KLEINBURG
INTEGRATIVE HEALTH

TEL. 905.893.2898
FAX. 1.833.523.2466
RECEPTION@KIHCLINIC.COM

INTRAVENOUS VITAMIN THERAPY INTAKE FORM

Please Complete and Return to Reception

Successful health care and preventive medicine are only possible when the doctor has a complete understanding of their patient physically, mentally, and emotionally. The nature of your responses to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Name: Date:

Address:

City/Postal Code:

Telephone number: Home: Cell:

E-mailAddress:

Keeping appointments are the responsibility of our patients however we do provide courtesy reminders. Would you like us to leave messages relating to your visits? Y / N

What mode of contact would you prefer? Phone Text Email

Age: Date of Birth: Gender: Female / Male

Occupation:

Emergency contact name:

Phone number: Relation:

How did you hear about this Clinic?

If internet: Google:_ OAND website:____ CAND Website:____ Other:

Has any other family member already been a patient at this clinic?

Why did you choose to come to this clinic?

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What do you know or what would you like to learn about the approach?

What *three* expectations do you have from ***this*** initial visit to the clinic?

What ***long term*** expectations do you have from working with this clinic?

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

STRESS

How stressful is your work? 0 = No stress 10 = Highest level of stress:

How stressful are other aspects of your life?

How do you handle these stresses?

CURRENT HEALTHCARE

Are you currently receiving healthcare? Yes / No

If yes, where are from whom? This includes MD's (please include phone and fax number), Physiotherapist, Chiropractor etc.

1.	_____	**2.**	_____	**3.**	_____
	_____		_____		_____
Phone:	_____		_____		_____
Fax:	_____		**(___)**_____		**(___)**_____

Do you get regular screening tests done? Y / N If so, which ones?

If no, when and where did you last receive medical or health care?

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What are your most important health concerns? List as many as you can in order of importance.

1.
2.
3.
4.

Do you have any known contagious disease at this time? Yes / No

If yes, what?

If you are female are you currently pregnant? Yes No (Please circle one)

GENERAL

Height: Weight: Weight one year ago:

Maximum Weight: When:

When during the day is your energy the best: Worst?

Main interests and hobbies:

Exercise: Y / N If so, what kind and how often:

Do you have a religious or spiritual practice? Y / N If so, what kind?

TYPICAL FOOD INTAKE

Briefly describe a typical day's diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages (and total quantity):

FAMILY MEDICAL HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay fever	Hives	

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Any other relevant family history?_____

What is your family heritage?_____

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, ECGs have you had?

_____ year _____ _____ year _____
_____ year _____ _____ year _____
_____ year _____ _____ year _____

ALLERGIES

Are you hypersensitive or allergic to:
Any drugs?
Any foods?
Any environmentals or chemicals?

CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping pills	Thyroid medications
Birth Control Pills	Hormone Replacement		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

1.
2.
3.
4.

Do you think that there is anything else important that has not been covered so far?

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Thank-you for taking the time to fill out this intake form, we look forward to working with you in your journey towards better health.