Synthera THERAPEUTICS

INTAKE FORM

All information contained in this questionnaire is strictly confidential and will become part of your medical record.

TODAY'S DATE (DD/MM/YYY):

NAME (Last, First, Middle):

◯ Male ◯ Female

DATE OF BIRTH (DD/MM/YYYY):

MARITAL STATUS: ◯ Single ◯ Partnered/Common-Law ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

ADDRESS: (Street)

CITY/PROVINCE:

POSTAL CODE:

TELEPHONE: **(Home)** **(Business/Work)** **(Cellular)**

EMAIL:

OCCUPATION:

EMPLOYER:

Do you have extended healthcare benefits? ◯ Yes ◯ No

Provider:

FAMILY PHYSICIAN:

DATE OF LAST VISIT (DD/MM/YYYY):

DATE OF LAST PHYSICAL EXAM (DD/MM/YYYY):

EMERGENCY CONTACT

Name:

Phone Number:

How did you hear about us? ◯ Friend ◯ Massage Therapist ◯ M.D./N.D./Dentist ◯ Website ◯ Newsletter ◯ Other _____

CURRENT HEALTH INFORMATION

List the condition(s) for which you are seeking treatment at this clinic:

1.

2.

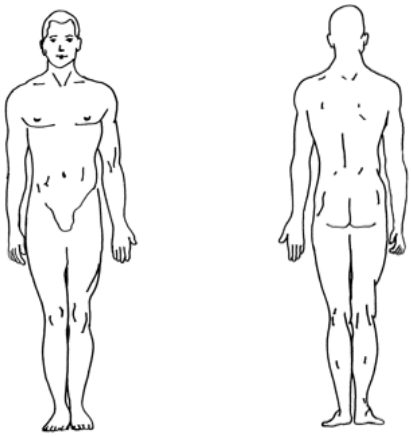
3.

4.

5.

6.

On the diagrams below, please specify the areas where you are experiencing symptoms and/or pain:



Please indicate the nature of your symptoms/pain using the following codes:

A – achy
B – boring
C – cold
D - deep
DU – dull
H – hot
N – numb
S – sharp
SU - superficial
T – tingling
TW – twisting
O – other: _____
_____
_____

Please rate the severity of your symptoms(s)/pain:

AM: (none) – 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 – (severe)

PM: (none) – 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 – (severe)

HEALTH HISTORY

Please list any serious illnesses, surgeries, or traumatic events or injuries (including childhood to the present day):	Year/Age	Recovery?
		◯ Full ◯ Partial
		◯ Full ◯ Partial
		◯ Full ◯ Partial
		◯ Full ◯ Partial
		◯ Full ◯ Partial
		◯ Full ◯ Partial
		◯ Full ◯ Partial

Have you ever received a blood transfusion? ◯ Yes ◯ No If yes, when?

Please list any medical conditions that have been diagnosed by your medical doctor(s):	Year diagnosed

MEDICATIONS & SUPPLEMENTS

Please list all prescription, over-the-counter, and recreational drugs, herbal and nutritional supplements you are currently taking

Name	Dosage/Frequency	Duration of Usage	Reason for Use

ALLERGIES & SENSITIVITIES

Please list any drug, food, or environmental allergy or sensitivity:	Confirmed	Describe Reaction

Are you allergic or sensitive to nickel or other metals? ◯ Yes ◯ No

OTHER HEALTH CONCERNS

Do you have or have you had any problems in the following areas to a significant degree? Briefly explain.

◯ Skin / Hair	◯ Circulation	Have you noticed any recent changes in your:
◯ Head	◯ Back	◯ Weight
◯ Neck	◯ Abdominal	◯ Energy levels
◯ Ears / Eyes	◯ Digestion	◯ Sleep
◯ Nose	◯ Intestinal / Bowel	◯ Other:
◯ Throat	◯ Urinary bladder	
◯ Lungs / Breathing	◯ Concentration	
◯ Chest / Heart	◯ Emotional state / Mood	