maxum health clinic
Maximizing health

Maxum Health Clinic
Unit 307
385 Silver Star Blvd
Scarborough, ON
M1V 0E3

# Adult Intake Form

## Patient Information

Date ______________________________
Name ______________________________
Address ______________________________
______________________________
Age __________ DOB ________________
Phone ______________________________
Email ______________________________
May we contact you by email? Yes No

**Emergency Contact:**
Name ______________________________
Relation ______________________________
Phone ______________________________

**Personal Details:**

**Occupation** ______________________________
**Marital Status** ______________________________
**Family Doctor** ______________________________

## Health History

What are your primary health concerns or treatment goals?
1) ______________________________
2) ______________________________
3) ______________________________

Please list any current medications or supplements you may be taking:
______________________________
______________________________
______________________________

Please list any previous hospitalizations, surgeries, or significant illnesses:
______________________________
______________________________

General Diet:
Vegetarian Vegan Omnivore Other

Please check any conditions that have occurred in family members:

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Cardiovascular Disease
- ❑ Cancer
- ❑ Mental Health Conditions

Other ______________________________

Please check any conditions you have, or have had in the past:

- ❑ Anemia
- ❑ Allergies or sensitivities: ____________________
- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ HIV
- ❑ Hepatitis
- ❑ Mental Health Conditions: ____________________

Please check any general symptoms you have experienced in the past year:

- ❑ Notable weight loss or gain
- ❑ Irritability
- ❑ Nervousness or anxiety
- ❑ Excessive Fear
- ❑ Excessive Anger
- ❑ Excessive Worry
- ❑ Excessive Joy
- ❑ Feelings of Sadness or Depression
- ❑ Feeling Overwhelmed
- ❑ Easily Startled
- ❑ Headaches / Migraines
- ❑ Notable Hair Loss
- ❑ Fatigue
- ❑ Difficulty Focusing
- ❑ Poor Memory or Concentration
- ❑ Night Sweats or Excessive Sweating

How would you currently rate your energy levels Low 0—1—2—3—4—5—6—7—8—9—10 High

Are you, or may you be Pregnant? Yes No

## Review of Systems

Please check any Symptoms you have experienced <u>at any time in your history:</u>

### Musculoskeletal:
- ❑ Tremors or Cramps
- ❑ Swollen Joints
- ❑ Pain or Weakness of Muscles

### Cardiovascular:
- ❑ Chest Pain
- ❑ Poor Circulation
- ❑ Swelling of Hands, Ankles, Feet
- ❑ Irregular Heart Beats
- ❑ Dizziness or Shortness of Breath

### Eyes, Ears, Nose, Throat, Respiratory:
- ❑ Asthma or Wheezing
- ❑ Allergies
- ❑ Blurred Vision or Visual Changes
- ❑ Eye Pain
- ❑ Loss of Hearing
- ❑ Earaches
- ❑ Ringing in the Ears
- ❑ Sore Throat

### Immune:
- ❑ Frequent Colds, Flus, or Infections
- ❑ Swollen Glands
- ❑ Long Recovery Following Infections

### Skin:
- ❑ Poor Wound Healing
- ❑ Easy or Unexplained Bruising
- ❑ Rashes
- ❑ Eczema
- ❑ Psoriasis
- ❑ Itching
- ❑ Dryness
- ❑ Frequent or Recurring Skin Infections

### Digestion:
- ❑ Gas or Bloating
- ❑ Abdominal Pain or Cramping
- ❑ Heartburn / Acid Reflux
- ❑ Difficulty Swallowing
- ❑ Nausea or Vomiting
- ❑ Poor Appetite
- ❑ Excessive Appetite
- ❑ Loose Stools or Diarrhea
- ❑ Undigested Food in Stool
- ❑ Blood or Mucus in the Stool
- ❑ Constipation or Difficulty Passing Stool
- ❑ Irregular Bowel Movements
- ❑ Pain or Itching of the Anus

### Sleep:
- ❑ Difficulties Falling Asleep
- ❑ Difficulties Staying Asleep
- ❑ Waking Unrefreshed
- ❑ Excessive Dreaming or Nightmares

### Genitourinary:
- ❑ Blood or Mucus in Urine
- ❑ Frequent Urination
- ❑ Difficulty Controlling Urine
- ❑ Urgency
- ❑ Kidney Stones
- ❑ Bladder Infections
- ❑ Lowered Sex Drive
- ❑ History of Sexually Transmitted Infections

### Men's Health:
- ❑ Erectile Difficulties
- ❑ Prostate Difficulties
- ❑ Discharge from the Penis

### Women's Health:
- ❑ Bleeding between Periods
- ❑ Clots in Menstrual blood
- ❑ Heavy or Excessive Menstrual Flow
- ❑ Scanty or Light Menstrual Flow
- ❑ Excessive Menstrual Pain or Cramping
- ❑ Irregular Cycles
- ❑ Difficulties Becoming Pregnant
- ❑ Difficulty Maintaining a Pregnancy or History of Miscarriages
- ❑ Menopausal Symptoms

Please list any health concerns not otherwise mentioned: ____________________________

How did you hear about us ____________________

**Thank you**

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## Consent to Treatment

I attest that the information provided on this form is correct to the best of my knowledge, and I consent to the treatment as I understand it. I understand that I am free to ask questions, and that I may withdraw my consent at any time.

Signature______________________________________ Date__________________