CHILLIWACK MOUNTAIN MEDICAL ADULT INTAKE FORM

TODAY'S DATE _____/_____/_____ BIRTHDATE _____/_____/_____ AGE: _____
MM DD YYYY MM DD YYYY

FULL NAME _____ PREFERRED NAME _____

GENDER _____ PREFERRED PRONOUNS _____ MARITAL STATUS _____ CARE CARD #_____

ADDRESS _____ CITY _____ POSTAL CODE _____

HOME PHONE _____CELL PHONE _____ EMAIL ADDRESS_____

PREFERRED PHARMACY _____

EMERGENCY CONTACT NAME _____ PHONE _____ RELATIONSHIP _____

PREVIOUS FAMILY PHYSICIAN _____CHIROPRACTOR _____ SPECIALIST _____

WHO REFERRED YOU TO THIS OFFICE? _____

PRESENT HEALTH PROBLEMS: LIST YOUR MAIN HEALTH CONCERNS

1) _____ 2) _____ 3) _____

WHAT TREATMENTS HAVE BEEN TRIED? _____

MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING (CHECK)

__ ANEMIA	__ RHEUMATIC FEVER	__ HEART ATTACK
__ HEPATITIS/LIVER DISEASE	__ KIDNEY STONES	__ HIGH BLOOD PRESSURE
__ HAYFEVER	__ ASTHMA	__ PNEUMONIA
__ TUBERCULOSIS	__ CANCER OF _____	__ BLADDER/VAGINAL INFEC.
__ STOMACH ULCER	__ MIGRAINE/HEADACHES	__ ABNORMAL PAP TEST
__ MEASLES	__ MUMPS	__ PROSTATE PROBLEMS
__ COLITIS	__ ARTHRITIS/RHEUMATISM	__ BLEEDING TENDENCIES
__ BLOOD CLOTS	__ HIVES	__ MONOUCLEOSIS
__ GALLBLADDER PROBLEMS	__ THYROID PROBLEMS	__ SEXUALLY TRANSMITTED
__ ANGINA/CHEST PAIN	__ HEART DISEASE	INFECTION (STI)
__ POLIO	__ DIABETES	__ ECZEMA
__ STROKE	__ MENTAL DISORDER:	__ EATING DISORDER
__ EPILEPSY	_____	__ DEPRESSION
__ SMOKER (Y OR N)	__ ALCOHOL/DRUG ABUSE	

SURGERIES (YEAR & TYPE) _____

_____

_____

HOSPITALIZATIONS (YEAR & REASON) _____

_____

_____

INJURIES/ACCIDENTS (YEAR & CAUSE) _____

_____

OTHER CONDITIONS _____

FAMILY HISTORY: INCLUDE BLOOD RELATIVES ONLY

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING? (CHECK)

__ DIABETES
__ GOUT
__ COLITIS
__ STROKE
__ GALLBLADDER PROBLEMS
__ NERVOUS BREAKDOWN
__ BLEEDING TENDENCIES
__ HEART DISEASE
__ ALLERGIES
__ KIDNEY DISEASE
__ ALLERGIES
__ ALCOHOLISM
__ TUBERCULOSIS
__ PSYCHIATRIC ILLNESS
__ HIGH BLOOD PRESSURE
__ STOMACH ULCERS
__ ASTHMA
__ ARTHRITIS
__ CANCER

WCB ACTIVE CLAIM ONLY

DATE OF LOSS: _____

CLAIM #: _____

ICBC ACTIVE CLAIM ONLY

DATE OF LOSS: _____

CLAIM #: _____

WOMEN ONLY

NUMBER OF CHILDREN ____ AGES _____

NUMBER OF PREGNANCIES _____

NUMBER OF DELIVERIES _____

MISCARRIAGES __ ACCIDENTAL __ INDUCED ___

COMPLICATIONS _____

BIRTH CONTROL METHODS

IN THE PAST _____

NOW _____

ARE YOU PREGNANT AT THIS TIME? __ YES __TRYING __NO

KNOWN ALLERGIES (include medicines, pollens, animals, foods & chemicals): _____

_____

_____

_____

CURRENT MEDICATIONS (list **all** prescription & over the counter medicines, vitamins, minerals, herbs that you take): _____

_____

_____

_____