# Intake Form

## Contact Information

First Name: _____ Last Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Email: _____

Date of Birth (MM/DD/YYYY): _____ Occupation: _____

Family Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

## Reason for Visit

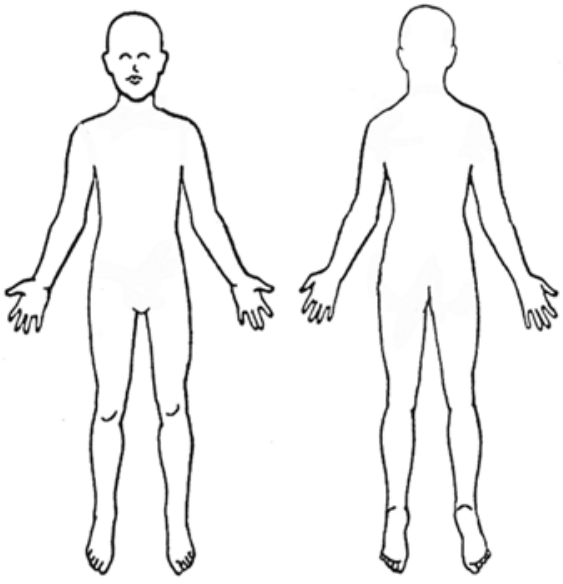
Please describe the main reason for your visit: _____

_____

_____

_____

Indicate painful or distressed areas. Please rate pain on a scale of 1 (mild pain) to 10 (worst pain).



How would you describe your symptoms? Select all that apply.

- ☐ Dull
- ☐ Sharp
- ☐ Aching
- ☐ Tingling
- ☐ Burning
- ☐ Tight / stiff
- ☐ Stabbing
- ☐ Numbness
- ☐ Other: _____

## Health History

Have you had any significant illnesses (childhood or adult)? _____

_____

_____

Have you had any surgeries, major accidents, or significant injuries? _____

_____

_____

Are there any major illnesses in your immediate family? (e.g., parents, siblings) _____

_____

_____

Please list all medications, supplements, vitamins, and herbal products you are currently taking: _____

_____

_____

_____

### Allergies & Sensitivities

Do you have any food allergies or sensitivities? _____

_____

Do certain foods aggravate your symptoms? _____

_____

Do you have any allergies or skin sensitivities to lotions, oils, or scents? _____

_____

### Substances & Stimulants

Caffeine intake: ☐ Low ☐ Moderate ☐ High

Cannabis use: ☐ None ☐ Occasional ☐ Regular

Alcohol use: ☐ None ☐ Occasional ☐ Regular

Substance use: ☐ None ☐ Occasional ☐ Regular

Tobacco use: ☐ None ☐ Occasional ☐ Regular

## Medical Precautions

*Please check any that apply to you. This helps ensure safe and appropriate treatment.*

- ☐ Cardiac pacemaker or implanted electronic device
- ☐ Heart condition (e.g. arrhythmia, heart failure)
- ☐ High blood pressure
- ☐ Seizure disorder / epilepsy
- ☐ History of stroke
- ☐ Fainting / dizziness / syncope
- ☐ Bleeding disorder or taking blood thinners
- ☐ Severe osteoporosis or fragile bones
- ☐ Active cancer treatment
- ☐ History of cancer
- ☐ HIV / AIDS
- ☐ Hepatitis (A, B, or C)
- ☐ Tuberculosis (active or past)
- ☐ Active skin infection or contagious condition
- ☐ Breast implants or other implants
- ☐ Currently pregnant or may be pregnant
- ☐ Other: _____

## Elimination & Reproductive Health

### Urination and Bowel Function

Urination is generally:

☐ Normal ☐ Frequent ☐ Infrequent ☐ Urgent ☐ Difficult

Urine colour is usually:

☐ Light / clear ☐ Pale yellow ☐ Dark yellow ☐ Cloudy ☐ Other: _____

Do you experience any of the following? Check all that apply.

☐ Burning or pain ☐ Difficulty starting urination ☐ Other: _____

☐ Strong odour ☐ Incontinence / leakage

Bowel movements are typically:

☐ Daily ☐ Every 2–3 days ☐ Irregular

Stool consistency is usually:

☐ Formed ☐ Loose ☐ Hard / dry

Do you experience any of the following? (check all that apply)

☐ Constipation ☐ Bloating / gas ☐ Mucus in stool

☐ Diarrhea / loose stools ☐ Pain or discomfort ☐ Other: _____

**Hormonal & Reproductive Health (All Genders)**

Do you experience any hormonal symptoms or concerns? ☐ Yes ☐ No ☐ Unsure

If yes, check all that apply:

☐ Hot flashes
☐ Night sweats
☐ Low libido
☐ Sexual dysfunction or discomfort
☐ Fertility concerns
☐ Hormonal acne or skin changes
☐ Pain, swelling, or discomfort in genital area
☐ Ejaculatory concerns
☐ Unusual discharge
☐ Mood changes related to hormones
☐ Other: _____

**Pregnancy & Postpartum (If Applicable)**

Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure

Are you currently breastfeeding? ☐ Yes ☐ No

Have you been pregnant before? ☐ Yes (specify number of pregnancies) _____ ☐ No

**Menstrual / Cycle Health (If Applicable)**

Do you currently menstruate? ☐ Yes ☐ No

Age at first period: _____

Are your cycles regular? ☐ Yes ☐ No ☐ N/A

Average cycle length (days): _____

Average duration of bleeding (days): _____

Flow is generally:

☐ Light ☐ Moderate ☐ Heavy ☐ N/A

Blood colour is typically:

☐ Bright red ☐ Dark red ☐ Brown ☐ N/A

Cycle-related symptoms (check all that apply):

☐ Cramps
☐ Blood clots
☐ PMS symptoms
☐ Breast tenderness or swelling
☐ Nausea during cycle
☐ Spotting between periods
☐ Heavy or irregular discharge
☐ Other: _____

Are you currently using birth control? ☐ Yes (please specify) _____ ☐ No

## Symptoms Checklist

**Lung & Large Intestine (Breathing, Immunity, Skin & Elimination)**
*This section relates to breathing, immunity, skin health, and bowel function.*

- ☐ Allergies
- ☐ Sinus congestion / sinusitis / frontal headaches
- ☐ Nasal congestion / runny nose / loss of smell
- ☐ Coughing / sneezing
- ☐ Asthma / bronchitis / wheezing / shortness of breath
- ☐ Frequent colds / low immunity
- ☐ Weak voice / throat irritation
- ☐ Skin issues (eczema / psoriasis / rashes / acne)
- ☐ Arm / wrist / elbow pain
- ☐ Shoulder pain
- ☐ Neck stiffness
- ☐ Stiff joints
- ☐ Constipation
- ☐ Loose stools / diarrhea
- ☐ Bloating / gas / flatulence
- ☐ Irritable bowel symptoms
- ☐ Fatigue / low energy
- ☐ Other: _____

**Kidney & Bladder (Energy, Hormones, Urinary System & Lower Body)**
*This section relates to energy levels, urinary health, reproductive health, and lower back/legs.*

- ☐ Low back pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Sciatica
- ☐ Cold hands and feet
- ☐ Fatigue / exhaustion / burnout
- ☐ Dizziness
- ☐ Memory issues
- ☐ Ringing in ears (tinnitus)
- ☐ Hair loss / premature greying
- ☐ Poor libido / sexual dysfunction
- ☐ Fertility concerns
- ☐ Menstrual irregularities
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Edema / swelling / water retention
- ☐ Bladder infections / urinary discomfort
- ☐ Urinary incontinence / urgency
- ☐ Kidney stones
- ☐ Other: _____

**Liver & Gallbladder (Stress, Muscles, Digestion & Cycles)**
*This section relates to stress, muscle tension, digestion, and hormonal cycling.*

- ☐ Headaches / migraines
- ☐ Irritability / anger / mood swings
- ☐ Stress / tension
- ☐ Depression / low mood
- ☐ PMS symptoms
- ☐ Menstrual pain or irregular cycles
- ☐ Breast tenderness
- ☐ Neck and shoulder tightness
- ☐ Muscle tension or spasms
- ☐ Rib / side pain
- ☐ Indigestion / bloating
- ☐ Nausea / vomiting
- ☐ Irritable bowel symptoms
- ☐ Bitter taste in mouth
- ☐ Eye strain / dry or bloodshot eyes / vision changes
- ☐ Seizures / convulsions
- ☐ Gallstones
- ☐ Other: _____

**Heart & Small Intestine (Sleep, Mind, Emotions & Circulation)**
*This section relates to sleep, emotional wellbeing, mental clarity, and circulation.*

- ☐ Anxiety / nervousness / dread
- ☐ Restlessness / agitation
- ☐ Sleep problems / insomnia
- ☐ Excessive dreaming
- ☐ Palpitations / irregular heartbeat
- ☐ Chest discomfort
- ☐ Poor circulation
- ☐ Low mood / lack of joy
- ☐ Difficulty concentrating
- ☐ Speech or tongue issues
- ☐ Hearing issues
- ☐ Upper back / shoulder / elbow / wrist pain
- ☐ Indigestion
- ☐ Hot flashes
- ☐ Other: _____

**Spleen & Stomach (Digestion, Energy Production & Focus)**
*This section relates to digestion, energy, appetite, and mental focus.*

- ☐ Bloating / abdominal distention
- ☐ Appetite changes (low or excessive appetite)
- ☐ Nausea / vomiting
- ☐ Acid reflux / heartburn
- ☐ Indigestion / slow digestion
- ☐ Loose stools / diarrhea
- ☐ Constipation
- ☐ Irritable bowel symptoms
- ☐ Fatigue after eating
- ☐ Muscle weakness
- ☐ Heavy limbs / sluggish feeling
- ☐ Poor concentration / brain fog
- ☐ Worry / overthinking
- ☐ Easy bruising
- ☐ Excessive sweating
- ☐ Hemorrhoids
- ☐ Other: _____