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Adult Patient Intake Form

Patient Name:_____Date:_____Date of Birth:_____

Street Address:_____

City:_____Province:_____Postal Code:_____

Home phone:_____Work Phone:_____Cell Phone:_____

Email Address:_____

Highest level of education:_____

Occupation:_____Employer_____Hours worked/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:_____

Regular Physician: _____

How did you hear of the clinic:_____

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

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

List in Order of Importance what your problems are:

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

Last time you had blood work done and with what doctor:_____

www.AspireMedicine.ca
P: 403.347.4002 F: 403.347.4022 info@aspiremedicine.ca
101-4419 50th Avenue, Red Deer, AB, T4N 3Z5

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Family history

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living						
Age when died						
Reason for death						
	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Cancer (Type)	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
High Blood Pressure	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Heart Attack/Stroke	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Heart Disease	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Asthma/Allergies	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Mental illness	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
TB	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Auto----immune disease	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Diabetes Mellitus	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Osteoporosis	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐

List All Surgeries and Hospitalizations—including date occurred:

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

Please Note When and Why You Had Each of The Following:

X-rays: _____

MRI/Cat Scans: _____

Ultrasounds: _____

Accidents: _____

Last time you had a:

Dental Exam: _____

Eye Exam: _____

Please List All Sensitivities/Allergies/Reactions

Drugs: _____

Foods: _____

Environment: _____

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Select Yes, No, or Past, regarding use of the following:

Antacids: Past
Laxatives: Past

Steroids: Past
Analgesics: Past
Smoking: Past Packs per day if Yes/Past:_____
Coffee: Past Cups per day if Yes/Past:_____
Soda Pop: Past Ounces per day if Yes/Past:_____
Alcohol: Past How often and how much if Yes/Past:_____

Any alcohol addiction: Past
Any alcohol treatment: Past

Recreational drugs: Past

Any drug addiction: Past

Any drug treatment: Past

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

_____

_____

Present Weight:_____ Weight one year ago:_____
Height: _____ Maximum weight and when:_____
Minimum Weight as adult and when: _____
Ideal Weight:_____

Exercise:

How often:_____
What type(s):_____
For How long:_____

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Hobbies:

_____

_____

Sleep:

How many hours per night: _____

Any troubles falling asleep: _____

Any troubles staying asleep:_____

If you wake up frequently, what is the reason: _____

Food:

Appetite Good?: _____

Foods crave: _____

Foods that don't sit well:

Toxin Exposure:

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:_____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:_____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?:_____

Are you particularly sensitive to perfumes, gasoline, or other vapors?:_____

Do you use pesticides, herbicides, other chemicals around your home?_____

_____

Social Life:

Enjoy job?: _____

Active Spiritual practice: _____

Quality of most significant relationship?_____

What is your greatest health concern?_____

How does it limit you the most? _____

How committed are you towards making valuable changes: ◉ Little ○ Moderately ○ Very

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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 or 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 first-hand. 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 ☐

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