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New Patient Intake Form

Date:_____

Please complete the following Questionnaire prior to your scheduled appointment.

Personal Information

Our professional regulatory college (CNDA) requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission.

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *Province* *ZIP Code*

Home Phone: _____ **Alternate Phone:** _____

AB Health Care #: _____

Email: _____

By signing below you give Paradigm Health Group permission to send you e-mails regarding appointment reminders only. This does not give us permission to send you lab results or consult with you over email. Your email will not be distributed for any other use.

_____ _____ _____
Print Name *Signature* *Dated*

Birth Date: ____/____/____ **Marital Status:** _____
YYYY MM DD

Occupation: _____ **Past Occupations:** _____

Height (cm): _____ **Weight (lbs):** _____

Children: Yes / No **Gender & Ages:** _____

Spouse's Name: _____

Home Phone: _____ **Work Phone:** _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Primary Phone: _____ **Alternate Phone:** _____

Relationship: _____

How did you hear about Paradigm Health Group? (check one)

Website: _____ **Word of mouth:** _____ **Referral by another Doctor:** _____ **If so, who:** _____

Other: _____

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Medical History

Current health conditions you desire improvement in **and** length of time they have been a concern to you, placed in order of importance:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Have you ever been hospitalized? If yes, when, and what for _____

_____

_____

Have you had surgery? If yes, when, and what procedure(s)_____

_____

_____

Have you had any major dental work done? If yes, when, and what kind: _____

_____

_____

Have you had vaccinations? If yes, which vaccination(s)?: _____

_____

_____

Allergies: (Drug Allergies, Environmental Allergies, Food Allergies etc…)

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

Childhood Illness: Please indicate below any illnesses you had as a child:

	Measles		Rubella		Whooping Cough		Rheumatic Fever		Allergies
	Mumps		Chicken Pox		Scarlet Fever		Polio		Asthma
	Ear Infections		Eczema/Psoriasis		Frequent Cold/Flu				

Family History: Please check all of the following conditions that are applicable to **you and your family** and note who:

Alcoholism			Headaches		
Allergies/Hayfever			Heart Disease		
Arthritis			Heart Murmurs		
Asthma			High Blood Pressure		
Auto-Immune			High Cholesterol		
Cancer			Hypo/Hyper Thyroid		
Crohn's or Colitis			Irritable Bowel		
Depression			Kidney Disease		
Diabetes			Liver Disease		
Eczema			Mental Illness		
Gallbladder			Osteoporosis		
GERD/hiatal hernia			Stroke or Aneurysm		
Glaucoma/Cataracts			Ulcers		
Gout			Other		

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Current Medication/Supplementation

Are you currently taking any prescription medications? If so, please list them below, as well as the dosage:

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

Have you used antibiotics? If so, how often? _____

Have you ever had general anesthetic? If yes, when? _____

Are you currently taking any supplements? (This includes non-prescription, herbal, over-the-counter, homeopathics etc…) If so, please list them below:

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

Lifestyle

How would you rate your energy level? _____ (from 1-10, *10 being highest*)

What time do you typically wake in the morning? _____ am.

What time do you typically go to sleep? _____ pm/am

Do you wake up feeling refreshed? If no, please give details: _____

_____

How many meals a day do you eat? _____/day. **Does this include breakfast?** Y or N

Meal	Time	Food/Drink
Breakfast		
Lunch		
Dinner		
Snacks/Dessert		
Cravings		

How many servings per week do you have of the following:

Meat _____ Fish _____ Fowl _____ Dairy _____ Eggs _____ Beans/Legumes _____ Fruits _____

Vegetables _____ Grains (bread/pasta/cereal) _____

How many glasses of water do you drink per day? _____ **What kind?** _____

How many cups/day do you drink of each of the following:

Coffee _____ Black Tea _____ Herbal Tea _____ Do you add cream/milk _____ or sugar _____

Do you drink alcohol? _____ **If yes, how many drinks per week?** _____

Do you smoke? _____. **If yes, for how long?** _____ years / months. **How often?** _____

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Do you use recreational drugs? _____. If yes, what kind, how often, and for how long? _____

_____

Do you exercise? _____ If yes, how many hours per week? _____ hours.

What kind of exercise do you do? _____

_____

_____

Do watch TV or use a computer at home? _____. If yes, how many hours per week? _____ hours.

Travel (list any backcountry & third world trips):

Location	When	Illness/Trauma (if applicable)

Support, Stressors & Personal Growth

Do you get along with your family? _____

_____

Please list the stressors that affect you the most:

1) _____
2) _____
3) _____
4) _____
5) _____

Please list the people/areas that support you the most:

1) _____
2) _____
3) _____
4) _____
5) _____

Do you currently follow a religious/spiritual belief system? Y or N

Do you feel comfortable and supported with this belief system? _____

Do you do any of the following? (Check any that apply):

	Meditate		Use Visualization
	Relaxation Techniques		Other:
	Pray		

Please check any statements below that apply to you with regards to suggestions or programs for your health: I…..

	Can follow plans/programs		Start programs, but let things slide
	Prefer choosing from options		Am easily overwhelmed

How will you know when you are feeling better? _____

_____

Do you have any concerns or reservations in pursuing complementary and alternative therapies? Y or N

If yes, what would those be? _____

Thank you for taking the time to complete this Questionnaire!