# HILLCREST CENTRE FOR HEALTH

832 St. Clair Ave W. Toronto, ON M6C 1C1 Tel: 416-651-6602 Fax: 416-651-9058


## Adult Intake

Name_____ Date of first visit _____
Date of birth _____ (M/D/Y) Gender M F

Address:_____
_____
_____
_____

E-mail Address:_____

May we add you to our mailing list? (Your email address will not be shared): Y N

Telephone number: Home: _____ Work:_____

May we leave messages relating to your visits? Y N

Emergency contact name:_____
Phone numbers: Daytime: _____ Evening: _____
Relationship:_____

Health Card Number: _____
Insurance Provider and Policy Number: _____

Are you: Married____ Separated____ Divorced_____ Widowed_____ Single_____
Significant Partnership_____
Live With: Spouse____ Partner____ Relatives____ Friends____ Alone____ Parents____

Occupation_____ Hours per wk_____ Retired _____

How did you hear about our Clinic? _____

Other health care providers you are seeing:

| 1. | 2. | 3. |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| Specialty/Focus | Specialty/Focus | Specialty/Focus |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| (___)_____ | (___)_____ | (___)_____ |

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Date of last visit to medical doctor: _____

Are you currently under his/her care? Y N

When were your last screening tests done by other physicians (blood tests, Pap, physical screening tests, etc.)? Please list:

_____

Date of last physical exam: _____

What are your health concerns, in order of importance to you:

1._____

2._____

3._____

4._____

5._____

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, surgeries and any hospitalizations; along with approximate dates.

_____

_____

_____

_____

_____

Have you ever had a blood transfusion? Y N

Do you have any allergies (medicines, environmental, etc.)?

_____

_____

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

| Medication | Dosage/day | Date started |
|---|---|---|
| | | |
| | | |
| | | |

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Please list past prescription medications, including discontinuation dates.

| Medication | Dosage/day | Date finished |
|---|---|---|
| | | |
| | | |
| | | |

How many times have you been treated with antibiotics?_____

Do you frequently use any of the following? (circle)
Aspirin / Laxatives / Antacids / Diet pills / Birth control pills / implants / injections

Alcohol—how much/day or week and type (e.g. beer, wine, liquor)
_____

Tobacco—form and amount/day _____
Are you exposed to second hand smoke? Y N
Have you smoked in the past? Y N Start date? _____ Quit date? _____
Caffeine (coffee, tea, cola, other) —form and amount/day
_____

Recreational drugs—what and how often _____
_____

If you are female, are you currently pregnant? Y N
If no, are you attempting to become pregnant? Y N
If not, list contraceptive or barrier method used: _____

Please indicate what immunizations you have had:

| | | |
|---|---|---|
| ☐ DPT (diphtheria, pertussis, tetanus) | ☐ Haemophilus influenza B | ☐ Hepatitis A |
| ☐ Tetanus booster; when? _____ | ☐ "Flu" | ☐ Hepatitis B |
| ☐ MMR (measles, mumps, rubella) | ☐ Polio | ☐ Smallpox |

Other _____

Please indicate if any caused adverse reactions:

_____

_____

**Diet**

Do you have any food allergies or intolerances? Please list.

_____

_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

**Family history**

Indicate if a close relative (parent, child, sibling) has had any of the following:

| | Who? | | Who? |
|---|---|---|---|
| Allergies | | Depression | |
| Asthma | | Other mental illness | |
| Heart disease | | Drug abuse/alcoholism | |
| High blood pressure | | Kidney disease | |
| Cancer | | Other | |
| Diabetes | | | |

**Environment**

Do you exercise regularly? Y N

What do you do for exercise? How much? How often?

_____

_____

_____

_____

Are you frequently exposed to animals (work, pets, etc.)? Y N

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

_____
_____
_____
_____

How would you describe the emotional climate of your home?

_____
_____
_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____
_____
_____
_____

Is there anything that you feel is important that has not been covered?

_____
_____
_____
_____

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1. Why did you choose to come to this clinic? What do you know about our approach?

2. What three expectations do you have from this visit to our clinic? What long term expectations do you have from working with our clinic? What expectations do you have of me personally as your doctor?

1.

2.

3.

Long term:

Expectations:

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health and in adhering to the therapeutic protocols, which we will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

7. What do you LOVE to do?

**THANK YOU FOR COMPLETING THE FORM! PLEASE BRING THIS WITH YOU ON YOUR FIRST VISIT.**