

First Name:	Last Name:	Male/Female
Address:		
City:	Province:	Postal Code:
Phone:		
Email:		
Date of birth:	Age:	
Marital status:	Weight:	Height:
Emergency contact:	Relationship:	Phone:
Referred by:		

Please describe the main reason for your visit today:

Please indicate if you have any of the following:

- Cardiac pacemaker
- Seizure disorder
- Bleeding disorder/ Blood thinners
- Fainting disorders
- High blood pressure
- Believe you are or may be pregnant
- HIV/AIDS positive
- Hepatitis
- Tuberculosis
- Other: _____

List all major childhood and adult illnesses:

Have you had any surgeries, major accidents or injuries, please explain:

List any major disease or illness in your immediate family and indicate family member:

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List all medications or supplements, including herbs and vitamins you are currently taking:

Occupation: _____

Do you have a regular exercise program? _____ Please describe.

Are you on a restricted diet? _____ What kind?

How much sugar/dessert do you eat per week?

How much dairy do you eat per week?

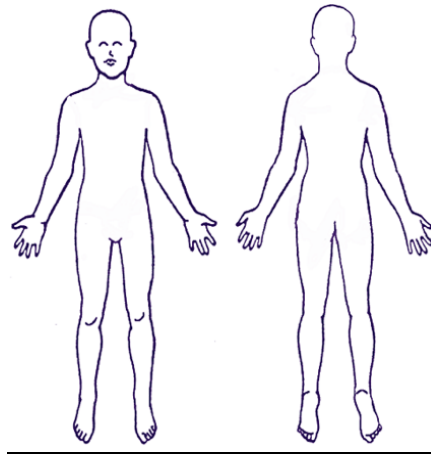
How many packs of cigarettes do you smoke per week?

How much coffee, tea, or cola do you drink per week?

How much alcohol do you drink per week?

Do you do any drugs? How much per week?

Indicate painful areas. Rate on pain scale 1(none)to 10(worst).



PLEASE CHECK ALL SYMPTOMS
THAT PERTAIN TO YOU AT THIS
TIME.

- Cold hands/feet
 - Fatigue
 - Feverish in the afternoon or flushes
 - Heat sensation in hands, feet, chest
 - Night sweats
 - Catch colds easily
 - Sweats easily during daytime
 - Dizziness
 - See floating black spots
-
- Palpitations
 - Sore on tongue
 - Restlessness
 - Anxiety
 - Chest pain
 - Insomnia
-
- Cough
 - Sinus congestion
 - Dry mouth, throat, nose, or skin
 - Allergies seasonal or food
 - Chills and fever
 - Stiff neck/shoulders
 - Sore throat
 - Difficult breathing
-
- Low appetite
 - Loose stools
 - Constipation
 - Abdominal bloating or gas after eating
 - Feeling tired after eating
 - Prolapsed organs (previously diagnosed)
 - Bruises easily
 - General feeling of heaviness in body
 - Mental heaviness or foginess
 - Swollen hands/feet
 - Burning sensation after eating
 - Bad breath
 - Large appetite
 - Mouth, canker or cold sores
 - Bleeding, swollen or painful gums
 - Heartburn/belching
 - Stomach pain
 - Vomiting/nausea
- Diarrhea alternating with constipation
 - Tight/suffocating feeling in chest
 - Bitter taste in mouth
 - Blood shoot eyes/dry eyes
 - Anger easily
 - Skin rashes
 - Headache
 - Numbness of hands and feet
 - Muscle spasms, twitching, cramping
 - Seizures/convulsions
 - Sore, cold or weak knees
 - Low back pain
 - Frequent urination
 - Get up more than once a night to urinate
 - Lack of bladder control
 - Memory problems
 - Hair loss
 - Ringing in ears
- Urine is:
- Normal color Clear
 - Dark yellow Reddish
 - Cloudy Scanty
 - Bad odor
 - Burning Painful
 - Difficult Urgent
- Libido (sex drive) is:
- Normal Low High

WOMEN ONLY:

1. Are you pregnant now?
 Yes No
2. Number of children: _____
3. Number of pregnancies: _____
4. Age of first period: _____
5. Age of menopause if applicable: _____
6. Is your menstrual cycle regular?
 Yes No

A. Average number of days in flow: _____

B. The flow is:
 Normal Heavy Light

C. The color is:
 red dark purple
 light brown brown

D. Do you have the following menstruation related symptoms?

- Blood clots
- Cramps
- Nausea
- Breast distension
- PMS
- Bleeding between periods
- Heavy vaginal discharge between periods

E. Birth control: _____

MEN ONLY:

- Discharge
- Pain or swelling of testicles
- Ejaculatory problems
- Impotence/erectile dysfunction

NOTICE OF PRIVACY POLICIES

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways;

- Information we receive.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.

You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters and appointment reminder, by calls, post cards or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

- Upon written request you have the right to access, review or receive copies of your healthcare records.
- Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
- You have the right to request that we amend your Protected Health Information; the request must be in writing.
- You have a right to receive all notices in writing.

If you have questions or want more information please contact Marie Zanol R.Ac. at telephone: 902-406-9642.

PATIENT SIGNATURE _____

DATE _____