HOLISTIC HEALTH NIAGARA

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ADULT INTAKE Today's Date_____

Full Name_____ Date of Birth_____ Age_____ Sex_____

If you are female, are you pregnant?_____

Address_____ _____

Phone Number_____ Email Address_____

Emergency Contact_____ Relation_____ Phone Number_____

Referred By_____ Marital Status_____ How many children_____

Occupation_____ Do You Like Your Job_____ How many hours of work/week_____

How many weeks of holidays do you take per year_____ Past Job_____

Other Health Care Providers:

1._____ 2._____ 3._____

_____ _____ _____

( )_____ ( )_____ ( )_____

What are your health concerns, in order of importance?

1. _____
2. _____
3. _____
4. _____
5. _____

Do you wear a pace maker? _____ Do you have high blood pressure_____ Do you have epilepsy?_____

Have you had any organs removed? If yes, please describe which organ and approximate date._____

Have you had any organ transplants? If yes which kind and when. _____

Nutritional and Lifestyle

Are you vegetarian?_____ How many meals per day do you have _____ Do you crave certain foods? _____

Do you consume tuna?_____ If so, how often_____ Do you consume alcohol? _____ If so, how often? _____

What kind of water do you drink?_____ How much per day?_____ Do you drink tea or coffee?_____

Please circle if you consume the following: Soy, Corn, Cocoa, Canola Oil, Dairy, Aspartame, Sucralose, MSG, food coloring

Do you use fluoride toothpaste or fluoride treatments? _____

Do you exercise? _____ What forms of exercise and how often? _____

What are your hobbies?_____

Do you wear anti-perspirant? _____ Do you Smoke? _____ How many cigarettes per day? _____

Does anyone in your household smoke?_____ How is your home heated?_____

What kind of shampoo do you use? _____ Do you live near power lines?_____

Do you have animals in the home? Yes____ No____

Have you had any dental work? What kind (fillings, root canal, pulled mercury fillings, implants)?

_____

_____

How would you describe the emotional climate of your home?

_____

Have you experienced emotional or physical trauma? If so when and how?

_____

_____

Please indicate any traumas (emotional or physical), serious conditions, illnesses or injuries and any hospitalizations along with approximate dates:

_____

_____

_____

_____

Do you have any blood disorders, AIDS, HIV, STD's, Hepatitis, TB or any contagious disease? Please circle. Explain.

_____

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

_____

Please list all current medications: _

_____

_____

_____

Please list all current supplements, herbs, homeopathics, etc.:

_____

_____

_____

How many times have you been treated with antibiotics per year_____

Family History

Please indicate what illness run in your family:

Mother_____

Father_____

Siblings_____

Grandparents_____

Informed Consent

This Clinic utilizes the principles and practices of Traditional Chinese Medicine, Holistic Medicine and other supportive therapies which assist the body's own ability to heal and improve quality of life through natural means. Our treatment modalities do not cure symptoms. Our goal is to identify where the stressors are in the body which are contributing to functional disturbances, clear those stressors and assist the body into a restorative state. We focus on the whole person, rather than just the symptom. Holistic Approaches are not designed to replace conventional medical treatments and are encouraged to be brought to your doctor's attention.

Your practitioner will conduct a thorough case history. Additional tests or therapies may be suggested to augment your treatment for optimal results.