brio LIVING™

ADULT INTAKE FORM

Date

First name | Last name

Age | Date of birth (mm/dd/yy) | Female/Male

Care Card # | Address

City | Province

Postal code | Email

Phone (home) | Phone (cell)

Status ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Partnership

Live with ◯ Alone ◯ Spouse ◯ Partner ◯ Parents ◯ Children ◯ Friends

Education

Occupation | Hours per week | Retired

Employer

How did you hear about the clinic?

Next of kin or other to reach in an emergency

Relationship | Phone

Address

CANCELLATION POLICY

I understand that I am responsible for paying the cost of the visit, before the next appointment, if I do not give 24 hours notice by phone of change or cancellation. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

CONSENT

I hereby consent to receive treatments by the practitioners at Brio Integrative Health Centre. I understand that this consent is voluntary and may be revoked by me at any time. I authorize the clinic and its associated practitioners to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contacted numbers I have provided.

I consent to receiving ◯ phone calls/messages from Brio ◯ email messages from Brio

Please add me to the newsletter list. ◯ Y ◯ N

Signature | **Date**

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along 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.

Why did you choose to come to this clinic?

What do you know about our approach?

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 physician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Please circle. 0 = not commited,10 = 100% committed)

0% —— 0 1 2 3 4 5 6 7 8 9 10 —— 100%

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

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

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?

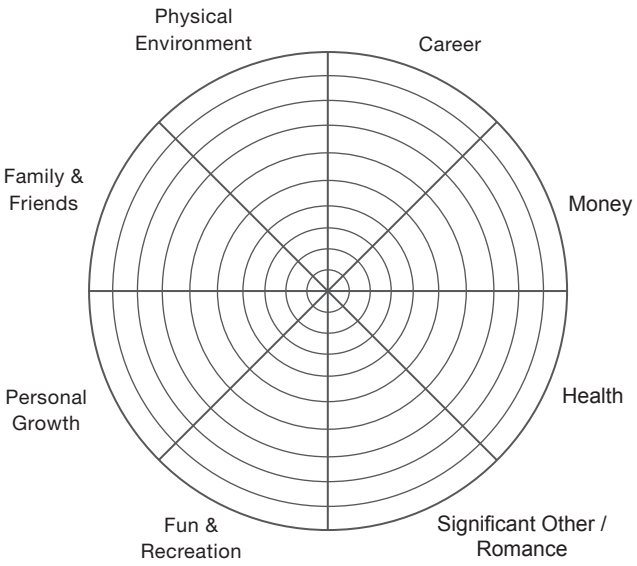
Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

WHEEL OF BALANCE

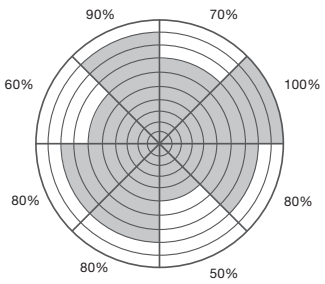
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Example:



Are you currently receiving healthcare? ◯ Y ◯ N

If yes, where and from whom _____

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

What was the reason? _____

_____

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

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you have any known contagious diseases at this time? ◯ Y ◯ N

If yes, what? _____

_____

_____

GENERAL

Height _____ Weight _____ Weight one year ago _____

Max weight _____ When _____ Min. Weight _____ When _____

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

TYPICAL FOOD INTAKE

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

FAMILY HISTORY

Is there a family history of any of the following?

Cancer	◯ Y	◯ N	Diabetes	◯ Y	◯ N	Heart disease	◯ Y	◯ N
Kidney disease	◯ Y	◯ N	Epilepsy	◯ Y	◯ N	High blood pressure	◯ Y	◯ N
Tuberculosis	◯ Y	◯ N	Stroke	◯ Y	◯ N	High cholesterol	◯ Y	◯ N
Asthma/Hay fever/Hives	◯ Y	◯ N	Arthritis	◯ Y	◯ N	Anemia	◯ Y	◯ N
Glaucoma	◯ Y	◯ N	Mental ilness	◯ Y	◯ N			

Any other relevant family history? _____

What is the child's ethnic heritage? _____

CHILDHOOD ILLNESSES

Have you had any of these as a child or as an adult? *Please inidcate age if you have had childhood ilnesses as and adult.*

Scarlet fever	◯ Y	◯ N	Diphtheria	◯ Y	◯ N	Rheumatic fever	◯ Y	◯ N
Mumps	◯ Y	◯ N	Measles	◯ Y	◯ N	German measles	◯ Y	◯ N
Chicken pox	◯ Y	◯ N						

IMMUNIZATIONS

Polio	◯ Y	◯ N		Pertussis	◯ Y	◯ N
Tetanus shot	◯ Y	◯ N	When? _____	Diphtheria	◯ Y	◯ N
Measles/Mumps/Rubella	◯ Y	◯ N		Travel related	◯ Y	◯ N
Any adverse reactions?	◯ Y	◯ N				

If yes, what ? _____

HOSPITALIZATION, SURGERY, IMAGING

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

ALLERGIES

Are you hypersensitive or allergic to any of the following? (please list)

Drugs _____

Foods _____

Environmentals or chemicals _____

CURRENT MEDICATIONS

Laxatives	◯ Y	◯ N	Pain relievers	◯ Y	◯ N	Antacids	◯ Y	◯ N
Cortisone	◯ Y	◯ N	Antibiotics	◯ Y	◯ N	Appetite suppressants	◯ Y	◯ N
Tranquilizers	◯ Y	◯ N	Sleeping pills	◯ Y	◯ N	Thyroid medication	◯ Y	◯ N

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

_____ _____

_____ _____

For the following, please indicate if you believe if any of the following apply to you?

Y = a condition now P = significant problem in the past

HABITS

Main interests and hobbies

_____

_____

_____

____ Do you exercise

If yes, what kind

_____

_____

How often

_____

____ Average 6-8 hrs. sleep

____ Sleep well

____ Awaken rested

____ Enjoy your work

____ Take vacations

____ Spend time outside

____ Watch television

How many hours _____

____ Read

How many hours _____

____ Computer use

How many hours _____

____ Video game use

How many hours _____

____ In a supportive relationship

____ Have a history of abuse

____ Any major traumas

____ Use recreational drugs

____ Treated for drug dependence

____ Use alcoholic beverages

____ Treated for alcoholism

____ Use tobacco

How many packs per day _____

____ Smoked previously

How many years? _____

How many packs per day _____

____ Drink coffee

____ Drink black/green tea

____ Drink cola/other sodas

____ Eat out often

____ Eat 3 meals a day

____ Go on diets often

____ Eat refined sugar

____ Add salt

____ Have a religious or spiritual practice

If yes, what

_____

For the following, please indicate if you believe if any of the following apply to you?
Y = a condition now P = significant problem in the past

REVIEW OF SYSTEMS

MENTAL / EMOTIONAL

____ Treated for emotional problems
____ Depression
____ Mood Swings
____ Anxiety or nervousness
____ Considered/Attempted suicide
____ Tension
____ Poor concentration
____ Memory problems

IMMUNE

____ Reactions to immunizations
____ Reactions to vaccinations
____ Chronic fatigue syndrome
____ Chronic infections
____ Chronically swollen glands
____ Slow wound healing

ENDOCRINE

____ Hypothyroid
____ Heat or cold intolerance
____ Hypoglycemia
____ Diabetes
____ Excessive thirst
____ Excessive hunger
____ Fatigue
____ Seasonal depression

NEUROLOGIC

____ Seizures
____ Paralysis
____ Muscle weakness
____ Numbness or tingling
____ Loss of memory
____ Easily stressed
____ Vertigo or dizziness
____ Loss of balance

SKIN

____ Rashes
____ Eczema, Hives
____ Acne, Boils
____ Itching
____ Color Change
____ Perpetual Hair Loss
____ Lumps
____ Night Sweats

HEAD

____ Headaches
____ Head Injury
____ Migraines
____ Jaw/TMJ problems

EYES

____ Spots in Eyes
____ Cataracts
____ Impaired vision
____ Glasses or contacts
____ Blurriness
____ Eye pain/strain
____ Color blindness
____ Tearing or dryness
____ Double Vision
____ Glaucoma

EARS

____ Impaired hearing
____ Ringing
____ Earaches
____ Dizziness

NOSE AND SINUSES

____ Frequent colds
____ Nose Bleeds
____ Stuffiness
____ Hayfever
____ Sinus problems
____ Loss of smell

MOUTH AND THROAT

____ Frequent sore throat
____ Copious saliva
____ Teeth grinding
____ Sore tongue/lips
____ Gum problems
____ Hoarseness
____ Dental cavities
____ Jaw clicks

For the following, please indicate if you believe if any of the following apply to you?
Y = a condition now P = significant problem in the past

NECK

- ____ Lumps
- ____ Swollen glands
- ____ Goiter
- ____ Pain or stiffness

RESPIRATORY

- ____ Cough
- ____ Sputum
- ____ Spitting up blood
- ____ Wheezing
- ____ Asthma
- ____ Bronchitis
- ____ Pneumonia
- ____ Pleurisy
- ____ Emphysema
- ____ Difficulty breathing
- ____ Pain on breathing
- ____ Shortness of breath
- ____ Shortness of breath at night
- ____ Shortness of breath lying down
- ____ Tuberculosis

CARDIOVASCULAR

- ____ Heart disease
- ____ Angina
- ____ High/Low Blood Pressure
- ____ Murmurs
- ____ Blood clots
- ____ Fainting
- ____ Phlebitis
- ____ Palpitations/Fluttering
- ____ Rheumatic Fever
- ____ Chest pain
- ____ Swelling in ankles

GASTROINTESTINAL

- ____ Trouble swallowing
- ____ Heartburn
- ____ Change in thirst
- ____ Abdominal pain or cramps
- ____ Change in appetite
- ____ Belching or passing gas
- ____ Nausea/vomiting
- ____ Constipation
- ____ Ulcer
- ____ Diarrhea
- ____ Jaundice (yellow skin)
- ____ Bowel Movements
  How often? _____
  Is this a change? _____
- ____ Gall Bladder disease
- ____ Liver Disease
- ____ Black stools
- ____ Hemorrhoids
- ____ Blood in stool

URINARY

- ____ Pain on urination
- ____ Increased frequency
- ____ Frequency at night
- ____ Inability to hold urine
- ____ Frequent infections
- ____ Kidney stones

MUSCULOSKELETAL

- ____ Joint pain or stiffness
- ____ Arthritis
- ____ Broken bones
- ____ Weakness
- ____ Muscle spasms or cramps
- ____ Sciatica

BLOOD / PERIPHERAL VASCULAR

- ____ Easy bleeding or bruising
- ____ Anemia
- ____ Deep leg pain
- ____ Cold hands/feet
- ____ Varicose veins
- ____ Thrombophlebitis

MALE REPRODUCTION

- ____ Hernias
- ____ Testicular masses
- ____ Testicular pain
- ____ Prostate disease
- ____ Venereal disease
- ____ Discharge or sores
- ____ Are you sexually active
- ____ # of children _____
- ____ Chlamydia
- ____ Sexual orientation _____
- ____ Gonorrhea
- ____ Impotence
- ____ Condyloma
- ____ Premature ejaculation
- ____ Herpes
- ____ Birth control
  Type _____
- ____ Syphilis

For the following, please indicate if you believe if any of the following apply to you?
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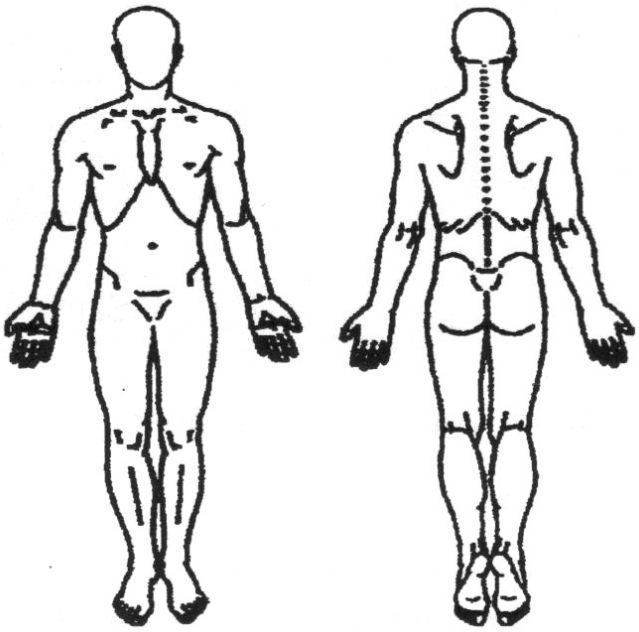
FEMALE REPRODUCTION / BREASTS

Age of first menses _____
Date of last annual exam/ PAP
_____
Age of last menses? (if menopausal)
_____
____ Are cycles regular?
Length of cycle? _____
____ Bleeding between cycles
Duration of menses (in days) _____
____ Painful menses
____ Heavy or excessive flow
____ PMS
If yes, what are your symptoms
_____
_____

____ Clotting
____ Discharge
____ Pain during intercourse
____ Birth control
____ What type
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
____ Endometriosis
____ Ovarian cysts
____ Difficulty conceiving
____ Cervical Dysplasia

____ Sexual difficulties
____ Menopausal symptoms
____ Abnormal PAP
____ Chlamydia
____ Gonorrhea
____ Condyloma
____ HerpesSyphilis
____ Are you sexually active
Sexual orientation _____
____ Do you do breast self exams
____ Breast lumps
____ Breast pain/tenderness
____ Nipple discharge

Please indicate painful or distressed areas. Please circle location(s) on picture.



Is there anything else you would like to add or comment on?

Welcome! Our team looks forward to providing you with the best possible care.