Integrated Health Clinic™

working together for your health FORT LANGLEY, BC

Patient Intake Sheet

Name: ……………………………………………………………

Date: ……………………………

GP: ……………………………………………………………

ND:……………………………………………………………

PAIN HISTORY:

Describe when and how your chronic pain started: ……………………………………………

……………………………………………………………………………………………………

Briefly describe your pain story: ……………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Past pain treatments included ……………………………………………………………

……………………………………………………………………………………………………

Current pain treatments include ……………………………………………………………

……………………………………………………………………………………………………

TRAUMA HISTORY:

Describe any motor vehicle accident injuries with year(s) and recovery: ……………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Describe any head injuries with year and recovery: ………………………………………

……………………………………………………………………………………………………

Describe any other significant injuries with year and recovery: ……………………………

……………………………………………………………………………………………………

MEDICAL HISTORY:

Current Medical Conditions include ………………………………………………………

……………………………………………………………………………………………………

Other Past Medical Conditions include ……………………………………………………

……………………………………………………………………………………………………

Past Surgical Procedures include …………………………………………………………

……………………………………………………………………………………………………

Medications taken ………………………………………………………………………………

……………………………………………………………………………………………………

Supplements taken ……………………………………………………………………………

Allergies to Medications include ……………………………………………………………………...

Family Pain History includes: ……………………………………………………………………...
………
Other ongoing symptoms include ………………………………………………………………….
………

CHILDHOOD HISTORY:
Briefly summarise your childhood experience: ………….……………………………………..
………
Describe Your Personality: ……………………………………………………………………………
Parents' Personalities were …………………………………………………..………………...
Brothers' / Sisters' Personalities were ……………………………………………………………

SOCIAL HISTORY:
Employed: Yes No If yes: What is your occupation? ………………………………
On Disability: Yes No If yes: How long? ………………………………………………
Marital Status: ……………….. Number of Children? …………………..
Exercise: Yes No If yes: Describe: ………………………………………………….
Smoker: Yes No. If yes, per day: ………. Alcohol drinks per week ……………..
Marijuana: Yes No If yes: Joints per Day/Week/Month (Circle one with #)……….
Other Street Drugs: Yes No If yes: Which and how often? ……………………………

PSYCHOLOGICAL - SPIRITUAL HISTORY:
How are you feeling today? ……………………………………………………………………..
Do you have anxiety / depression / bipolar / other mental health conditions? Yes No
If Yes: Which ones? ....
If not listed: Which ones? ……………………………………………………………………

Do you have inner drives to be perfect / good in life / a people pleaser?
If Yes: Which ones? ....
Do you have any others? ……………………………………………………………………

Do you have life stressors affecting your life right now?
If yes: Which: Illness / Money / Relationships / Future / Family / ……………………..
Others: ……………………………………………………………………………...

Are you spiritual? Yes NoIf yes: What is your spiritual practice? ………………………...
………………………………………………………………………………………………………...
Are you associated with a formal religion? Yes No If yes: Which one? ..…………..