enduraHEALTH

TCM & Acupuncture Intake Form

Suite 333, 1333 8th Street SW Calgary AB T2R 1M6

Name:____ Date:__________________

Address:____

City:__________________ Provence:___________ Postal Code: __________

Telephone (cell): ________________________ Telephone (Home):________________________

Email ___________________. Would you like to receive email reminders? ____ Yes _____ No

Marital status:_________________ Occupation:_________________

Name of physician: _________________(optional) Physician phone:_________________

Emergency Contact: ______________________ Emergency phone:________________

Do you have any significant diseases?

HIV ____, Hepatitis A___, B___, C____, Other____, Please specify____________________

Diabetes___ Hemophilia____ Heart Disease ___ Seizures ___ Tuberculosis ___

Significant Trauma (auto incident/falls, ect))____________________ Fractures ___

Do you have health extended health insurance? _____Yes _______No

___ Great West Life ___ Blue Cross ___Desjardens ___Sunlife ___GreenSheild ___Manuallife ___Other

Other: ____________________ Group ID: ________________ Policy Number: _____________________

How did you hear about EnduraHEALTH

___Website. ___ Advertisement ___ Friend/Relative, Who?______________________

Please indicate if you are under the care of the following with the name & date of the last appointment

Chiropractor: _____________________________ Physio Therapist: ______________________

Massage Therapist:________________________ Naturopathic Doctor:_______________________

Primary Health Concerns:

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PLEASE USE THE DIAGRAM TO SHADE IN THE AREAS WHERE YOU FEEL PAIN OR OTHER SYMPTOMS

Pervious Medical History: (include illnesses, name and dates), surgeries, trauma and childhood Illnesses

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Allergies:____

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Family History of Health Problems:______________________________________

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Current Medications (include Drug Name, Strength, Frequency Taken, Reason and How Long ______

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Current Supplements (include Drug Name, Strength, Frequency Taken, Reason and How Long._____

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Living Environment ____ Dry ___ Damp

Favourite Food and Drink Type: ___ Sour ___ Sweet ____ Salty ____ Greasy _____ Spicy______

Do you drink: ____ Coffee. (No. _____ cups) ____ Cold drinks _____ Warm Drinks

Do you use any of the following? ____ Cigarettes _____ Alcohol ____ Recreational Drugs

What are your major sources of stress?

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______Are you recently in a state of ____ Fear ___ Worry ___ Anger ___ Sadness ___ Anxiety ___ Joy

Please comment on your level of physical exercise: (Type & Frequency)____

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