Urban Wellness & Fertility Toronto
Intake Form
416.324.8888

General Health History

Date:_____

Name: _____(M)(F) Date of Birth(D/M/Y): _____ Age: ____

Address:_____Postcode_____

Phone (h):_____(c)_____e-mail _____

Occupation:_____

Name of Doctor/Specialist: _____ phone:_____

Name of other Health Practitioners: _____

Emergency contact: _____phone: _____

Referred by: _____

From time to time we send out an electronic newsletter with our upcoming workshops, events and talks, healthful ideas, recipes and inspirations. Are you interested in receiving this?
_____

What is the main condition for which you are seeking treatment?
_____
_____

What is the history of this condition (ie. when did it start, what makes it worse/better? what have you already tried for treatment?)
_____
_____
_____

Previous Medical History:
List any previous **illnesses** including childhood illness or chronic viral infections, any **surgeries**, **traumas** or accidents, even if unrelated to your current condition.
_____
_____
_____
_____

Are there any conditions that are significant in your **family's medical history**?
(eg. heart disease, cancer, stroke, high blood pressure, kidney disease, diabetes, asthma, ulcers, mental/emotional disorders, etc)
_____
_____

Please list any allergies and the reaction you have:
_____
_____

Please be assured that your information is confidential and will be shared only with your practitioners.

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Lifestyle:
Diet – List what you might eat on a typical day:
_____
_____How is your appetite? _____
How often do you have a bowel movement? _____
What medications or supplements are you currently taking and for what reason?
_____
_____
Do you drink coffee? _____ If so, how many cups per day?_____
Do you drink alcohol? _____If so, how much and how often? _____
Do you smoke? _____ If so, how many cigarettes per day? _____
Do you use recreational drugs? _____ If so, how often? _____
How many cups of water do you drink in a day? _____

Exercise – What is your typical activity in a day?
_____
_____
Are you on a regular exercise program? (type of activity and frequency)
_____
_____

Relaxation – What is your level of personal and occupation related stress?
_____
When you are under stress, what is your most common emotional response? (please check all that apply)
__sadness __anger __worry __anxiety
__depression __ fear

What do you do for relaxation? How often do you actively relax?
_____
_____

How many hours of sleep do you get each night? _____
Do you feel rested when you wake up? _____

Do you have a TV in your bedroom? _____ a computer? _____
Do you work at a computer? _____ Do you use a cellphone? _____

What are your expectations from our work together?
_____
_____
_____

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Mark **current** symptoms **"C"** Mark **past** symptoms **"P"**

General
- ❑ Fatigue
- ❑ Insomnia
- ❑ Disturbed sleep
- ❑ Frequent dreams
- ❑ Excessive sleep
- ❑ Dislike cold
- ❑ Dislike heat
- ❑ Weight loss
- ❑ Weight gain
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Daytime sweating
- ❑ Usually thirsty
- ❑ Seldom thirsty
- ❑ Edema or swelling
- ❑ Other _____

Skin
- ❑ Rashes
- ❑ Hives
- ❑ Dry skin
- ❑ Acne
- ❑ Bruise easily
- ❑ Changes in moles
- ❑ Unusual bleeding
- ❑ Other _____

Head and Neck
- ❑ Headaches (location and type of pain)
- ❑ Dizziness
- ❑ Jaw pain
- ❑ Other _____

Eyes and Ears
- ❑ Failing vision
- ❑ Blurred vision
- ❑ Visual spots
- ❑ Night blindness
- ❑ Eye pain or redness
- ❑ Ringing in the ears
- ❑ Decreased hearing
- ❑ Ear pain/discharge
- ❑ Other _____

Nose, Throat and Mouth
- ❑ Nosebleeds
- ❑ Nasal discharge/ infection
- ❑ Frequent sneezing
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult swallowing
- ❑ Tooth or gum pain
- ❑ Bleeding gums
- ❑ Mouth ulcers
- ❑ Other _____

Muscles and Joints
Pain, weakness or numbness in:
- ❑ Neck/shoulder/arm
- ❑Hips/leg/feet
- ❑Low back & knees
- ❑Muscle cramps
- ❑Body pain
- ❑Heavy limbs
- ❑Swollen joints
- ❑Hot joints

Nervous System
- ❑Fainting
- ❑Paralysis
- ❑Tremors
- ❑Poor balance
- ❑Seizures
- ❑Other _____

Heart, Lungs & Chest
- ❑Palpitations
- ❑Chest pain
- ❑Chest tightness
- ❑Rapid heart beat
- ❑Irregular heart beat
- ❑Swelling of ankles
- ❑Cough
- ❑Dry cough
- ❑Coughing phlegm
- ❑Coughing blood
- ❑Short of breath
- ❑Asthma/wheezing
- ❑Frequent colds
- ❑Pain in rib cage
- ❑Other _____

Mental/Emotional
- ❑Difficult concentrating
- ❑Poor memory
- ❑Worry
- ❑Anxiety
- ❑Depression
- ❑Irritability
- ❑Frustration or anger
- ❑Fearfulness
- ❑Stress
- ❑Other _____

Digestive System
- ❑Nausea
- ❑Vomiting
- ❑Diarrhea
- ❑Constipation
- ❑Loose stools
- ❑Stomach pain
- ❑Abdominal pain
- ❑Poor appetite
- ❑Excessive hunger
- ❑Abdominal bloating
- ❑Belching
- ❑Indigestion
- ❑Acid reflux
- ❑Hemorrhoids
- ❑History of eating disorder

Urinary/Genital
- ❑Painful urination
- ❑Difficult urination
- ❑Frequent daytime
- ❑Nighttime urination
- ❑Incontinence
- ❑Cloudy urine
- ❑Genital pain or itch
- ❑Genital discharge
- ❑Low sex drive
- ❑Excessive sex drive
- ❑History of STD _____

Female
- ❑Irregular periods
- ❑Painful periods
- ❑Spotting
- ❑Passing clots
- ❑Scanty or no periods
- ❑Early periods
- ❑PMS
- ❑Menopausal symptom
- ❑Abnormal PAP smear
- ❑Vaginal discharge
- ❑Breast lump
- ❑Breast pain/discharge
- ❑Other _____

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