

_____

_____

_____

_____

_____

Please list past prescription medications

_____

_____

_____

_____

How many times have you been treated with antibiotics (approx)? _____

Any adverse reactions? _____

Do you frequently use any of the following?

Aspirin / Laxatives / Antacids / Diet pills / Birth control: pills / implants / injections

Alcohol: how many drinks per month _____

Tobacco: method and amount per day _____

Caffeine: form and amount per day _____

Recreational drugs: what and how often _____

Please circle which immunizations you know you have had:

DPT H. influenza B Hepatitis A Hepatitis B Flu

Tetanus booster (when?) MMR Polio smallpox

Other: _____

Any adverse reactions: _____

Do you get regular screening tests done by another doctor? (i.e. blood tests, PAP, etc…) Y / N

<u>Dietary</u>

Do you have any food allergies or intolerances?

_____

_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc…)?

_____

Family History

*We will go into more detail during the intake but try to brainstorm so you have a good idea once we cover this section. Please check off which conditions apply.

√	Condition	√	Condition
	Allergies		Multiple Sclerosis
	Asthma		Fibromyalgia
	Heart disease		Lupus
	High blood pressure		Arthritis
	High cholesterol		Autoimmune disease
	Cancer		Celiac disease
	Diabetes		Crohn's disease
	Depression		Myasthenia gravis
	Other mental illness		Liver issues
	Drug abuse/alcoholism		Skin issues
	Kidney disease		Sjogren's syndrome
	Thyroid issues		Other

*Please let me know if you are unsure of your family medical history

Environment

Occupation: _____

Are you exposed to significant tobacco smoke? Y / N

Are you frequently exposed to animals? Y / N

Do you have a carbon monoxide detector? Y / N

Are you regularly exposed to toxins or other hazards? Y / N

How would you describe the emotional climate of your home?

_____

How stressful is your work or other aspects of your life? How well do you handle these stresses?

_____

_____

Thank you for taking the time to complete these forms. As mentioned earlier we will discuss this information in further detail. All of this information is and will be kept confidential.

Sincerely, Dr. Gallant ND