Tri-City Wellness Centre Inc.
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Winter Health Intake Form

Date: ____________________

Birthdate: ____________________

Name: ____________________

Mailing Address: ____________________

____

____

E-mail Address: ____________________

Telephone: ____________________ Home

____________________ Work

____________________ Cell

Please * telephone preference for appointment reminders.

General Health History

Immunizations

1) Have you had the flu shot in the past 5-10 years?
   a) If so, which years: ____________________
   b) Have you ever had a noticeable reaction to a flu shot? ____________________
   c) Have you ever had a noticeable reaction to any vaccination? ____________________
2) Have you contracted a *true* flu (much more serious than the common cold) in the past 5-10 years?____________________
3) How many travel vaccinations have you had in the past 5-10 years? ____________________
4) Any noticeable reactions?____________________

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General Immune System

1) On average, how frequently do you catch colds (ear, nose, throat, etc.)?

2) Where do you suffer cold symptoms the most (throat, lungs, sinuses, ears, etc.)?

3) Do you have any allergies or sensitivities?
   a) Foods:
   b) Environmental:

4) Current medications (prescription or over-the-counter)?

Health History

What other health concerns do you have?

1) General immune system function:
2) Asthma/Bronchitis:
3) Skin:
4) Digestion:
5) Mental/Emotional (stress, anxiety, depression, etc.):
6) Energy levels/fatigue:
7) Seasonal health issues (such as Summer allergies, Winter SAD, etc.):
8) Aches and pains:
9) Other:

Do you have a family history which contains?

Heart Disease	□ no	□ yes	Cancer	□ no	□ yes	Tuberculosis	□ no	□ yes
Allergies	□ no	□ yes	Asthma	□ no	□ yes	Mental illness	□ no	□ yes

Other

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General Lifestyle

1) Your *hydration* level:

   a) How much pure water do you drink daily? ______________

   b) How much of everything else do you drink per day?

   Coffee ________ Tea __________ Pop __________ Juice ________ Alcohol ________

2) *Sleep*

   a) How much do you sleep on the average night? _______

   b) Do you generally have a refreshing sleep (full of energy and ready to tackle the day)? □ no □ yes

   c) If not, what disturbs your sleep? ______________________________

3) *Food and Activity*

   a) Blood Type (A, B, AB, or O)? ______________

   b) Vitamins and supplements: ______________________________

   c) If your diet and lifestyle were a best-selling health fad book, what would it be called, and what would be its main principles? ______________________________

4) *Stress Scale*

   a) On a scale of 1 to 10 (1 the lowest, 10 the highest), how would you rate your own stress level? ______________

   b) Where do you "hold" your stress? How does it impact your health? ______________________________

5) *General Well-being*

   a) How would you describe your overall happiness and satisfaction in your life (personal, family, work, etc.)?

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