WELCOME TO APPLEBY TOTAL HEALTH

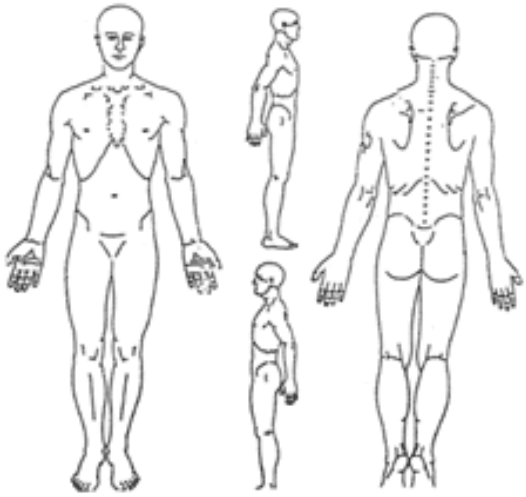
PATIENT INTAKE FORM

Date:	**Name:**	
Address:	**City:**	**Postal Code:**
Phone: (H)	**(C)**	**(W)**
Date of Birth:	**Occupation:**	
Email Address:	**Would you like email reminders? Y / N**	
Emergency Contact:	**Phone:**	
Family Doctor:	**Phone:**	**How did you hear about us?**

What is the present complaint? _____

Please mark the location of your pain or symptoms on the diagram. Use the following to describe your symptoms:

A: Ache B: Burning S: Sharp/Stabbing N: Numb P: Pins and Needles O: Other



When did your symptoms begin? □ Recent Onset □ Chronic □ Recurring problem

Describe what happened? _____

_____

Is this a reported work related injury (WSIB)? □No □Yes

Is this complaint a result of a motor vehicle accident? □No □Yes

How severe is the pain? **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

No Pain **Mild** **Moderate** **Severe** **Excruciating**

Does the condition interfere with: □ Daily life □ Sleep □ Work □ Sports

What relieves your symptoms? □ Rest □ Ice □ Heat □ Stretching □ Exercise □ Medication □ Treatment
Other: _____

What aggravates your symptoms? □ Rest □ Desk work □ Driving □ Walking □ Exercise □ Standing □ Bending
Other:_____

Have you been given a medical diagnosis?_____

Have you had any treatment for the present complaint? _____

Have you had any tests? □ X-Ray □ Ultrasound □ MRI/CT scan □EMG □ Blood work □ Other: _____

Medical History

Please list any medication you are currently taking: _____
_____

Please list dates and description of any accidents, fractures or hospitalizations:_____
_____
_____

Please check the following conditions or symptoms that apply to you:

□ Headaches
□ Neck pain
□ Low back pain
□ Hip pain
□ Knee pain
□ Foot pain
□ Shoulder pain
□ Elbow pain
□ Wrist pain
□ Jaw pain
□ Tendonitis
□ Bursitis
□ Spasms/Cramps
□ Osteoporosis
□ Scoliosis
□ Osteoarthritis
□ Rheumatoid Arthritis
□ Lupus
□ Fibromyalgia

□ Dizziness
□ Fainting
□ Fatigue
□ Shortness of breath
□ Cold hands/feet
□ Swollen ankles
□ Varicose veins
□ Diabetes
□ Low blood pressure
□ High blood pressure
□ High cholesterol
□ Acid reflux
□ Indigestion
□ Constipation
□ Diarrhea
□ IBS
□ Celiac Disease
□ Crohn's Disease
□ Colitis

□ Chronic fatigue
□ Numbness/tingling
□ Sleep difficulty / Insomnia
□ Epilepsy
□ Parkinson's Disease
□ Heart Disease / Pacemaker
□ Angina
□ Blood clots
□ Stroke / TIA
□ Asthma / Chronic bronchitis
□ Allergies
□ Weight loss / gain
□ Thyroid disease
□ Kidney disease
□ Liver disease
□ Skin problems
□ Depression
□Loss of appetite
□ Other: