

## 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:

<input type="checkbox"/>	Measles	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	Eczema/Psoriasis	<input type="checkbox"/>	Frequent Cold/Flu	<input type="checkbox"/>		<input type="checkbox"/>	

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

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

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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):

<input type="checkbox"/>	Meditate	<input type="checkbox"/>	Use Visualization
<input type="checkbox"/>	Relaxation Techniques	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Pray	<input type="checkbox"/>	

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

<input type="checkbox"/>	Can follow plans/programs	<input type="checkbox"/>	Start programs, but let things slide
<input type="checkbox"/>	Prefer choosing from options	<input type="checkbox"/>	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!**