ASPIRE MEDICINE

More Science.
Targeted Treatments.
Real Results.

Adult Patient Intake Form

Patient Information:

Patient's Full Name:_____ Preferred Name:_____

Date of Birth:_____ Sex (M/F/other):_____

Street Address:_____

City:_____ Prov:_____ Postal Code:_____

Email:_____ Phone Number:_____

Occupation:_____ Employer:_____ Hours work/week:_____

Marital Status (Select): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ With Partner ☐ Widow(er)

Person to call in case of Emergency:_____ Relationship to you:_____

Phone number contact for them:_____

How did you hear about our clinic?_____

Would you like to receive our email newsletter? ☐ Yes ☐ No

Would you like to receive appointment confirmation via email? ☐ Yes ☐ No

REASON FOR OFFICE VISIT: Please list in order of importance

1. _____
2. _____
3. _____
4. _____
5. _____

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Medical History:

Regular Family Physician:_____

Any previous blood work? If so, when:_____

List any Current / Past Diagnoses, Surgeries & Hospitalizations, including date occurred:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any past Imaging (i.e.: x-ray, CAT, MRI, ultrasound), including the approximate date, body area, and findings:

_____

Please indicate yes (Y), no (N), or past (P), regarding use of the following:

Antacids: _____ Laxatives: _____ Steroids: _____
Analgesics: _____ Birth Control Pills: _____ Intrauterine Device (IUD): _____

Family History:

Please check (✓) if any of the family members below have been diagnosed (at any time) with any of the following conditions:

	Autoimmune	Diabetes Mellitus	Obesity	Mental Illness	Cardiovascular Disease	Celiac	Cancer	Allergies / Asthma	Other
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Medications / Supplements:
Please list all medications, including their dosages, of any over the counter AND prescription medication you are currently taking:

_____

Please list all supplements, including their dosages, you are currently taking:

_____

Allergies:

Please list any known allergies to foods, drugs, environment, or animals:_____
Please list any suspected allergies to foods, drugs, environment, or animals:_____

LIFESTYLE:

Exercise: Do you exercise: ☐ Yes ☐ No If yes; What Type:_____How often:_____

Sleep: Hours per night:_____ Difficulties Falling asleep: ☐ Yes ☐ No

Difficulties staying asleep: ☐ Yes ☐ No

Quality of your sleep: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Do you wake refreshed: ☐ Yes ☐ No

Alcohol / Smoking / Recreational:Drugs:

Alcohol Consumption: _____ If yes/past; how much, how often:_____
Tobacco Use (including vaping): _____ If yes/past; how much, how often:_____
Recreational Drug Use: _____ If yes/past; how much, how often:_____

Environmental:
Any significant environmental exposures (i.e.: mold, living near refinery, known toxin / chemical / solvent / pesticides exposures):_____

Diet / Nutrition:

Do you have any dietary restrictions (i.e.: gluten free, vegan):_____
Water Intake (cups per day):_____Caffeine Intake (type & amount per day):_____
Other beverages consumed (i.e: soda, juice, tea - type, amount per day):_____

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Mental Emotional:

How would you rate your stress levels on a scale of 1-10 (10 highest):_____
What are your outlets for managing stress:_____

Over the **past 2 weeks**, how often have you been bothered by any of the following:

	Not at all (1)	Several Days (2)	More than half the days (3)	Nearly every day (4)
1. Little interest of pleasure in doing things	◯	◯	◯	◯
2. Feeling down, depressed, or hopeless	◯	◯	◯	◯
3. Thoughts you would be better off dead or hurting yourself in some way	◯	◯	◯	◯
4. Feeling nervous, anxious, or on edge	◯	◯	◯	◯
5. Worrying too much about different things	◯	◯	◯	◯
6. Trouble relaxing	◯	◯	◯	◯
7. Becoming easily annoyed or irritable	◯	◯	◯	◯
8. Times when you feel a sudden rush of intense fear or discomfort	◯	◯	◯	◯

9. Think about the biggest threat to life you've EVER witnessed or experienced. In the PAST MONTH how much have you been bothered by this experience?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
Not bothered at all — Extremely bothered

10. If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Goals:

What goal(s) do you have when it comes addressing your health concerns:_____

On a scale of 1-10 how committed are you towards making changes:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
Not at all — Depends — I will do whatever I can

Thank you for the information – we look forward to meeting with you!

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