Confidential Intake Form

Section A: Personal History

Name: ____________________________________ Today's Date: ________________________________

Address: ___________________________City: _________________ Prov:__________ Postal:________

Home Phone: _______________________Work Phone: _______________________________________

Cellular Phone: ______________________Birth Date: Yr ______ mm ______day _______age _____

Weight:/Height ______ / ______________Occupation: ____

Number of Children ____(Women) ______ Pregnancies: _________________Miscarriages:___________

Marital Status: _______________________Referred to office by: __________________________________

Do you have extended health benefits: ____yes ____no

Are you here because of an injury from car or work related accident: yes ______ no ______

Please give dates of missed work due to the accident or injury:

Date of accident/injury: ________________Work related Injury __________or Car Accident ___________

Section B: Current Health Condition

Purpose of this appointment: ____

Major Complaint: ____

Other Doctors seen for this condition: ____

When did this condition begin?____

Are there others in your family with the same condition?____

Please list your medications: ____

____

____

Do you suffer from any conditions other than that for which you are now consulting us?____________________

____

Section C: Past Health History

List any major operations: ____

List any major accidents/falls: ____

Hospitalization (other than above): ____

Doctor's name and approximate date of last Visit: ____

Have you been treated for any major health condition in the last year: yes ______no ______

If yes, please explain: ____

Does anyone else in your family have the same or similar conditions:____________________________________

____

Check any of the following that you have had:

__pneumonia __pleurisy __tuberculosis __heart disease	__small pox __HIV/AIDS __diabetes __whooping cough	__influenza __polio __cancer __measles	__mumps __chicken pox __anemia __thyroid	__hepatitis __arthritis __lumbago	__rheumatic fever __epilepsy __measles __mental disorder

Daily Intake: coffee_______ tea_______ alcohol_______ cigarettes_______ white sugar_______

Check any of the following you have had in the past six months:

Muscular skeletal code	Gastro-Intestinal code	C-V-R code
__low back pain __pain shoulders __neck pain __arm pain __joint pain/stiffness __walking problems __difficulty chewing __jaw issues __gall bladder issues __abdominal cramps	__poor/excessive appetite __excessive thirst __frequent thirst __vomiting __diarrhea __constipation __hemorrhoids __liver problems __weight problems __gas/bloating __heartburn __black/bloody stool __colitis	__chest pain __short breath __irregular heart beat __heart problems __lung problems/congestion __varicose veins __ankle swelling __stroke __chest pain

Nervous system code	Genito-Urinary code	Male/Female code
__nervousness __numbness __paralysis __dizziness __forgetfulness __confused/depression	__bladder trouble __painful/excessive urination __discolored urine	__menstrual irregularity __menstrual cramping __vaginal pain/infections __breast pain/lumps __prostate/sexual dysfunction __genital herpes

General code	EENT code	Female
__fatigue __loss of sleep __allergies __fever __headaches __stuffed nose	__vision problems __dental problems __sore throat __earaches __hearing difficulty	Are you pregnant? yes___ no___

Habits	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

Please list your vitamin supplements:____
____
____
____

Fees are payable for all services at the time of scheduling the appointment.

Your appointment time is reserved for you. If unable to keep your appointment, please notify us 8 hours in advance.

Failure to do so will result in a missed appointment charge of $50.

Patient or Guardians signature: ______________________________________

Date: ____

Doctor's signature: ____________________

Dr. Ariel Schultz