

PATIENT INTAKE FORM

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (H): _____ (Bus.): _____ (Cell) _____

E-mail: _____

Male: Female: Date of Birth: _____

Occupation: _____ Employed By: _____

Marital Status: _____ Number of children: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Name of Medical Doctor: _____ Phone: _____

How did you hear about us? Radio T.V. Newspaper Website Friends Family
 Other: _____

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.

Health Concerns

What are your main health concerns in order of importance to you?

Vitamins and Supplements

Are you taking any vitamins/ mineral/ herbal supplements? Y N

If yes, what and indicate the total dosage taken in one day (i.e. if you take two tablets of Vitamin C 500mg/day, then the total daily is 1000mg)

Prescription Drugs

List all prescription drugs that you are currently taking. Indicate present dose and how long you have been on each medication.

List all prescription drugs you have taken in the past for longer than six months. Indicate how long you were on each medication.

Family History

Please put an "L" for living and "D" for deceased, and present age or age at the time of death. Please indicate if the family member suffered from any diseases such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies or arthritis.

Relationship	L/D	Age	Diseases Suffered/ Cause of Death
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Father			
Mother			
Brother(s)			
Sister(s)			
Paternal Uncles			
Paternal Aunts			
Maternal Uncles			
Maternal Aunts			

Medical History

List any surgery or injury or cosmetic procedure and when it happened?

Visual Pain Rating Scale

Make a mark (/) along the line which you think represents your current level of pain

No pain at all _____ As bad as it could be

Pain Diagram

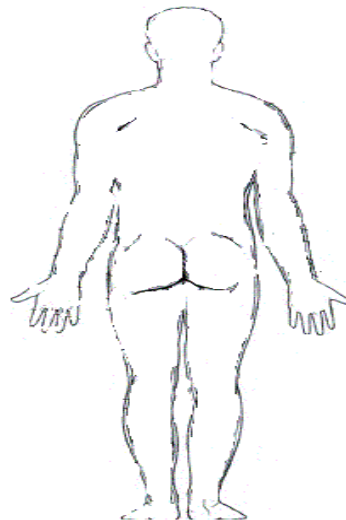
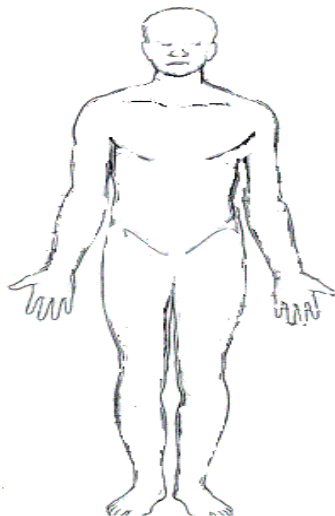
On the following diagrams, indicate all areas of:

Pain - xxxx

Stiffness - ////

Numbness - 0000

Other (Specify) - _____



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Medical History

In the lists below, check all major illnesses that you have experienced.

Measles	Stomach/Duodenum Ulcers	Genital Herpes	Heart Problems
German Measles	Hiatal Hernia	Genital Warts	Heart attack, angina
Chicken Pox	Constipation	Gonorrhea	Palpitation
Mononucleosis	Crohn's Disease	Spleen Disease	Circulation Problems
Mumps	Appendicitis	Hypoglycemia	Varicose Veins
Whooping Cough	Rheumatoid Arthritis	Jaundice	Anemia
Scarlet Fever	Osteoarthritis	Hepatitis	Raynaud's Disease
Polio	Rheumatism	Liver Disease	Platelet Disorders
Reye's Syndrome	Back pain/Sciatica	Pancreatic Disease	Miscarriage
Worms/Parasites	Fibromyalgia	Bladder Problems	Abortion
Cholera	Gout	Prostate Problems	Gestational Diabetes
Malaria	Strep Throat	Diabetes	Uterine Prolapse
Food Poisoning	Sinusitis	Gall Bladder Disease	Pre-eclampsia
Typhoid	Allergies (Environmental)	Eye Problems	Other Pregnancy Related Illness
Diarrhea	Hay Fever	Kidney Problems	Fibrocystic Breast Disease
Acne, Boils, Impetigo	Bronchitis	Cushing's Disease	PMS
Shingles	Pneumonia, Pleurisy	Addison's Disease	Uterine Fibroids
Eczema	Asthma	Hypothyroid	Endometriosis
Keloids	Tuberculosis	Hyperthyroid	Ovarian Cysts
Psoriasis	Malnutrition	Eating Disorder	Vaginitis (recurrent)
Warts	Ricketts	Schizophrenia	Painful Periods
Herpes (cold sores)	Osteoporosis	Bipolar Disease	Infertility
Urticaria	Wilson's Disease	Clinical Depression	Migraine Headaches
Ulcers	Chronic Fatigue Syndrome	Suicidal Tendencies	Dizziness
Skin Cancer	Environmental Illness	Multiple Sclerosis	Numbness
Candida (yeast syndrome)	Human Papillovirus (HPV)	Lupus	Cramps
Irritable Bowel Syndrome	Chlamydia	Myasthenia Gravis	Epilepsy
Colitis	Syphilis	High Blood Pressure	Meningitis
Diverticulitis	HIV	Low Blood Pressure	Cosmetic procedure
Cancer, specify type:	Cancer, specify type:	Fainting	Other:

Vaccinations (please check)

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> Flu Shot |
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella) | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Other _____ |

Did you experience any adverse effects from them? If yes, please explain

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Please check “√” if you are experiencing the following symptoms or write “P” beside the box if you have experienced these symptoms in the past.

General

- Poor/Change in appetite
- Nervousness
- Weight gain
- Weight loss
- Cancer
- Diabetes
- Poor sleep
- Fatigue
- Allergies
- Chills and fevers
- Night sweats
- Sweat easily
- Cravings
- Strong thirst

Skin and Hair

- Rash
- Itching
- Eczema
- Acne
- Loss of hair
- Thinning hair
- Dandruff
- Recent moles
- Dryness
- Hives or allergy reaction
- Boils
- Other skin problem(s)

Eyes Ears Nose Throat

- Ear aches
- Ear infections
- Ringing in ears
- Sinus infections
- Enlarged glands
- Enlarged thyroid
- Recurrent sore throat
- Tonsillitis
- Nasal obstruction
- Post nasal drip
- Nosebleeds
- Headaches
- Loss of taste/smell
- Eye pain
- Eye strain
- Blurry vision
- Vertigo
- Impaired vision
- Cataracts
- Facial pain/tics
- Jaw pain or clicks

- Mercury fillings

- Sores in mouth

Cardiovascular

- High blood pressure
- Low blood pressure
- Congestive heart failure
- Heart attack
- Phlebitis
- Stroke/cardiovascular accident
- Pacemaker or similar device
- Artificial valve
- Irregular heartbeat
- Dizziness
- Fainting
- Chest pain
- Varicose veins
- Cold hands or feet
- Swelling of limbs

Respiratory

- Difficulty breathing
- Chronic cough
- Bronchitis
- Asthma
- Emphysema
- Shortness of breath
- Coughing blood
- Throat phlegm
- Wheezing

Muscle, Bone & Joints

- Neck pain
- Back pain
- Muscle pain
- Muscle weakness
- Arthritis
- Bursitis
- Other pain
- Artificial joint

Gastrointestinal

- Indigestion
- Gas or burping
- Bad breath
- Constipation
- Diarrhea
- Incomplete bowel movements
- Abdominal pain or cramps
- Nausea
- Vomiting

- Chronic laxative use

- Rectal pain

- Hemorrhoids

- Blood in stool

- Constant hunger

- Colon trouble

- Bloating

- Gall bladder trouble

- Intestinal worms

- Jaundice

Neurological

- Loss of balance
- Irritable
- Poor memory
- Anxiety
- Depression
- Dizziness
- Lack of coordination
- Seizures/Epilepsy
- Concussion
- Loss of sensation
- Emotional problems
- Other psychological problem

Infections

- Hepatitis
- Tuberculosis
- HIV/AIDS

Genito-Urinary

- Frequent urination
- Urgency to urinate
- Pain on urination
- Wake up at night to urinate
- Incontinence
- Kidney stones
- Kidney infection
- Blood in urine

Male

- Prostate problem
- Impotence
- Sores on genitals

- Pain
- Infertility/low sperm count
- STD
- Hernia

Female

- Irregular periods
 - Heavy
 - Light
 - Clots

- Painful periods
- Vaginal discharge
- Pregnant
- Infertility
- Vaginal sores
- Sore breasts
- STD
- Date of last Pap _____
- Age of first menses _____
- Menopausal Y N
- Age of last menses _____

- Pregnant Y N
- Do you practice birth control?
Y N Type _____
- Number of:
- pregnancies _____
 - abortions _____
 - miscarriages _____
 - births _____

Personal Habits and Lifestyle

How many cups/bottles/glasses do you drink on average per day?

Coffee		Milk 2%		Fruit Juice	
Tea		Skim Milk		Soft Drinks (diet)	
Water		Beer		Soft Drinks (regular)	
Herbal Tea		Wine		Vegetable Juice	
		Liquor			

What is the source of your drinking water?

Tap (city)		Well		Bottled (spring)		Filtered		Distilled	
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Do you smoke? Y N If yes, how many per day? _____

Do you use recreational drugs? Y N

How frequently do you move your bowels? _____ (# of movements) per day or week?

How many hours of sleep do you get on average? _____

Do you feel refreshed in the morning? Y N

How many hours do you work each day? _____

Do you often feel overworked? Y N

Do you exercise? Y N If yes, How often? _____

What do you do for exercise? (indicate frequency, intensity and duration)

Do you frequently use any of the following? Please check and indicate amount.

- Aspirin
- Laxatives
- Antacids
- Diet pills
- Sleeping pills
- Pain pills

Diet

Diet: Non Vegetarian Vegetarian Vegan For how long? _____

Known Food Allergies/Intolerance:

Known Environmental or Drug Allergies/Sensitivities:

Please describe a typical day's diet

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Physical Activity Readiness Questionnaire (PAR-Q)

- Yes No 1. Has your doctor ever said you have heart trouble and that you should only do physical activity recommended by a doctor?
- Yes No 2. Do you feel pain in your chest when you do physical exercise?
- Yes No 3. In the past month, have you had chest pain when you were not doing physical activity?
- Yes No 4. Do you lose your balance because of dizziness or do you ever lose consciousness?
- Yes No 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- Yes No 6. Is your doctor currently prescribing drugs (e.g. water pills) for your blood pressure or heart condition?
- Yes No 7. Do you know of any other reason why you should not do physical activity?

SIGNATURE

I attest that the information provided is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

*Thank you for taking the time to fill out this questionnaire.
It will help greatly in our study of your present health concerns
and in our understanding of your health goals.
Your responses will assist us in choosing the appropriate treatment that will
bring about your return to optimal health.*