Dr. Halldorson, ND

Adult New Patient Medical Intake Form

Last name:_____ First name:_____

Age_____ Date of Birth:_____ Gender: □ M □ F □ Other

Personal Health Number: _____

Address: _____

City: _____ Province:_____ Postal Code:_____

Telephone: (Primary)_____ (Secondary)_____

Occupation: _____ Marital Status:_____

Email Address:_____

How did you hear about Dr. Halldorson?_____

Would you like to receive our newsletter via email? □ Yes □ No

Emergency Contact Person:

Name: _____Relation: _____ Phone: _____

If under the age of 18, please list the contact information of your legal guardian:

Name: _____Relation: _____ Phone: _____

Contact Information for your other Health Care Provider(s):

Name: _____Profession: _____ Phone: _____

Name: _____Profession: _____ Phone: _____

Name: _____Profession: _____ Phone: _____

Please List your Health Goal(s):

_____

_____

_____

Please list any **medications** (with dose) you are taking:

_____

_____

_____

_____

Please list any **supplements** (with dose) you are taking:

Please list any known **allergies**:

Please list and date any **hospitalizations**, **serious injuries/conditions**, and/or **surgeries**:

Please describe your **average daily** diet:

Morning	Afternoon	Evening

Family Medical History:

□ Alcoholism	□ Eating Disorder	□ Liver Disease
□ Asthma	□ Epilepsy	□ Mental Disease
□ Anxiety	□ Allergies	□ Neurologic Disorder
□ Arthritis	□ Heart Disease	□ Obesity
□ Cancer	□ Herpes	□ Substance Abuse
□ Diabetes	□ High Blood Pressure	□ Thyroid Problems
□ Depression	□ Kidney Disease	□ Other:_____

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Personal Medical History (Past or Present)

General
Current Weight:_____
Weight last year:_____
Height:_____
□ Night Sweats
□ Fatigue
□ Sleep Disturbances
□ Stress
□ Exposure to toxic chemicals
□ Tobacco use
□ Recreational Drug Use
□ Alcoholism

Skin
□ Rashes/hives
□ Infections/fungus
□ Dryness/scaling
□ Hair/nail changes
□ Moles/growth
□ Other:_____

Head
□ Headaches/Migraine
□ Head injury
□ Other:_____

Mouth & throat
□ Sore throat/hoarseness
□ Mouth sores/Gum problems
□ Dental problems
□ Root canals
□ Silver/mercury fillings
□ Loss of taste
□ Other:_____

Nose/Sinuses
□ Sinus Problems/congestion
□ Nosebleeds
□ Loss of smell
□ Frequent colds
□ Hay fever

Eyes/Ears
□ Change in vision
□ Red/itchy eyes
□ Eye pain, tearing or dryness
□ Loss of hearing
□ Ringing in ears
□ Ear infections
□ Other:_____

Respiratory
□ Cough
□ Difficulty breathing
□ Shortness of breath
□ Asthma
□ Bronchitis
□ Tuberculosis
□ Other:_____

Cardiovascular
□ Heart attack/angina
□ Abnormal blood pressure
□ Stroke
□ Murmurs
□ Chest pain
□ Ankle swelling
□ Palpitations/Irregular beat
□ Poor circulation
□ Other:_____

Blood
Blood type: □ A □ B □ AB □ O
Rh Status: □ Positive □ Negative
□ Anemia
□ Easy bruising/bleeding
□ Clotting/thrombosis/DVT
□ Other:_____

Endocrine
□ Thyroid condition
□ Hot or cold intolerance
□ Blood sugar irregularities/diabetes
□ Easy weight gain

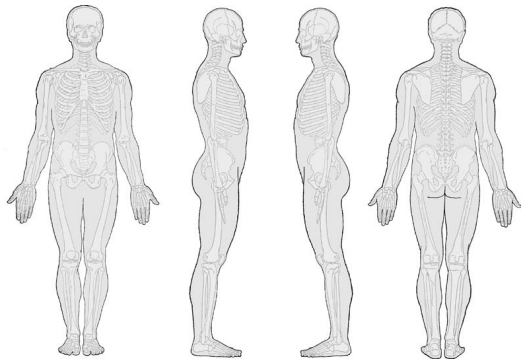
Digestion
□ Constipation
□ Diarrhea
□ Trouble swallowing
□ Heartburn
□ Abdominal pain
□ Parasites

□ Change in thirst/appetite
□ Nausea/Vomiting
□ Blood/mucus in stool
□ Diverticulosis
□ Gas/bloating
□ Gall bladder disease
□ Liver disease/jaundice
□ Hemorrhoids
□ Eating disorder
□ Other:_____

Neurologic
□ Fainting/seizure
□ Numbness/tingling/paralysis
□ Memory loss
□ Dizziness
□ Other:_____

Emotional
□ Depression
□ Mood disorder
□ Anxiety
□ Other:_____

Musculoskeletal
□ Joint Pain/Stiffness
□ Broken bones
□ Cramps/Spasms/weakness
□ Other:_____
Please Mark areas of Pain on Diagram



Urinary
□ Painful urination
□ Excessive urination
□ Frequency urination
□ Incontinence
□ Bladder/Kidney infection
□ Other:_____

For female patients
Pregnant □ Yes □ No □ Unsure
#of Pregnancies: _____
# of Miscarriages/Abortions:_____
Date of last Pap:_____
Date of Last Period:_____
Days of Flow:_____
Length of cycle:_____
□ Attempting conception
□ Infertility
□ History of Abnormal Pap(s)
□ Hysterectomy
□ Abnormal discharge
□ Sexual difficulties
□ Low libidos
□ Breast lump/tenderness
□ Nipple discharge
□ Sexually Transmitted Infections
□ *Menopausal (skip rest of section)*
□ Bleeding between cycles
□ Menstrual cramps
□ Excess flow
□ PMS
□ Other:_____

For male patients
□ Hernia
□ Testicular Pain
□ Sexual difficulties
□ Erectile difficulties
□ Prostate problems
□ Sexually Transmitted Infections
□ Abnormal discharge
□ Sores
□ Difficulty starting/stopping urination
□ Decreased flow/force of urination
□ Nipple discharge
□ Other:_____