New Patient Form

A comprehensive understanding of you and your past and current medical health helps us provide you with the best medical care. Please complete the following form to the best of your abilities.

Patient Name *

Given Name(s) Last Name

PROVINCIAL HEALTH CARE NUMBER

** REQUIRED**

Preferred Name:

Date Of Birth *

Month Day Year

Patient Weight (kg's) *

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number *

Area Code Phone Number

Patient E-Mail *

example@example.com

Cell Phone

Area Code Phone Number

Relationship Status:

married, single, partnered etc.

Occupation

Emergency Contact Information

Name

First Name

Last Name

Phone Number

Area Code

Phone Number

Relationship

Personal Medical History

Have you ever had (Please check all that apply)

- ☐ Asthma/COPD
- ☐ Arthritis
- ☐ Cancer
- ☐ Gout
- ☐ Diabetes
- ☐ Emotional Disorder
- ☐ Epilepsy Seizures
- ☐ Fainting Spells
- ☐ Gallstones
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Sleep Apnea
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Neurological Disorders
- ☐ Bleeding Disorders
- ☐ Lung Disease

- [ ] Emphysema
- [ ] Skin Conditions
- [ ] Autoimmune Disease
- [ ] Depression/Anxiety

Please list any drug allergies

Other Illness:

Surgical And Acute History

Have you ever had surgery Or been treated for any acute conditions?

- ☐ Appendix
- ☐ Hysterectomy
- ☐ Gallbladder
- ☐ Fracture Repair
- ☐ Joint Replacement
- ☐ Tonsils/Adnoids Removed
- ☐ Cardiac/Stent

Pregnancies and Deliveries

- ☐ Yes
- ☐ No
- ☐ Vaginal
- ☐ Cesarean

Number of Pregnancies

Lifestyle- Check all that Apply

Alcohol Consumption

- ○ I don't drink
- ○ 1-2 glasses/day
- ○ 3-4 glasses/day
- ○ 5+ glasses/day

Tobacco

- ☐ 1-2 per day
- ☐ 3-4 per day
- ☐ 5+ per day

Vape Consumption

- ○ I don't Vape
- ○ 1-2 Times/day
- ○ 3-4 Times/day
- ○ 5+ Times/day

Exercise

- ☐ Daily
- ☐ 2-4 times per week
- ☐ 4+ times per week
- ☐ Never

Do you smoke?

- ○ No
- ○ 0-1 pack/day
- ○ 1-2 packs/day
- ○ 2+ packs/day

Drug Use

- ☐ Current
- ☐ Past

Marijuana

- ☐ Yes
- ☐ No

Allergies

- ○ YES
- ○ NO

Please Describe:

Biological Relative Medical History

Please Check all that Apply

Please Check All That Apply

	Parent	Aunt/Uncle	Grandparent	Child	Sibling	Unknown
Cancer	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○
Stroke	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○
Autoimmune	○	○	○	○	○	○
Liver or Kidney Disease	○	○	○	○	○	○

Other Illness Not Listed:

Medications

Please list all medications, vitamins and supplements that you are currently taking.

Other information you would like to share

Trauma, phobias, finacial stresses etc.

If this form is for a child please fill in this additional information:

Parent/Gaurdian Contact Information:

Name

First Name

Last Name

Phone Number

Area Code

Phone Number

Relationship to child:

Custody Arrangement

Name

First Name

Last Name

Phone Number

Area Code

Phone Number

Relationship to child:

Custody Arrangment

Other Health and Wellness Professionals or Resources

speech pathology, pediatrician, optician, individual learning plan, etc.

Eating following a diet

- ○ I have a loose diet
- ○ I have a strict diet
- ○ I don't have a diet plan