Adult Intake Form

First Name: ______________________ Initial: __________ Last Name: ______________________ Sex: M/F

Address: _________________________________ City: __________________ Postal Code: ____________

Home Phone: __________________ Cell Phone: __________________ Work Phone: __________________

Best number to reach you at: Home □ Cell □ Work □ Email: ______________________________________

Date Of Birth: __________________ Occupation: ____

Emergency Contact: _________________________________ Number: ____________________________

Relationship to you: _________________________________

How did you hear about our clinic? ____

What health concerns brought you to this office today? ______________________________________

____

____

If you are female, are you currently pregnant? Yes □ No □

List all current prescribed medications:

Drug name: _________________________ Dosage: ________________ Length Taken: _______________

Drug name: _________________________ Dosage: ________________ Length Taken: _______________

Drug name: _________________________ Dosage: ________________ Length Taken: _______________

Drug name: _________________________ Dosage: ________________ Length Taken: _______________

List all current non-prescription medication used (such as Advil, Tums, etc.): ____________________________

____

____

List all current vitamins, minerals and herbs that you take regularly: ____________________________________

____

____

____

List all allergies:

____

____

2425 Bloor Street West, Suite 205 Toronto, ON M6S 4W4
Tel: 416.551.3395 Fax: 416.551.4330 www.aspire-health.ca