

Robert McDonald & Associates
Osteopathy, Chinese Medicine, Acupuncture and Massage Therapy

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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:_____