NEW PATIENT INTAKE FORM – ADULT

PERSONAL INFORMATION

Full Name: AHC#:

Phone Number: Date of Birth: / /

Home Address: Occupation:

City: Province: Postal Code:

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Say

Emergency Contact Name: Relationship: Phone:

REASON FOR SEEKING CARE

What brings you into our office?

How long has this been present? ☐ Recent ☐ Weeks ☐ Months ☐ Years

Have you experienced this before? ☐ Yes ☐ No

GOALS

What are your goals for your health, and care?

☐ Pain relief ☐ Improved movement/posture ☐ Better sleep

☐ Increased energy ☐ Nervous system regulation ☐ Long-term wellness

Other:

HEALTH HISTORY

Previous injuries (car accidents, sports, falls, etc.):

Surgeries or hospitalizations:

Current medications/supplements:

Other healthcare providers you are currently seeing:

DAILY FUNCTION & LIFESTYLE

Activity Level: ☐ Sedentary ☐ Moderate ☐ Active ☐ Athlete

Current activities/exercise:

_____

_____

SLEEP & ENERGY

Hours of sleep per night: _____

Sleep quality: ☐ Restful ☐ Interrupted ☐ Poor

STRESS LEVELS

Stress at home: ☐ Low ☐ Moderate ☐ High

Stress at work: ☐ Low ☐ Moderate ☐ High

NUTRITIONAL HABITS

Meals per day: ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Breakfast: ☐ Consistent ☐ Occasional ☐ Skipped

Lunch: ☐ Consistent ☐ Occasional ☐ Skipped

Dinner: ☐ Consistent ☐ Occasional ☐ Skipped

NUTRIENT INTAKE

Carbohydrates: ☐ Low ☐ Moderate ☐ High

Protein: ☐ Low ☐ Moderate ☐ High

Fats: ☐ Low ☐ Moderate ☐ High

Sugars: ☐ Low ☐ Moderate ☐ High

Water Intake: ☐ Low ☐ Moderate ☐ High

Gluten intake: ☐ Low ☐ Moderate ☐ High

Dairy intake: ☐ Low ☐ Moderate ☐ High

High processed foods: ☐ Low ☐ Moderate ☐ High

Alcohol: ☐ None ☐ Occasional ☐ Frequent

Recreational Drugs: ☐ None ☐ Occasional ☐ Frequent

Smoking/Vaping: ☐ None ☐ Occasional ☐ Frequent

FINAL NOTES

Is there anything else you would like us to know about your health or intentions?