# Adult Intake Form

## Personal Information

Name: _____

Date of Birth: _____ Gender: _____

Address: _____

Telephone Number:
Home: _____ Work: _____ Cell: _____

Email Address: _____

Preferred method of contact: Email Home phone Work phone Cell

## Emergency Contact Information

Name: _____ Relation: _____

Telephone Number: _____

## Other current Health Care Providers

Name: _____ Name: _____ Name: _____

Specialty: _____ Specialty: _____ Specialty: _____

Phone: _____ Phone: _____ Phone: _____

## Health Goals

What are your health concerns and goals, in the order of importance to you:

1. _____

2. _____

3. _____

4. _____

5. _____

## Health Habits

Occupation: _____

What behavioral or lifestyle activities are you currently engaged in to promote your health?

_____

_____

What behavioral or lifestyle activities are you currently engaged in that could be harming your health?

_____

_____

Do you exercise regularly? Y N What form and how often? _____

Do you currently smoke? Y N If yes, how many per day? _____

Do you regularly drink alcohol? Y N If yes, how much and how often? _____

### Medical History

Please indicate any previous diagnoses not listed above

1._____

2._____

3._____

Please indicate any serious conditions, illnesses, or injuries, and any hospitalizations. Please include approximate dates.

1. _____ 2. _____

3._____ 4. _____

5._____ 6. _____

Do you have any allergies (medicines, environmental, food, etc)

1._____

2._____

3._____

Please list all current medications (prescription and over-the-counter)

1._____ 2._____

3._____ 4._____

5._____ 6._____

Please list all past medications

_____

Please list all current natural health products

1._____ 2._____

3._____ 4._____

5._____ 6._____

Do you get regular screening tests done by another doctor (PAP, blood tests etc) Y N

Last time regular blood work was performed _____

Last time screening physical exam was performed _____

Last time diagnostic or screening imaging was performed _____

**Family Health History**

Please indicate if anyone in your family has experienced or is experiencing any of the following conditions and indicate your relation (i.e. mother, father, sibling, child, grandmother, grandfather)

Alcoholism _____ Depression/anxiety _____

Allergies (specify)_____ High blood pressure_____

Arthritis _____ Heart Disease _____

Asthma _____ Stroke _____

Cancer (specify)_____ Osteoporosis _____

Diabetes _____

**How did you hear about Little Oak Wellness? (circle all that apply)**

Patient Referral
Advertising (Brochure)
Media (Radio)
Website
Social Media (Facebook)
Information Session


**Little Oak Wellness Cancelation Policy**

Initial ☐

In order to keep appointments running smoothly, we ask that you arrive at your appointments in a timely manner. Patients arriving more than 15 minutes late will be considered a "no-show" and will be required to reschedule their appointment for another time. If it is necessary that you cancel your appointment, we ask for 24 hours notice prior to your appointment time.

Any patient who fails to come to an appointment without notice to the clinic, **will be charged the full fee of the missed appointment**. Any patient who arrives more than 15 minutes late, or who cancels less than 24 hours prior to their appointment **will be charged 50% of their appointment fee**.

**Reminder Calls**

Initial ☐

In hopes of avoiding missed appointments and cancelation fees, Little Oak Wellness will make reminder calls 1-2 days prior to your appointment or emails 1 day prior to your appointment. If you would like a reminder call, text, or email, please sign below and indicate which telephone number or email you would like it to be made to.

Telephone number: _____ Call ☐ Text ☐

OR

Email:_____

**Collection of Personal Information**

Initial ☐

Personal information is collected under the authority of the *Regulated Health Professionals Act* and related legislation and in accordance with the *Personal Health Information Protection Act.* We collect only the personal information needed to provide service. Your information may be shared with others as required or permitted by law. For more information please ask to see our full Privacy Policy or see the privacy statement on our web-site at www.littleoakwellness.ca

**Circle of Care Policy**

Initial ☐

In order to provide optimal care in an integrated, complimentary health clinic, a circle of care model is beneficial. Information will only be shared with practitioners within Little Oak Wellness Center or with other practitioners in your circle of care. Practitioners will not have direct access to your records unless you have provided direct consent. Only the minimum amount of information will be shared to ensure quality of service is provided and information transfers are done in a secure manner. For more information, please request to see our full Privacy Policy.

I, _____, am providing permission to the practitioners of Little Oak Wellness Centre to share personal health information within the clinic's circle of care.

Please sign below indicating that you have read and acknowledge the above outlined policies of Little Oak Wellness Center.

Signature: _____ Date: _____