



Lifecycles Wellness

Intake Form
647.428.7200

General Health History

Date: _____

Name: _____ (M)(F) Date of Birth: _____ Age: _____

Address: _____ Postcode _____

Phone (h): _____ (c) _____ e-mail _____

Occupation: _____

Name of Doctor/Specialist: _____ phone: _____

Name of other Health Practitioners: _____

Emergency contact: _____ phone: _____

Referred by: _____

Are you interested in receiving our electronic newsletter and emails about upcoming workshops and events and talks that we are hosting? _____

What is the main condition for which you are seeking treatment?

What is the history of this condition (ie. when did it start, what makes it worse/better? what have you already tried for treatment?)

Previous Medical History:

List any previous **illnesses** including childhood illness or chronic viral infections, any **surgeries**, **traumas** or accidents, even if unrelated to your current condition.

Are there any conditions that are significant in your **family's medical history**?
(eg. heart disease, cancer, stroke, high blood pressure, kidney disease, diabetes, asthma, ulcers, mental/emotional disorders, etc)

Please list any allergies and the reaction you have:

Please be assured that your information is confidential and will be shared only with your practitioners. Please remember to fill out the form most appropriate to your condition in addition to this one. You will find them under "Forms" on the website. lifecycleswellness.com

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Lifestyle:

Diet – List what you might eat on a typical day:

_____ How is your
appetite? _____
How often do you have a bowel movement? _____
What medications or supplements are you currently taking and for what reason?

Do you drink coffee? _____ If so, how many cups per day? _____
Do you drink alcohol? _____ If so, how much and how often? _____
Do you smoke? _____ If so, how many cigarettes per day? _____
Do you use recreational drugs? _____ If so, how often? _____
How many cups of water do you drink in a day? _____

Exercise – What is your typical activity in a day?

Are you on a regular exercise program? (type of activity and frequency)

Relaxation – What is your level of personal and occupation related stress?

When you are under stress, what is your most common emotional response? (please check all that apply)

sadness anger worry anxiety
 depression fear

What do you do for relaxation? How often do you actively relax?

How many hours of sleep do you get each night? _____
Do you feel rested when you wake up? _____

Do you have a TV in your bedroom? _____ a computer? _____
Do you work at a computer? _____ Do you use a cellphone? _____

What are your expectations from our work together?

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Mark **current** symptoms “C”

Mark **past** symptoms “P”

General

- Fatigue
- Insomnia
- Disturbed sleep
- Frequent dreams
- Excessive sleep
- Dislike cold
- Dislike heat
- Weight loss
- Weight gain
- Fever
- Chills
- Night sweats
- Daytime sweating
- Usually thirsty
- Seldom thirsty
- Edema or swelling
- Other _____

Skin

- Rashes
- Hives
- Dry skin
- Acne
- Bruise easily
- Changes in moles
- Unusual bleeding
- Other _____

Head and Neck

- Headaches (location and type of pain)
- Dizziness
- Jaw pain
- Other _____

Eyes and Ears

- Failing vision
- Blurred vision
- Visual spots
- Night blindness
- Eye pain or redness
- Ringing in the ears
- Decreased hearing
- Ear pain/discharge
- Other _____

Nose, Throat and Mouth

- Nosebleeds
- Nasal discharge/infection
- Frequent sneezing
- Sore throat

- Hoarseness
- Difficult swallowing
- Tooth or gum pain
- Bleeding gums
- Mouth ulcers
- Other _____

Muscles and Joints

- Pain, weakness or numbness in:
- Neck/shoulder/arm
 - Hips/leg/feet
 - Low back & knees
 - Muscle cramps
 - Body pain
 - Heavy limbs
 - Swollen joints
 - Hot joints

Nervous System

- Fainting
- Paralysis
- Tremors
- Poor balance
- Seizures
- Other _____

Heart, Lungs & Chest

- Palpitations
- Chest pain
- Chest tightness
- Rapid heart beat
- Irregular heart beat
- Swelling of ankles
- Cough
- Dry cough
- Coughing phlegm
- Coughing blood
- Short of breath
- Asthma/wheezing
- Frequent colds
- Pain in rib cage
- Other _____

Mental/Emotional

- Difficult concentrating
- Poor memory
- Worry
- Anxiety
- Depression
- Irritability
- Frustration or anger
- Fearfulness

- Stress
- Other _____

Digestive System

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Loose stools
- Stomach pain
- Abdominal pain
- Poor appetite
- Excessive hunger
- Abdominal bloating
- Belching
- Indigestion
- Acid reflux
- Hemorrhoids
- History of eating disorder

Urinary/Genital

- Painful urination
- Difficult urination
- Frequent daytime
- Nighttime urination
- Incontinence
- Cloudy urine
- Genital pain or itch
- Genital discharge
- Low sex drive
- Excessive sex drive
- History of STD _____

Female

- Irregular periods
- Painful periods
- Spotting
- Passing clots
- Scanty or no periods
- Early periods
- PMS
- Menopausal symptom
- Abnormal PAP smear
- Vaginal discharge
- Breast lump
- Breast pain/discharge
- Other _____

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