SOUL REMEDY HOLISTIC CLINIC

New Patient Intake Form

Personal Information

Full Name_____ Date _____
Date of birth _____ Age _____ Sex: □ Male □ Female
Birthplace _____
Address _____ City _____
Province _____ Postal Code _____
Phone: Home _____ Work _____ Other _____
Personal email _____
Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated □ Common-Law
Number of Children: _____
Occupation: _____ Employer: _____

Emergency contact:
Name _____Relation _____ Phone _____

How did you hear about our clinic? _____

What are your main health concerns that you would like addressed?
1. _____
2. _____
3. _____
4. _____
5. _____

If you are female, are you currently pregnant? □ Yes □ No

Soul Remedy Holistic Clinic respects your rights to privacy. This information will remain on your file and will accessed solely as a resource for your personal treatment and for the purpose of confirming your appointments. If any other situation arises, your consent will be sought

Medical history

How would you describe your general state of health?

□ Excellent □ Good □ Fair □ Poor

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

_____

Please list all current medications, including dosages, duration of use and why you are taking them:

Medication	Dose	Duration	Condition Treating

Please list all natural health products you are taking:

Natural Health Product	Dose	Duration	Condition Treating

Please list **past** prescription medications.

_____

_____

How frequently are you treated with antibiotics? _____

Do you regularly use any of the following?

□ Aspirin □ Laxatives □ Antacids □ Diet pills

□ Birth control pills □ Implants □ Injections

Please list any surgeries, dates of surgery and any complications (please include all cosmetic and elective surgeries as well as dental surgery)

_____
_____
_____
_____

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

_____
_____

Average daily water consumption _____ Type _____
Sleep posture: side _____ back _____ stomach _____

Number of hours sleep per night _____

Quality of sleep (Refreshing, unbroken)

_____

Sleep environment (Quiet, peaceful, 100% darkness): _____

Did/do you wear braces on your teeth? No _____ Yes _____ # months/years _____

Did/do you wear a dental appliance? No _____ Yes _____

Did/do you have mercury dental amalgam? No _____ Yes _____ Explain: _____

Do you drink alcohol? (Daily average) _____

Do you smoke? (Daily average) _____
Weekly consumption of beverages? Coffee _____ Tea ____ Soft Drinks _____

Other_____

Do you use recreational drugs? (What and how often)

_____

Please indicate which immunizations you have had:

□ DPT (diphtheria, pertussis, tetanus)	□ Haemophilus influenza B	□ Hepatitis A
□ Tetanus booster; when? _____	□ "Flu"	□ Hepatitis B
□ MMR (measles, mumps, rubella)	□ Polio	□ Smallpox

Other

_____
_____

Please indicate if any caused adverse reactions:

_____
_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? □ Yes □ No

When were your most recent tests performed? _____

All Current (C) and Past Conditions (P). Check box if applicable; Circle specific conditions.

MUSCLES/JOINTS/NERVES

C P

Head and Neck

__ __ headaches/migraines
__ __ neck pain/whiplash
__ __ tingling/numbness
__ __ tooth/jaw/ear pain/TMJ
__ __ vision condition (s)
__ __ hearing condition/dizziness
__ __ head trauma/concussion
__ __ loss of coordination

Trunk

__ __ back pain/injury/scoliosis
__ __ degenerative/herniated disc
__ __ hip pain/sciatica

Arms / Hands / Legs / Feet

__ __ pain/tingling
__ __ weakness/numbness
__ __ fractures/strains/sprains
__ __ tendonitis/fibrositis/bursitis
__ __ osteo/rheumatoid arthritis
__ __ muscle/nerve disease

Skin

__ __ lack of sensation/numbness
__ __ irriated condition/frostbite
__ __eczema/psoriasis/skin infection

HEART/CIRCULATION

C P

__ __ high/low blood pressure
__ __ chest pain/angina
__ __ heart attack/stroke
__ __ heart disease
__ __ pacemaker
__ __ bruise easy
__ __ arrhythmia
__ __ phlebitis/thrombosis

LUNGS RESPIRATION

__ __ shortness of breath
__ __ chronic cough
__ __ asthma bronchitis
__ __ emphysema

DIGESTION

__ __ IBS/Crohn's/colitis
__ __ Celiac disease
__ __ constipation/diarrhea (chronic)
__ __ nausea/bloating/gas (chronic)
__ __ ulcer/hernia

UROGENITAL

__ __ liver/gall bladder
__ __ urinary infection/disease
__ __ kidney infection/disease

GENERAL/SYSTEMIC

C P

__ __ anxiety/stress
__ __fatigue/insomnia
__ __eating disorder
__ __drug/alcohol issues
__ __ fibromyalgia/chronic fatigue
__ __ osteoarthritis/osteoporosis
__ __inflammatory arthritis
__ __diabetes
__ __ undiagnosed lump
__ __cancer
__ __epilepsy
__ __TB/hepatitis/HIV
__ __internal pins/plates/wires
__ __artificial joints

WOMEN

__ __ menstrual changes/problems
__ __endometriosis
__ __PMS/menopausal complications
__ __other gynecological conditions
__ __pregnant –due date? _____
__ __
other_____

MEN

__ __ prostrate problem
__ __ other
_____

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Pregnancy and Gynecology – Women only

Age at first menses _____Length of cycle _____ Duration of menses _____
□ Unusual menses □ Painful periods □ Clots □ Heavy ⇑ Light
□ Irregular periods □ Last PAP _____ □ Vaginal discharge
□ Vaginal sores □ Breast lumps
□ Changes in body / psyche prior to menses _____

Do you practice birth control? Y /N
What type and for how long? _____
Could you be pregnant now? Y/N (circle Yes if it is possible)
1st day of last menses: _____

Number of pregnancies _____
These pregnancies resulted in:
Premature births: _____ Abortion: _____ Miscarriage: _____
Full term birth: _____ Postdate birth: _____
Any other obstetrical or gynecological issues? _____
_____

Diet

Do you have any food allergies or intolerances? Please list.
_____
_____

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

Family History (□ I don't know my family medical history)
Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

Environment

Hobbies_____
_____

Do you exercise regularly? □ Yes □ No

What do you do for exercise, for what duration and how often?
_____
_____

Are you exposed to significant tobacco smoke (at work, home, etc.)? □ Yes □ No

Are you frequently exposed to animals (work, pets, etc.)? □ Yes □ No

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.
_____
_____

How would you describe the emotional climate of your home?
_____
_____

How would you rate your stress levels?
□ Overwhelming □ High □ Moderate □ Low □ Minimal

Is there anything that you feel is important that has not been covered?
_____
_____
_____
_____

Statement of Acknowledgement

Each patient seeking care from Soul Remedy Holistic Clinic should understand that the Bowen Practitioner is certified and specialized in Bowen Therapy and specialized in Heilkunst Treatment and is not a Medical Doctor. If standard medical diagnosis or treatment is required, it must be obtained from a licensed Medical Doctor.

Patient Consent Form

Privacy of your personal information is an important part of providing you with quality care. This document is confidential information and will not be released to any persons without your consent.

Signature _____

Date _____