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ACCEPTING NEW PATIENTS

PREVENTATIVE MEDICINE - ACUPUNCTURE – PRESCRIPTIONS – NUTRITION – ADVANCED LAB TESTING

To help us serve your health needs, please complete the following information as accurately as possible. Thank you!

PERSONAL INFORMATION

Name____ Age ________ M__ F__ Today's Date (Mo/Day/Year)_________________

How would you prefer to be addressed in our office? ______________________________ Birth Date (Mo/Day/Year) ___________________

Home Address______________________________________City ___________________ Postal Code_______________________________

Occupation_____________________________________ Work Phone ________________ Home Phone______________________________

Cell Phone Provider (ex:telus, rogers, koodo)_____________________________________ Cell Phone_____________________________.

Email Address (for clinical purposes only) _______________________________________ BC Care Card # ____________________________

Check box ☐ if you would not like to receive our newsletter - sent by email approximately 1/month; please see reverse side of fee schedule for privacy policy.
How do you want appointment reminds: ☐ **Text message** ☐ **E-mail** ☐ **Text & E-mail** ☐ **Phone**
Spouse's Name_______________________________ Children (name(s)/age) ____

If the above is a child: Father's Name_______________________________ Mother's Name____

Who referred you to our office? ____ Do you have Extended Coverage? Yes__ No __

NOTE: *This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us in writing to do so. Please complete this questionnaire as thoroughly as possible. Thank you.*

1. What health concerns/problems brought you to this office today? ____
____
____

2. What questions do you have that you would like answered? ____
____

3. What kind of help do you want or expect to be provided? ____
____

4. Are you being treated for any condition by a physician now? Yes___ No ___ Condition ____

Physician_______________________________ Family Physician ____

CURRENT MEDICATIONS AND PRODUCTS

Please list all your prescription medications (such as sleeping pills, birth control pills), non-prescription medications (such as aspirin, antacids, laxatives, antihistamines) vitamins, herbs, etc., that you take more than occasionally.
____
____

KNOWN ALLERGIES

Please list any known allergies to medicines (such as penicillin, sulpha drugs, aspirin), or other substances (such as pollens ragweed), foods, chemicals, etc.
____

HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES (Date/Reason for hospitalization)

____
____

OVER…

PERSONAL HEALTH HABITS

Height_____________ Current Weight_____________lbs Ideal weight__________lbs. Maximum Weight__________Year ______________

Smoker: Yes__ No__ Smoked for ___________years Amount per Day_____________ Year Stopped, If Applicable___________________

Alcohol Use: Yes__ No__ Type of Alcohol Preferred______________________________ Frequency_________________________________

Recreational Drug Use: Yes __ No __ Type_____________________________________ Frequency_________________________________

Coffee: Yes__ No__ ______Cups per day Tea: Yes__ No__ ______Cups per day Soda Pop: Yes__ No__ ______Cups per day

Water: _____________ Cups per day

Diet: Are there any food groups you avoid? Yes__ No__ If "Yes", what____

Do you exercise regularly? Yes__ No__ Type ___________________________Duration_________ Frequency_________________________

Hobbies____

Blood Type (if known): A__ B__ AB__ O__ Additional Information____

Women: Are you currently pregnant? Yes __ No __ ____

MEDICAL HISTORY

Please check only those that pertain to YOU personally.

__	Alcohol Abuse	__	Female Gynecological Problems	__	Skin Problems
__	Allergies	__	Gallstones	__	STI (ie. AIDS, syphilis, gonorrhea, herpes)
__	Anemia	__	Gum/Teeth Problems		
__	Arthritis	__	Heart Attack	__	Stroke
__	Asthma	__	Heart Problems	__	Suicide
__	Back, Muscle, Joint Pain	__	High Blood Pressure	__	Thyroid Problems
__	Bladder/Urinary Problems	__	Kidney Problems	__	Tuberculosis
__	Colitis	__	Liver Problems	__	Ulcers
__	Depression	__	Lung Problems		
__	Diabetes	__	Overweight		Other______________________________
__	Epilepsy	__	Psychological Difficulties		___________________________________
__	Fatigue, chronic	__	Rheumatic Fever		___________________________________

FAMILY MEDICAL HISTORY

	Age	Health Problems	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Brothers And Sisters				
Children				

**** Please Note: A 24 hour notice is required for all cancellations or the full visit fee will be charged***