Robert Lloyd McDonald & Associates
Traditional Chinese Medicine, Acupuncture, and Other Therapies

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INTAKE FORM – NEW PATIENT

Today's Date:_____ Patient's Name:_____

Patient's Address:_____

City:_____ Province:_____ Postal Code:_____

Telephone Home (____)____-_____ Work (____)____-_____ Cell (____)____-_____

Date of Birth:_____ Occupation: _____

What is your reason for seeking treatment? _____

_____

Past Medical History:

Have you or any of your immediate family member ever been told you have:

Cancer [ ] Yes [ ] No [ ] Myself [ ] Family
Diabetes [ ] Yes [ ] No [ ] Myself [ ] Family
Hypoglycemia (low blood sugar) [ ] Yes [ ] No [ ] Myself [ ] Family
Hypertension (high blood pressure) [ ] Yes [ ] No [ ] Myself [ ] Family
Heart disease [ ] Yes [ ] No [ ] Myself [ ] Family
Angina [ ] Yes [ ] No [ ] Myself [ ] Family
Shortness of breath [ ] Yes [ ] No [ ] Myself [ ] Family
Stroke [ ] Yes [ ] No [ ] Myself [ ] Family
Kidney disease / stones [ ] Yes [ ] No [ ] Myself [ ] Family
Urinary tract infection [ ] Yes [ ] No [ ] Myself [ ] Family
Asthma [ ] Yes [ ] No [ ] Myself [ ] Family
Hay fever [ ] Yes [ ] No [ ] Myself [ ] Family
Rheumatic / Scarlet fever [ ] Yes [ ] No [ ] Myself [ ] Family
Hepatitis / Jaundice [ ] Yes [ ] No [ ] Myself [ ] Family
Cirrhosis / Liver disease [ ] Yes [ ] No [ ] Myself [ ] Family

Polio [ ] Yes [ ] No [ ] Myself [ ] Family
Chronic bronchitis [ ] Yes [ ] No [ ] Myself [ ] Family
Pneumonia [ ] Yes [ ] No [ ] Myself [ ] Family
Emphysema [ ] Yes [ ] No [ ] Myself [ ] Family
Tuberculosis [ ] Yes [ ] No [ ] Myself [ ] Family
Migraine headaches [ ] Yes [ ] No [ ] Myself [ ] Family
Anemia [ ] Yes [ ] No [ ] Myself [ ] Family
Ulcers / Stomach problems [ ] Yes [ ] No [ ] Myself [ ] Family
Depression [ ] Yes [ ] No [ ] Myself [ ] Family
Anxiety [ ] Yes [ ] No [ ] Myself [ ] Family
Chemical Dependency (alcohol/drugs) [ ] Yes [ ] No [ ] Myself [ ] Family
Arthritis [ ] Yes [ ] No [ ] Myself [ ] Family
Gout [ ] Yes [ ] No [ ] Myself [ ] Family
Hemophilia [ ] Yes [ ] No [ ] Myself [ ] Family
Slow Healing [ ] Yes [ ] No [ ] Myself [ ] Family
Epilepsy [ ] Yes [ ] No [ ] Myself [ ] Family
Thyroid problems [ ] Yes [ ] No [ ] Myself [ ] Family
Multiple Sclerosis [ ] Yes [ ] No [ ] Myself [ ] Family
Fibromyalgia [ ] Yes [ ] No [ ] Myself [ ] Family

Other :_____

General Health:

1. What medications are you taking? Please list both prescription and over the counter medications.

_____

_____

_____

2. Have you had any illness within the last 3 weeks? (e.g. colds, flu's , infections)

[ ] Yes [ ] No If Yes explain_____

3. Do you smoke or chew tobacco? [ ] Yes [ ] No

4. How much alcohol do you drink in the course of a week?

_____

5. Do you use recreational drugs? If yes, what, how much and how often?

_____

6. How much caffeine do you consume daily? (including soft drinks, coffee, tea and chocolate)_____

7. Are you on any special diet?_____

8. Do you have a pacemaker, organ transplant, joint replacements, or metal implants?

Please list:_____

9. Have you had any medical tests done recently? (i.e. X-rays, CT scans, MRI's, ultrasounds, bone scan etc..)
Please list:_____

10. Have you had any lab work done? If so do you know the results?

_____

11. What surgery have you had done in your life? Please list the year it was done as well.

_____

_____

12. Please list any allergies that you have_____

_____

13. What is your history of injury? (i.e. car accidents, slip and fall, sports injury, etc.)

_____

_____

Clinic Policy:

We require 24-hour notice for cancellation of your appointment. Missed appointments or last minute cancellation will be charged a full fee.

I have filled out the above New Patient Intake form to the best of my knowledge and I have read the clinic policy.

Name:_____ Today's Date:_____

Signature:_____